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UTMB's History of Care for the Indigent

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UTMB's History of Care for the Indigent

by

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Dedication

Ruth V. Peterson Forman

Acknowledgements

During my years at the *Detroit Free Press*, from 1972 to 1989, I was member of The Newspaper Guild, the union representing most reporters, editors, photographers, and the like (known collectively as editorial workers) at the newspaper. Early in that time frame, Guild representatives negotiating a new contract rejected the company's offer to use a small portion of a negotiated increase to pay health insurance premiums for employees, who were bearing the entire cost themselves, albeit at the reduced group rate. The Guild officials' reasoning at the time was that the benefit would not apply to every union member, because some had working spouses in other businesses who carried the journalists on their company health plans. The fact of the matter was, ten cents an hour (or some ludicrously low figure) was a miniscule amount for health insurance, even then. At the next union election, the single-minded representatives were turned out. Their replacements sought the same offer at the next round of contract negotiations. As I recall, the company asked for another nickel out of the increase, but the Guild members agreed it was worth it.

At the time, my spouse was one of those whose insurance coverage included me—at his company's expense. Nevertheless, I wanted the opportunity to apply for *Free Press* health benefits if I needed them. Some years later, I did. But, during those years when the employees had to pay for their own health coverage, even though the premiums

were relatively low, they still were more than some of my colleagues could afford. Several co-workers who were single parents paid for their own health insurance, and then prayed every day their children would not hurt themselves so badly as to require a trip to the pediatrician or emergency room. After the new benefit was added, since their own premiums were, for all intents and purposes, free, they could afford to add the rest of their families.

Ever since then, I have advocated some form of universal health insurance and maintained an interest in health policy. As a student in the Institute for the Medical Humanities (IMH), I was able to enroll in courses about health policy, access to care, and health care legislation, which provided the background for this thesis. William Winslade, J.D., Ph.D.; Laura Hermer, J.D., L.L.M.; and Patricia Gray, J.D., L.L.M., taught the courses. Subsequently, when I decided to pursue the topic of UTMB's history of care for the indigent, Laura and Patty helped focus the document and provided advice, encouragement, and assistance as the project moved forward.

A very key ally in obtaining information about legislative activities is Laura Smith, J.D., M.A., Assistant Vice President for Legal Affairs and the Austin voice for the University of Texas Medical Branch (UTMB). Laura provided the tables in chapter 2 that are essential in clarifying the State Legislature's actions related to UTMB finances and confirmed details with State Senator Bill Ratliff about why the Texas Senate would not consider the university's plan to pay for an indigent care program with an additional penny of sales tax in Galveston County. More important, she reviewed the second chapter and guided me with some language that more specifically conveyed what happened in the State Legislature in recent years. Laura also introduced me virtually to James C. Guckian, M.D., a UTMB faculty member and Vice President for Medical Professional Affairs in the late 1980s and University of Texas (UT) System Executive Associate for Health

Policy and Planning in 1988-1999. Dr. Guckian clarified information about how state officials moved into the state general revenue fund the federal Disproportionate Share Hospital dollars that UTMB had identified and was using to support unsponsored care.

Speaking of finances, Lawrence E. Revill, Vice President for Finance, and his staff in the Office of Decision Support, James Kitchen and Andrea Cortinas, were very helpful in providing information about the hospitals and clinics income and expenses for unsponsored care over the last several years.

Ben G. Raimer, M.D., Vice-President and Chief Executive Officer, Community Health Services, and his directors in the Office of Community Health Services, Rebecca T. Walsdorf, Executive Director Community Health Promotion, and Kathleen M. Tiernan, Program Manager for Health Outcomes, were extremely helpful in explaining the activities of their office that increase preventive care as well as accessibility for indigent, under- and uninsured people in the community. Dr. Raimer also explained the impact of health maintenance organizations and the managed care movement on UTMB in particular and hospitals in general.

Another key member of the university's leadership who was a wealth of historical background is Alvin L. LeBlanc, M.D., Associate Dean Emeritus for Graduate Medical Education. Al, as he asked me to call him, explained the details of UTMB's first outreach to the counties through what is now the Regional Maternal and Child Health Program, as well as the evolution of the contracts with the Texas Department of Criminal Justice (TDCJ), the prison hospital, and Correctional Managed Care. The TDCJ automatically brings to mind the Electronic Health Network (EHN), with which physicians at UTMB see incarcerated patients throughout the state's prison system. Glenn G. Hammack, Ph.D., Assistant Vice President and Executive Director of the EHN, provided the information for chapter 4 about the network's planned forays into retail health clinics, as

well as background on how Wal-Mart is developing its in-store convenient clinic programs with physicians and hospitals in areas where it has stores.

My deepest gratitude goes to my thesis committee, Jason G. Glenn, Ph.D., Assistant Professor of the History of Medicine, IMH, chair; Harold Y. Vanderpool, Ph.D., Th.M., James Wade Rockwell Professor in the History of Medicine and Dr. and Mrs. Joseph T. Painter Distinguished Professor in Teaching Excellence, IMH; and John D. Stobo, M.D., John P. McGovern Distinguished Chair in Oslerian Medicine and Executive Director for Academic Programs, UT System Office of Health Affairs. All three have a sincere interest in access to health care and each comes to the topic from a different perspective. Their insight and input, I believe, added texture and interest to what might otherwise be a dry topic. Anne Hudson-Jones, Ph.D., Hobby Family Professor in the Medical Humanities and IMH Graduate Program Director, put her blue pen to work in checking formatting on this paper. Her invaluable aide, Donna Vickers, Administrative Coordinator, Graduate Program, came through time and again with answers to key questions and kept me on deadline throughout this process.

An IMH alumna, Patricia Jakobi, Ph.D., who helped the late Dr. Chester Burns with the research on his 100-year history of UTMB, *Saving Lives, Training Caregivers, Making Discoveries: A Centennial History of the University of Texas Medical Branch at Galveston,* gave me background material and regular encouragement to nudge me through the research, writing, and editing process. Likewise, Sarita Oertling, Library Services Manager, in the Blocker Collection of the Moody Medical Library, was always on hand to guide me through the voluminous files in Dr. Burns' Centennial History Project, as well as other material in the archives of Presidents Truman G. Blocker and William C. Levin. My good friend, Suzanne Simpson, deserves special recognition for taking the time to perform final copy editing on this tome, and I really appreciate her

eagle eye and sharp pencil in identifying and fixing awkward phrasing, potentially missing information, and hundreds of serial commas, about which I forgot to tell her.

Saving the best for last, I will never be able to fully express how important my husband, James A. Bremer, has been in supporting and encouraging me along the path of obtaining this degree and pursuing the year or more of effort I have taken to complete the research and writing on this thesis. His love and belief in my ability to see this through have guided every step.

UTMB's History of Care for the Indigent

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Today, 24.1 percent of Texas inhabitants have no health insurance, by choice or happenstance; medical inflation is approximately 6 percent annually; and federal support for indigent health care is eroding in the face of a war in the Middle East. With the 2008 race for the presidency of the United States in full swing, however, candidates increasingly are focusing on providing some kind of health care coverage for the 15.6 percent of U.S. citizens who live—and die—without it. Thus, with this national focus, one can see that the crisis of finding ways to pay for treating unsponsored patients is not unique to Texas nor to UTMB.

Nor is this issue new to the contemporary era. Even before Texas voters in 1881 selected Galveston as the location for the Medical Department of the University of Texas, the island city was the home of the Texas Medical College and Hospital, founded with the notion that serving paupers was part of its mission. When the medical department opened ten years later, that mission transferred to the new institution, known today as the University of Texas Medical Branch at Galveston (UTMB). Ever since, it has been considered the charity care provider for the state, as the home of the John Sealy Hospital,

the only full-service hospital owned by the State of Texas. The state, however, viewed care of paupers (including maintaining their health) as a local prerogative, and delegated that responsibility to the counties without providing an enforcement mechanism, nor requiring any financial allocation toward that end.

This paper will review the history of UTMB *vis a vis* its mission of providing health care for indigents and uninsured; examine the role of the State Legislature in helping or hindering UTMB in caring for patients who cannot pay for their treatment; discuss measures enacted by other states that are models for pilot programs the state hopes will recover or reduce uncompensated health care costs; and propose some solutions currently being undertaken or that UTMB may consider to address the problems.

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Introduction

It comes as no surprise to anyone who pays attention to the news that rising health-care costs have put more and more people into the ranks of the uninsured. In an apparent paradox, even as household incomes rise and the poverty rate declines, the number of individuals and families who do not have health insurance goes up. Why? The answer is almost simple: Over time, U.S. citizens have by and large assumed that medical expenses should be covered by insurance or borne by the government, and most Americans' source of health coverage is their employers. Job creation in the United States—usually during good economic times—is largely among small businesses, which hire employees as demand for their goods and services increases. The problem is that small businesses tend to pay lower wages and to have smaller operating margins. Meanwhile, health-care inflation averages about 6 percent annually (for 2007, it was 5.2 percent). In comparison, at the end of 2007, the national measure of inflation, the Consumer Price Index, was about 4 percent.[1] As a result, the cost of health care rises faster than the cost of doing business, so small business owners (with little room to absorb those costs) choose to reduce benefits, increase workers' premiums, co-pays, and deductibles, or eliminate health insurance altogether. Most often, they choose the last.

In Texas, the problem is worse because only 31 percent of companies with fifty employees or fewer provide health coverage, against 43 percent nationally. As a result, 24.1 percent of the population does not have health insurance. On top of that, in order to

[1] Bureau of Labor Statistics, "Consumer Price Index: December 2007," United States Department of Labor, January 16, 2008, http://www.bls.gov/news.release/pdf/cpi.pdf (accessed February 1, 2008). These are not audited numbers.

qualify for Medicaid, the maximum annual income a family of three may earn is $4,822, the lowest in the nation and at the bottom of the federal limits.[2] Meanwhile, the state of Texas estimates that 23 percent of all Galveston County residents lack health insurance, as opposed to 15.6 percent of the national population. The Office of the Texas Comptroller estimates that 59 percent of those have incomes under 200 percent of poverty.[3] The overall rate of county uninsured would be higher were it not for the Children's Health Insurance Program. That program insures children whose families' incomes exceed county eligibility levels for Medicaid (21 percent of the Federal Poverty Level [FPL] or $3,606 for a family of three) but are less than 200 percent FPL. The 2007 FPL for a family of three is $17,170; 200 percent FPL would be $34,340.[4]

This lack of health insurance is an issue for the University of Texas Medical Branch at Galveston (UTMB) as the only full-service hospital and academic medical center owned by the state. By law, every patient who comes to its emergency department (ED)—or that of any hospital in the country, for that matter—must be seen and stabilized, no matter what his or her insurance status may be. With a high proportion of state and local residents uninsured, the number of people who go to the ED for health-care services for which they cannot pay is understandably high, as well.

EARLY HISTORY

Caring for uncompensated patients at UTMB was not always a problem. In fact, the Galveston hospitals that preceded the establishment of the university received charity

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[2] Richard Wolf, "What Does a Health Crisis Look Like? See Houston," *USA Today*, June 18, 2007.

[3] Office of the Texas Comptroller, "The Uninsured: A Hidden Burden on Texas Employers and Communities," April 2005, http://www.window.state.tx.us/specialrpt/uninsured05/ (accessed January 31, 2008).

[4] U.S. Department of Health & Human Services, "The 2007 HHS Poverty Guidelines: One version of the [U.S.] Federal Poverty Measure," January 23, 2008, http://aspe.hhs.gov/poverty/07poverty.shtml (accessed February 16, 2008).

patients, whose care was covered by paying patients, city allotments, and philanthropy. When the state's first medical college, Galveston Medical College Hospital, opened on the island in 1871, the students learned their profession at the bedsides of paupers and indigents. The practice continued after the Medical Department of the University of Texas opened in 1891, subsuming the Texas Medical College and Hospital (which had succeeded Galveston Medical College in 1873) and some of its physician/professors, who believed it their duty to take care of the poor. At the time, a pauper or an indigent was defined as an individual who has:

> neither money nor estate, is without credit, and unable to maintain himself because of inability to work or to obtain employment … [or] though he has property of his own, it is not available for his immediate relief, or is manifestly disproportionate to his needs.[5]

Throughout its early history, Galveston was a center of commerce, trade and immigration. The U.S. Congress made the island an official port of entry in 1837, eight years before the Republic of Texas became one of the United States. In 1839, with construction of the Galveston wharves, exports to foreign countries exceeded $1 million.[6] Europeans fleeing revolutions in their homelands during the 1840s and 1850s arrived in the island city on the Gulf of Mexico, where they built homes for themselves and others. Steamer ships also hauled cargo between Galveston and New Orleans.[7]

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[5] Jose Jorge Anchondo, "Medically Indigent Costs Affecting Local Governments: Background and Issues," Intergovernmental Report No. VIII-1 (Austin, TX: second printing, October 1983), Texas Advisory Commission on Intergovernmental Relations, June 1980, 3-4.

[6] Samuel H. Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1790-2006," *MeasuringWorth.Com*, 2007, http://www.measuringworth.com/uscompare/ (accessed January 13, 2008). Equivalent value in 2005 dollars, using the Consumer Price Index, is $1,000,000=$21,651,884.70.

[7] *Handbook of Texas Online*, s.v. "Galveston County," http://www.tsha.utexas.edu/handbook/online/articles/GG/hcg2.html (accessed December 29, 2007).

That same shipping industry also transmitted the eight yellow fever epidemics that struck between 1839 and 1867, killing hundreds at a time, and laying the foundation for Galveston's selection as the state's first academic medical center.

Throughout its 117-year history, UTMB's financial situation has endured highs and lows, due to the state of the economy at the time, political sentiment at the local and state levels, and the ability of the school's administration to convince the UT Board of Regents and the Legislative Budget Board of the need for financial assistance for the hospital. Chapter 1 will review those eras in terms of the individuals, organizations, and government agencies who covered the costs of caring for patients who could not pay for it themselves and how the university coped with those costs.

During its earliest eras, paying patients, the City of Galveston, and philanthropists (primarily John Sealy's widow and children) covered operating losses for the John Sealy Hospital, largely attributable to caring for paupers. In fact, John Sealy II and Jennie Sealy Smith modeled the Sealy & Smith Foundation after major East Coast family philanthropies, such as the Rockefeller and Carnegie Foundations, with the sole purpose of creating a source of permanent support for the hospital.

In 1941, the state and the regents took over hospital management from the city, which allowed UTMB to solicit referrals of indigent patients from county officials and physicians from across Texas, in order to increase the caseload for teaching purposes. While the first purpose of the university is teaching medical professionals, and of course a large number and variety of patients are required for that purpose, this move exposed the hospital to operating deficits that have rarely abated.

What might be considered a golden era in terms of UTMB growth and favor on the part of the State Legislature and the regents occurred from the mid-1960s through the 1970s. A number of factors during those years contributed to this: a growing state and

national economy, the advent of the federal Medicare and Medicaid safety net insurance plans for the aging and indigent populations, and charismatic UTMB Presidents Truman G. Blocker, Jr., and William C. Levin, who were home grown physicians with ties throughout the community and state. Even so, as the 1970s waned and the 1980s dawned, academic medical centers across the land began a painful period: the economy faltered; inflation rose dramatically; and health maintenance organizations and managed care strategies cut deep into hospital operating margins.

Toward the end of the 1980s, UTMB officials negotiated indigent care contracts with eight counties, which paid for care to unsponsored patients not eligible for Medicaid. Even though the contracts were for care at one-third the private rate, they brought in revenue UTMB would not otherwise have had. By 1991, contracts with sixteen counties and three hospital districts contributed $5.8 million toward indigent care.[8] In January 2007, UTMB had contracts with forty-four counties and four hospital districts for indigent care.[9] Income from these contracts amounted to approximately 2.4 percent of UTMB unsponsored care revenues and expenses revenues for 2006.[10]

In 1999, UTMB implemented the Demand and Access Management Program (DAMP), intended to relieve the financial drain of uncompensated care to patients from

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[8] Burns, 94; Williamson: $5.800,000 = $8,316,740.

[9] Office of Community Health Services, "County Contract Status—Effective January 2007," Galveston: University of Texas Medical Branch, http://www.utmb.edu/osainfo/CountyInfo/CountyContracts.htm (accessed July 3, 2007). Link accessible only to UTMB internal users. The contracts are for managed care for these patients. The other counties in the state whose indigent patients seek care at UTMB have hospitals of their own, where these patients are supposed to go first. They are referred to specialists at UTMB.

[10] Office of Finance, Decision Support, "The University of Texas Medical Branch Unsponsored Care Revenues and Expenses for Fiscal Year August 2006 (in millions)," December 18, 2007; obtained from the UTMB Finance Department; and Office of Community Health Services, "The University of Texas Medical Branch at Galveston Indigent Health Care and Treatment Act County Indigent Care Contract Services," September 1, 2005, through August 31, 2006; obtained from the UTMB Office of Community Health Services.

throughout the region who live in counties without one of these contracts. The DAMP measures include:

- Pre-registration by trained administrators or financial screeners to determine payment method before any patient receives an appointment.
- Charity (medically indigent) patients from counties contracting with UTMB must have a referral from a primary care physician or clinic and an indigent care card provided by the county indigent care coordinator. Co-pay fees also are required.
- Patients not covered by any payer or county contract, those requesting services that are not covered, or patients from contract counties seeking primary care services at UTMB are asked to pay 25 percent of the standard reimbursement prior to care if their income is documented to be below 250 percent of the poverty index. If their income is above 250 percent of the poverty index, they are asked to pay half of the standard reimbursement prior to care.[11]

Through the Office of Community Health Services, the university also has taken a variety of steps to increase access and model preventive self-care for unsponsored patients with chronic diseases and mental health problems in Galveston, LaMarque and Texas City, participating with community, nonprofit, and nongovernmental organizations. Other programs in conjunction with adjacent counties have proved success, as well.

Recommendations from the Chicago-based health care consulting firm, Navigant Consulting, Inc. (NCI), cut a wide swath through UTMB in 2006. Among the steps NCI recommended were to "achieve labor expense saving opportunities" in the hospitals and clinics ($22 million), institutional support ($12 million), School of Medicine ($31

[11] John D. Stobo, "A Message from President John D. Stobo: The Demand and Access Management Program" (Galveston: University of Texas Medical Branch, 1998): 2-3, http://www.utmb.edu/president/damphome.htm (accessed May 1, 2005). DAMP has undergone a number of revisions since it was first implemented, but these policies still generally apply.

million), Correctional Managed Care ($2.7 million), and other schools ($1.1 million); "achieve supply expense savings" of $11 million; enhance revenue by about $16 million via "tightening financial screening policies, improving accuracy of information collected, monitoring contract compliance and reducing accounts receivable."[12] At a Town Meeting on May 7, 2007, President John D. Stobo said the university's financial situation had improved in the first half of fiscal year 2007 (as of March 1, 2007) to a positive margin.[13]

THE LEGISLATURE

From the 1940s, when the state sought control of the UTMB hospital enterprise, to today, University of Texas officials, members of the Board of Regents, and UTMB executives have had to use every tactic at their disposal to obtain enough operating money from the State Legislature. Chapter 2 reviews its role in financing UTMB in its mission to serve the indigent, during the eras of 1891-1940, 1941-1969, and 1970 to the present.

The main University of Texas campus in Austin absorbed most of the allocations between 1881 and 1891. In fact, had not the Sealy family built and supported the hospital for its first fifty years, the academic medical center may well have been displaced. The City of Galveston managed the hospital throughout this period, but the regents assumed that responsibility in 1941. Along with that came costs they had not anticipated. Meanwhile, new academic medical centers in Houston and Dallas drew legislative attention—and funding. The cost of patient care in those cities was not a concern for them, however, because the hospitals affiliated with the medical schools were financed and managed locally via hospital districts.

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[12] Navigant, 28-29.

[13] John D. Stobo, "Town Meeting" (Galveston: University of Texas Medical Branch, May 7, 2007), Webcast: http://www.utmb.edu/townmeeting/#webcast (accessed May 13, 2007).

After a survey by the Texas Department of Human Resources in 1981 found that 28 percent of the poverty population in the state had no health insurance of any kind, the State Legislature established the Task Force on Indigent Care, which issued a comprehensive report in December 1984. In its introduction, the report laid out the crux of the problem:

> Indigent health care is an issue which affects all Texans, not just poor individuals in health crisis. The longer the problem is ignored, the more expensive the consequences become for everyone.… Ambiguous state statutes regarding county responsibility and restrictive state and federal programs have resulted in great disparities in the tax burden in different parts of the state. The inequities among health care providers threaten the viability of certain types of hospitals, and create disincentives to providing services to the poor and uninsured.[14]

The group's 50 recommendations were divided into three categories: "allocation of responsibilities for providing and financing indigent health services;...priorities for those services which should be included in the responsibilities of governments and providers;...and proposals for addressing issues requiring further consideration." In a summary statement, the task force said:

> The major recommendations...propose including many more individuals in tax-supported programs, which would finance a greater portion of the demand for free care, with additional revenues derived from federal income taxes, state general taxes, as well as local property taxes.… [And that] the balance of indigent care costs remaining after the expansion of private and tax-supported insurance programs should be more equitably distributed among public and private hospitals.[15]

It is unclear what came of those recommendations because the problems remained. In the meantime, the U.S. Congress in 1981 passed the Omnibus Budget Reconciliation Act, which contained the Boren Amendment, establishing the Disproportionate Share Hospital (DSH) reimbursement system to compensate hospitals

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[14] Helen J. Farabee, Gordon Arnold, Chet Brooks, et al., "Task Force on Indigent Health Care: Final Report, December 1984," www.lrl.state.tx.us/scanned/interim/68/in2.pdf (accessed June 12, 2007), 1.

[15] Ibid., 3-4.

for revenues lost from serving a disproportionately large number of Medicaid and other low-income patients. UTMB did not begin to receive DSH reimbursements until 1987, however. In the early 2000s, because Medicaid reimbursements are lower than those for Medicare, a second class of reimbursement, called Upper Payment Limit (UPL), was created in an attempt to close this gap, as well.[16]

In about 1990-1991, the office of Lieutenant Governor Bob Bullock learned of the federal DSH income for UT System Hospitals, and worked out an arrangement for the federal dollars to go to the state General Revenue Fund, from which UTMB, UT M.D. Anderson Cancer Center and UT Health Center at Tyler would receive their usual state allocation, plus some extra to support indigent care. For UTMB at the time, the additional allocation was $30 million, which was about the amount it had been receiving. Since that time, however, UTMB has received none of the DSH reimbursement from the state; but the state allocation in lieu of DSH for years was not nearly the amount the hospital was spending on indigent care and reported to the Centers for Medicare and Medicaid Services via the state. Any net gain through DSH goes to the state general revenue fund, rather than to UTMB.

Today, the State Legislature is testing a variety of solutions in hopes that at least one of them will bring some kind of insurance coverage to the 24.1 percent of Texans currently without it. Should that happen, it presents a good news-bad news scenario for UTMB. The good news will be that all of the unsponsored patients who currently come to Galveston for their health care will have insurance to pay for it. The bad news is that these patients will not *need* to come to Galveston because their community doctors will take them—and the insurance dollars they will bring along.

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[16] David C. Warner, Lauren R. Jahnke, and Kristie Kimbell, "Medicaid and the State Children's Health Insurance Program in Texas: History, Current Arrangements, and Options," *Code Red*, Appendix B (April 2005), B-8, B-18–B-19.

MODELS FROM OTHER STATES

The Texas Legislature ended the 2007 session passing Senate Bill 10 (SB10), authorizing new Medicaid and indigent health-care programs and pilots. Most of those programs derived from those implemented by other states that were attempting to increase the number of insured residents or enhance benefits for those already covered by state and federally financed health-care programs. The third chapter will discuss those states' initiatives, as they are reflected in the Texas legislation. Most of the other programs were instituted since 2005, which is not enough time to determine whether they are accomplishing their expected goals. It is not within the scope of this thesis to thoroughly evaluate the programs. Rather, they are discussed as models. Because SB10 established most of its initiatives as pilot programs, with reports to the Legislature and other state officials due before the 81st session (which begins in January 2009), one can question whether that is enough time to evaluate their effectiveness.

Consultant Sellers Feinberg conducted an evaluation of SB10 and its provisions for the Texas Health and Human Services Commission, and delivered its report, "A Vision for Texas Health Care Reform," on May 8, 2007. The report notes that the state's total health-care expenditures in 2004 of $107 billion put Texas' spending at third in the nation. Yet, the state still has the highest rate of uninsured residents, 24.1 percent, or 5.5 million individuals. For the most part, the uninsured do not seek primary or preventive health care. Rather, they wait until their ailments are at a critical point, when they seek attention at the ED of a hospital. This leads to higher costs.

> Given the high numbers and cost of care for the uninsured, Texas employers pay higher insurance premiums to support the cost of care for the uninsured. These high premiums, in turn, make it increasingly difficult for small businesses to provide health insurance to their employees, contributing to the high rate of

uninsured and creating a greater challenge for Texas businesses to compete economically.[17]

Thus, the goals of SB10 include increasing employer-sponsored insurance, adding new business opportunities for individual and small-group insurance plans, enhancing the state's high-risk pool and other coverage, while emphasizing beneficiaries' sense of personal responsibility by providing incentives to improve their health.[18] The provisions also follow key points of President Bush's "Affordable Choices" program, including supporting the commercial insurance market by subsidizing premiums for private policies, diverting beneficiaries to a more limited benefit package, while encouraging cost-sharing and personal responsibility, and improving management and coordination of care for Medicaid recipients.[19]

POSSIBILITIES

Solutions to the issue of financing health care for those who lack the ways and means to pay for it need to be addressed on a national level, because national policies affect local reimbursement for uninsured patients. For more than a decade, ever since the Clinton administration's attempt to establish universal health care in the early 1990s, presidents and Congressional leaders have implemented politically conservative health-care measures that appease senators and representatives on both sides of the aisle. Even so, health-care costs continue to rise at about 6 percent per year, fewer employers and their workers can afford to pay the ever-higher health insurance premiums, and more individuals and families find themselves uninsured.

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[17] Sellers Feinberg, "A Vision for Texas Health Care Reform," Texas Health and Human Services Commission (Austin, TX, May 8, 2007) 7, http://www.hhs.state.tx.us/medicaid/HealthCareReform.pdf (accessed September 13, 2007).

[18] Ibid, 5.

[19] Ibid, 10-11.

The final chapter not only will look at suggestions for national solutions from the Commonwealth Fund (more general) and the Public Policy Institute (more specific), it also will review proposals on a local level, such as creating a multi-county health district for the hospital. However, a greater portion of chapter 4 will discuss programs that have been undertaken and proposed in Galveston—primarily by the Office of Community Health Services, working in concert with county governments and local nongovernmental organizations—that, in the process of making health care more accessible to the unsponsored and indigent, save the institution money and enable UTMB to continue its mission.

Some alternatives will be suggested that may hold promise for at least reducing costs for the number of indigent patients who arrive at the ED because their ailments have advanced to crisis stage, and they believe they have nowhere else to turn. One of these is a UTMB version of the retail or convenient care clinic, taking advantage of the institution's highly regarded Electronic Health Network (EHN) capabilities. Using the same mechanism, another suggestion that will simultaneously help train future medical professionals is to establish evening and weekend clinics in Galveston elementary schools, which are within walking distance of nearly every resident.

One program UTMB introduced in Texas is Three-Share, a limited-benefit HMO that was adopted by the State Legislature in part of SB10. Modeled on a successful plan in Michigan, Three-Share would be available to small businesses and their employees. The company would pay one-third of an affordable monthly premium, each employee would pay one-third, and UTMB would cover the rest through state and federal allocations. However, none of these alternatives is a panacea that will insure large numbers of indigent patients, *and* make UTMB solvent, *and* still provide the number of

medical cases the academic medical center requires to teach its students and train its residents.

Officials at UTMB can take small comfort in knowing they are not alone in the struggle to address the health needs of every single person who comes through the hospital doors. Nevertheless, because indigent health care is a national problem that has far-reaching economic consequences, calls for solutions are echoing throughout the country. They also are being heard by the woman and men seeking the highest office in the land. Therefore, perhaps in another decade, UTMB's problem will not center on how to pay for all the unsponsored patients who seek care in the hospital. The problem will be how to attract *more* patients.

In conducting research for this paper, it was necessary to interview a number of university and state officials, current UTMB employees, and others who have personal historical information that was incorporated into this document. The Institutional Review Board conducted an expedited review and authorized these interviews, provided that the participants were informed they would be identified by name in association with what they said, could refuse to answer any questions, and could terminate the interviews at any time. Everyone agreed to those conditions. In fact, when I submitted the sections of the thesis related to their interviews, several individuals enhanced their original comments with further exposition, which was incorporated. Some material came from responses to e-mail queries, seeking information, which was provided and inserted where appropriate. In a few cases, statements quoted below were obtained during meetings or conversations about the topics covered. When that occurred, the people involved also were allowed to review and approve the related text. These people and the nature of the information are included in footnotes and in the bibliography.

Chapter 1: Mission of Indigent Care

INTRODUCTION

Throughout its early history, Galveston was a center of commerce, trade and immigration. The U.S. Congress made the island an official port of entry in 1837, eight years before the Republic of Texas became one of the states. In 1839, with construction of the Galveston wharves, exports to foreign countries exceeded $1 million.[1] Europeans fleeing revolutions in their homelands during the 1840s and 1850s arrived in the city bordering the Gulf of Mexico, where they built homes for themselves and others. During the same time-frame, Galveston was a center for the trading of slaves, shipped over from Africa and the West Indies. Steamer ships also hauled cargo between Galveston and New Orleans.[2]

Unbeknownst to the inhabitants at the time, the shipping industry is what brought the eight yellow fever epidemics that struck between 1839 and 1867, killing hundreds at a time, and laying the foundation for Galveston's selection as the state's first academic medical center. Even before voters in a statewide referendum in 1881 voted for Galveston as the location for the Medical Department of the University of Texas (UT), the city had a medical college, Texas Medical College and Hospital (TMCH), founded with the notion that serving paupers was part of its mission. When the medical department opened ten years later, that mission transferred to the new institution because several of the physician-professors also were on the TMCH faculty.

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[1] Samuel H. Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1790-2006," *MeasuringWorth.Com*, 2007, http://www.measuringworth.com/uscompare/ (accessed January 13, 2008). Equivalent value in 2005 dollars, using the Consumer Price Index, is $1,000,000 = $21,651,884.70.

[2] *Handbook of Texas Online*, s.v. Galveston County, http://www.tsha.utexas.edu/handbook/online/articles/GG/hcg2.html (accessed December 29, 2007).

This chapter will examine the four eras of indigent health care that Galveston experienced from its beginnings to this point in the history of UTMB:

- Pre-1891, before the official opening of the University of Texas (UT) Medical Department;
- 1891-1940, the first days of the medical school to the Great Depression;
- 1941-1969, the waning years of the Depression before World War II to President Lyndon Johnson's Great Society, in which Congress legislated the Medicare and Medicaid safety net health-care programs for the aging and indigent; and
- From 1970, when UTMB felt the economic benefit of those programs, to the present, as indigent health care has made a huge impact on the institution's ability to survive into the future.

Throughout the 117 years from 1891 to the present, UTMB's financial situation endured highs and lows, owing to the state of the economy at the time, political sentiment at the local and state levels, and the ability of the school's administration to convince the UT Board of Regents of the need for financial assistance for the hospital. This chapter will review those eras in terms of which individuals, organizations, and government agencies covered the costs of caring for patients who could not pay for it themselves (Figure 1-1) and how the university coped with those costs. The role of the legislature in UTMB's financial picture will be addressed in chapter 2.

Figure 1-1: Who Financed the Costs of Care for Indigent Patients?

Era	**Who Paid?**			
Pre-1891	City of Galveston	Philanthropy	Paying Patients	
1891-1940	City of Galveston	Philanthropy (including	Paying Patients	

Era	Who Paid?					
		Sealy family and Sealy & Smith Foundation*)				
1941-1969	City of Galveston, County of Galveston	Philanthropy (including Sealy & Smith Foundation*)	Paying Patients (including insurance)			
1970-2007	County of Galveston, other Texas counties (includes Medicaid)	Philanthropy (including Sealy & Smith Foundation*)	Paying Patients (private insurance and Medicare)	State of Texas (hospital subsidy, does not include education, Medicaid)	U.S. Government (Veterans' Administration, medical education, other)	Hospital Deficit

* The Sealy & Smith Foundation contributed to deficits, salaries, maintenance, and operation of the John Sealy Hospital from its founding in 1922 until 1988.[3] Although some of those payments did not directly support indigent patients, they covered expenses the hospital would otherwise have incurred, including those for indigent care.

PRE-1891

From the time it was incorporated in 1839 until it was largely destroyed by the hurricane of 1900, the City of Galveston was the largest port of entry on the Gulf of Mexico west of the Mississippi River (New Orleans). From a population of 300 in 1839, the city grew wildly after Texas became a state in 1845. It became the home for 14,000 by 1870, and 20,000 in 1876. By 1876, Galveston was the biggest city in Texas, writes Chester R. Burns in *Saving Lives, Training Caregivers, Making Discoveries: A Centennial History of the University of Texas Medical Branch at Galveston*. Many

[3] Robert B. Nichols, *A Bridge to a Better World*, (Galveston: Office of External Affairs, The University of Texas Medical Branch, 1989), 109-118.

immigrants arrived with little more than the clothes on their backs, dreams in their heads, and not the best of health.[4]

Although Texas was under Mexican jurisdiction from 1821 to 1836, American settlers arrived in 1827, and settled near Galveston's Offatts Bayou east of the center of the 32-mile long island. In 1830, David G. Burnet and Lorenzo de Zavala received authority to settle families in Galveston under Mexico's colonization laws, and formed the Galveston Bay and Texas Land Company to encourage others to move to the island. Their plan took root in 1835, after Mexico relinquished authority over the island, and the city and county began to grow. Before the Civil War, cotton and cottonseed oil, sugar, and cattle, among other goods, moved through the port from throughout the region. Exports in 1839 exceeded $1 million; local agriculture and commerce received financial support from banks and commission businesses; and Galveston was the only locality in Texas with active labor unions.[5]

Thus, when City Hospital opened in 1845 at Ninth and Strand, it had a steady stream of patients: some paying, some not. The paying patients, of course, subsidized those who did not. Although the state constitution that same year mandated counties to be responsible for the "care of paupers," financial records from that time do not show payments from any county in Texas. [6]

Among the budding entrepreneurs who sensed opportunity in Galveston after Texas's statehood was twenty-four-year-old Pennsylvanian John Sealy. Having apprenticed with a merchant in his hometown of Kingston for seven years, and staying on for another three, Sealy rose quickly in the enterprise. But stories about the new state

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[4] Chester R. Burns, *Saving Lives, Training Caregivers, Making Discoveries: A Centennial History of the University of Texas Medical Branch at Galveston* (Austin: Texas State Historical Association, 2003), 1.

[5] *Handbook of Texas Online*.

[6] Burns, 77.

appealed, and the young man headed south. Sealy first worked for a dry goods company whose bookkeeper, John H. Hutchings, became a friend and, soon, a business partner in Sabine Pass, Texas. Seven years later, the Hutchings & Sealy Company moved to Galveston, after yellow fever took the lives of nearly everyone in Sabine Pass. With $50,000 from their business, the two bought into an established business owned by George Ball. As Ball, Hutchings & Company expanded into banking, John enticed his younger brother, George, to join them; and the company prospered even more.[7] The family business expanded further when it purchased several wharf businesses in 1854, and formed the Galveston Wharf Company, of which John became president in 1858. Other enterprises included oil, gas, and railroads. John Sealy and Rebecca Davis of Bedford, Pennsylvania, married in 1857. They had two children, Etta Jane (Jennie) and John Hutchings Sealy.[8]

Galveston also was the home for the Texas diocese of the Catholic Church, whose second bishop for the territory, Claude-Marie Dubuis, had arrived from France as a missionary in 1846, two years after his ordination. He was appointed bishop in 1862, and unsuccessfully appealed almost immediately to congregations in his home country to help him address the alarming poverty and disease he had witnessed in his travels throughout Texas. Dubuis was, however, able to obtain enough money to begin building a hospital on the island. In 1866, he wrote Mother Angelique Hiver, superioress of the Order of the Incarnate Word and Blessed Sacrament, in Lyons, France. The letter said, in part:

> Our Lord Jesus Christ, suffering in the persons of a multitude of the sick and infirm of every kind, seeks relief at your hands. … [T]oday he begs you to accept

[7] Nichols, 1-11.

[8] *Handbook of Texas Online*, s.v. Sealy, John, http://www.tsha.utexas.edu/handbook/online/articles/SS/fse2.html (accessed October 15, 2007).

> the mission of corporal works of mercy, by sending Sisters to take charge of our hospitals and orphan asylums.[9]

The appeal worked. Mother Angelique immediately sent three nuns, who created a new congregation, the Sisters of Charity of the Incarnate Word, to nurse the sick. They arrived in October 1866, and were followed by two other groups of nuns over the next two years.[10] The order opened Charity Hospital on the eastern edge of the city April 1, 1867, and renamed it St. Mary's Infirmary in 1869. It was the first Catholic hospital in the state.[11] Within the next decade, the city and the sisters built and opened new facilities: a 100-bed, three-story City Hospital that opened for patients in October 1875; and a new, 250-bed St. Mary's Hospital opened six months later.[12]

From the beginning, Galveston city coffers, philanthropy, and paying patients supported City Hospital operations—nursing, food, maintenance, administration, etc. The Catholic diocese and charitable contributions supported St. Mary's. Perhaps because Galveston was the most populous and most prosperous city in the state in the late 19th century, its citizens carried on the Christian tradition of charity—a beneficent attitude toward the poor who were sick and needed attention in its hospitals. Among those who did not manage the city finances, at least, the feeling seemed to be that they could afford to help them—and so they should.

Approximately fifty physicians on the island ministered to the sick in their offices, at patients' homes, and at both hospitals—often gratis. Many of these doctors had a dream of their own: creating and staffing a medical school to rival the best institutions in the East. Among the most ardent of them was Greensville Dowell, a surgeon who

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[9] Sisters of Charity of the Incarnate Word, San Antonio, "Our History," http://www.incarnatewordsisters.org/ourhistory.htm (accessed January 12, 2008).

[10] Ibid.

[11] Sisters of Charity of the Incarnate Word, "Legacy," http://www.sistersofcharity.org/legacy.htm (accessed January 12, 2008).

[12] Burns, 9-10.

headed Galveston Medical College, which opened in 1865 as a component of Soule University, a Methodist college based in Chappell Hill, Texas. By 1873, however, Dowell sought and received a new charter from the state to establish the Texas Medical College and Hospital (TMCH), which he divested from Soule, then having financial problems.[13]

In obtaining the state's charter to open a new medical school in Texas, Dowell and his colleagues said the indigents would comprise the apprentices' patient loads. (Medicine at that time was taught in an apprentice-type model.) In negotiating the original charter, Dowell asked for state money, which the legislators did not provide outright. However, their legislation provided for counties to send their indigent sick to Galveston for a fee not to exceed one dollar per person per day. At the time, under Article XII, Section 26 of the Texas Constitution of 1869, counties were directed to provide "a manual labor poor-house for taking care of, managing, employing, and supplying the wants of its indigent and poor inhabitants.…[which] the courts have interpreted to include medical services."[14] Thus, in the negotiations for the revised, 1873 charter, one of the legislators noted: *"[I]t is the duty, under the law, for each county to provide for the poor and destitute in their limits."* While the State Legislature would not go so far as to commit state money to the purpose, it did agree to pay up to $5,000 annually to the hospital if state money was "not otherwise appropriated."[15] In 1876, however, the constitution changed, moving it to Article XVI and making Section 26 permissive, thus *authorizing* counties to care for their indigent and poor, rather than *requiring* them to do it.[16] By 1880, unfortunately, no otherwise unspent dollars had come from the state.[17]

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[13] Ibid., 11.

[14] Helen J. Farabee, Gordon Arnold, Chet Brooks, et al., "Task Force on Indigent Health Care: Final Report, December 1984," www.lrl.state.tx.us/scanned/interim/68/in2.pdf (accessed June 12, 2007), 11.

[15] Burns, 11.

[16] Farabee, 11.

By 1880, however, Galveston remained the largest city in the state, with commerce valued at $30 million. Some 172 establishments employed workers, who produced $2 million in products.[18] The Galveston and Western Railway was completed on the island, and an elaborate bath house on the beach, called the Electric Pavilion, sparked the beginning of tourism as an industry for the city.[19]

A statewide referendum in 1881 established the University of Texas, which voters decided would have a main campus in Austin and a medical department in Galveston. Ten years later, the Medical Department opened its doors. The meager finances allocated to the new university were spent first on building the Austin campus.[20] Prodded by Galveston city officials not to renege on the voters' wishes, the State Legislature and the UT Board of Regents finally budgeted for the medical school in 1889, they negotiated for the City of Galveston to build, furnish and staff a hospital, except for the physician-professors, who were paid by the university and private patients.[21]

A portentous event contributed to Galveston's ability to swing the Board of Regents in its favor. John Sealy died in August 1884, bequeathing $50,000 from his estate "to a charitable purpose." His widow, Rebecca, and brother, George, conveyed that bequest, plus $19,000 of their own, to build the John Sealy Hospital (JSH), which sealed the deal for the regents. [22] The hospital opened January 10, 1890. With the opening of the new hospital, the former City Hospital was divided into two segments; the upper floor

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[17] Burns, 13.

[18] Williamson: 2005 dollar equivalents, $30,000,000 = $591,220,988.90; $2,000,000 = $39,414,732.59.

[19] *Handbook of Texas Online*, Galveston County.

[20] Burns, 16.

[21] Ibid., 18.

[22] *The University of Texas Medical Branch at Galveston, A Seventy-Five Year History by the Faculty and Staff* (Austin: University of Texas Press, 1967), 15; Williamson: 2005 dollar equivalents, $50,000 = $1,026,813; $19,000 = $390,189.

was dedicated to nurses and nursing students, and the first floor became the Negro Hospital.[23]

1891-1940: UTMB'S EARLY YEARS

In the contract between the State of Texas, on behalf of the University of Texas, and the City of Galveston, the state received the deed to the John Sealy Hospital, which the city council agreed to lease for one dollar annually for twenty-five years. At the same time, as lessee, the city pledged to equip and maintain the hospital, pay staff and doctors, except for the professor-physicians, and appoint two councilmen to a Board of Managers for the hospital. The agreement also dedicated use of the facilities for teaching medical students and authorized the university to provide "the treatment of all charity patients" there.[24] In the meantime, the university authorized construction of the Ashbel Smith Building for medical education. It opened in 1891 and classes began that October.

Dr. Ashbel Smith, a member of the University of Texas Board of Regents and president of the Texas State Medical Association, was instrumental in attracting the medical department to Galveston. As David G. McComb describes him in *Galveston: A History*:

> [Smith] was a small, ugly man with strong opinions and a feisty temper. Known as "Old Ashbarrel" behind his back, Smith never married, held women in low esteem, and yet exhibited courtly manners. Born in Connecticut in 1805, he studied medicine at Yale and in Paris. He arrived in Texas shortly after the revolution and became the first surgeon general of Texas. He served in the Texas Legislature, fought in the War with Mexico, and suffered injury in the defense of the South at Shiloh. … Smith argued before the legislature in favor of Galveston because the Island City possessed size, wealth, opportunity to study diseases, noble citizens, and a school already in operation.[25]

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[23] Melvin Williams, *From Africa to America: Africa's Contribution to American Healthcare, A Celebration in Memory of Herman A. Barnett III, M.D.* (Galveston: University of Texas Medical Branch, 1998), 57.

[24] Burns, 18.

[25] David G. McComb, *Galveston: A History* (Austin: University of Texas Press, 1986), 97-98.

"The approximate cost of the three University buildings of the Medical College, at Galveston, was $165,000, of which the State paid $50,000, and $115,000 was donated," according to a report to the Texas House of Representatives in 1901.[26]

Incomplete hospital and city budget records for John Sealy Hospital for the period show that the city and paying patients covered most of the costs of hospital operations.[27] But after the hospital opened, and for many years after, the Sealy family (at first Rebecca and George, and later Rebecca's children, John H. and Jennie) covered the hospital's operating deficit. The Sealy family members "were constant in their support of the John Sealy Hospital. The hospital's monthly deficit was met regularly by Mr. [John] Sealy as his interest in the indigent sick seemed to over-shadow his many other acts of charity, few of which were ever publicized."[28]

Since both had no heirs to carry on "the family's philanthropic tradition and to assure continued support [of the hospital and UTMB] after their deaths," John H. Sealy and Jennie Sealy Smith established the Sealy & Smith Foundation for the John Sealy Hospital in 1922, modeled after the Rockefeller Foundation and other family foundations they had investigated.[29]

In 1901, the total JSH budget was $23,410, of which the city paid $16,316 and paying patients, $3,697.[30] The $3,397 unrecorded difference could have been made up by the Sealys, other philanthropists or fund-raising activities of women in the community.

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[26] State Representatives Oscar F. McNally, Pat Neff, M. T. Lively, George W. McKnight, "Report of Special Committee Appointed to Visit the University of Texas and Medical Branch," February 26, 1901, in Journal of the House of Texas of the Twenty-Seventh Legislature 1901, http://www.lrl.state.tx.us/scanned/interim/27/27_0+univTX&UTMB.pdf (accessed June 12, 2007), 515; Williamson: 2005 dollar equivalents, $165,000 = $3,910,740; $115,000 = $2,725,667.

[27] Burns, 447.

[28] Robert Nesbitt, *50th Anniversary Report 1922-1972* (Galveston, TX: Sealy & Smith Foundation for the John Sealy Hospital, 1972), 3.

[29] Robert B. Nichols, *A Bridge to a Better World* (Galveston, TX: Sealy & Smith Foundation by the Office of External Affairs, University of Texas Medical Branch, 1989), vii and 36.

[30] Burns, 447; Williamson: 2005 dollar equivalents, $23,410 = $554,851; $16,316 = $386,712; $3,697 = $87,624.

For example, in 1910, Galveston churchgoers, in keeping with their Christian tradition, contributed $3,000 in response to an appeal by the Lady Board of Advisors to the Sealy Hospital Board. Through its charitable activities on behalf of JSH, the Hospital Aid Society had donated more than $50,000 in total by 1938.[31]

These fundraisers and the Sealy legacy accounted for 28 percent of the hospital's operating income from 1890 through 1940. Fees collected from paying patients accounted for approximately 50 percent of the hospital's income through 1940.[32]

The city's portion of hospital support during that timeframe equals about 22 percent. State contributions are not evident. It must be said that state support for maintaining the university infrastructure inevitably went toward some physical costs in the hospital. In spite of repeated pleas, the Board of Regents allocated money only toward costs that benefited education. However, a committee of legislators who visited both UT campuses in 1900 reported to the State House of Representatives in February 1901 that, in Galveston, the effect of the 1900 storm was "everywhere visible." The report indicated, "Money appropriated … has at all times been inadequate … [And] the Faculty, one of the ablest obtainable, have been greatly handicapped in their work."[33]

The hurricane that hit Galveston in 1900 killed approximately 6,000 people and temporarily handicapped the city. It also damaged the Negro Hospital and nurses' home to the point the building was uninhabitable. An unidentified New York philanthropist donated $15,000 to build a new hospital as a replacement, the first such facility in the state to be built for the black community, in the same location as the original, at Ninth and Strand. While the building was under construction, African American patients who

[31] Burns, 76.
[32] Ibid., referring to Appendices K, 427; L, 428; and U, 447.
[33] McNally, Neff, Lively, McKnight, 522.

required hospitalization were admitted to JSH. Still in keeping with the area's Christian tradition, donations from the community equipped the new hospital.[34]

By 1910, the inhabitants who remained in Galveston had raised the island's grade and built a seawall. The Galvez Hotel opened in 1911, assuring return of tourism. And the island once again became a major point of entry for immigrants, as the federal government redirected them from the Northeast to the Gulf. Some 50,000 immigrants arrived at Galveston between 1906 and 1914, giving rise to the island being considered a "second Ellis Island," for the island outside New York City where they were processed.[35]

Although Galveston County contributed a small amount to City Hospital and St. Mary's Hospital for indigent patients from the county before 1900, the County Commissioners did not allocate any more money until 1920. At that time, they designated a small amount for indigent care at UTMB.[36] For the most part, though, county residents were on their own when it came to paying for health care. That being said, the largest population center in the county was inside the Galveston city limits.

And, until the Great Depression began in 1929, the area continued to grow. With the opening of a causeway to the mainland and an interurban railroad system north from the island, ongoing growth of the oil and refinery industries, and the start of a rice mill and brewery, the picture looked rosy. The Houston Ship Channel and the growing Port of Houston cast a shadow. Nevertheless, the Galveston port reached a peak of $877.5 million in foreign and domestic tonnage in 1923, and county population climbed, as well. When Prohibition was enacted in 1917-18, the island became a center for gambling, crime, and bootlegging. Tourism boomed in response to advertising for local resorts and bathing beauty contests. The first ferry between Galveston and Point Bolivar plied the

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[34] Williams, 58.
[35] *Handbook of Texas Online*, Galveston County.
[36] Burns, 77.

waves in 1930. Truck farming, dairy and cattle ranching, and sugar production highlighted the agricultural scene; and a refinery in Texas City reflected the growing petroleum industry.[37]

With the crash, however, "Galveston began a decline in relation to other Texas cities that lasted until the 1970s…. Manufacturing firms continued to close, and by 1947 only sixty-six remained."[38]

Before 1941, UTMB received some federal income for patient care, but it did not go toward any indigent care. For example, the U.S. Public Health Service paid UTMB $32,316 for its employees and for merchant marine families in fiscal year 1921.[39] Government dollars in 1936 paid for a grant of $128,319 from the Works Project Administration (WPA) to help build a new Negro Hospital. It was billed at the time as the "largest federal grant ever received by an institution in Texas." [40] The first two floors of the three-story facility, whose total cost was $285,000, opened on August 31, 1937, and the third story two weeks later. This hospital remained in operation until 1953, when a replacement John Sealy Hospital opened, and African American patients were treated in segregated wards.[41]

It is possible that, even during the Depression, the need for charity care was limited, because the university and the Sealy & Smith Foundation were investing in new structures, which provided economic benefit to the community through construction jobs, supported business, and purchased construction material and supplies, along with workers' and contractors' individual spending that found its way into pockets throughout

[37] Ibid.
[38] Ibid.
[39] Williamson: 2005 dollar equivalents, $32316 = $352,587, $128,319 = $1,808,131.
[40] Burns, 79.
[41] Williams, 62.

the area.[42] The bottom line is that hospital expenses in that period grew nearly 20-fold, from $23,410 in 1901 to $448,650 at the end of fiscal year 1939.[43]

1941-1969: SERVING THE 'INDIGENT SICK OF THE STATE'

The state and the UT Board of Regents took a big step in 1941: discontinuing the lease of JSH to the City of Galveston. This allowed the hospital to accept patients from throughout the state. In a letter dated March 1, 1942, to physicians, state and county medical societies, and county judges, Dr. Raymond Gregory, director of UTMB's Out-Patient Clinic, asked for referrals of indigent and part-pay patients "for the purpose of providing additional and diversified clinical material for teaching purposes." Patients classified as truly indigent "will be received at the clinic and in the hospital, when necessary, without cost for any services to the patient." The part-pay patients would be divided into two categories: 1) those who would pay a $2 registration fee, $3.50 per day for hospitalization, half the normal fee for such services as x-rays, electrocardiograms and the like, and zero professional fees for attending physicians; and 2) those who would pay half the amounts of category 1.[44] The professional fees were reduced or waived because the patients "will be used for teaching purposes."[45]

While increasing the number of patients for teaching purposes, this action positioned UTMB to "[assist] in the care of the indigent sick of the state"[46] and opened up the hospital for uncompensated costs that continue to this day. (In calendar year 1943, the Diagnostic Clinic alone served 1,279 patients from 124 counties.[47]) Barely two years

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[42] Nichols, 55.

[43] Burns, 448. Figures for 1940 are not available, except for a contribution from Sealy & Smith for $120,964; Williamson: $23,410 = $554,851; $448,650 = $6,308,232.

[44] Williamson: $2 = $23.96; $3.50 = $41.94.

[45] Raymond Gregory to state physician community, March 1, 1942, letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[46] Ibid.

[47] Chauncey D. Leake to Homer P. Rainey, February 21, 1944, attachment to letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

after the policy was instituted, UTMB's Executive Vice President and Dean Chauncey Leake Jr., wrote UT President Homer P. Rainey, suggesting "that part of the expense of hospitalization and the expense of transportation might be borne by the counties involved."[48]

In an interesting change of heart, by 1947, Leake believed the state, rather than the counties, should bear this cost. In a letter to UT President T. S. Painter dated April 5, 1947, Leake writes:

> We are studying the proposed bill to allocate a share of the cost of hospitalization of indigent patients in the teaching hospital to counties. The idea is unsound in principle, if we accept the proposition that medical education is a responsibility of the state as a whole, and that provision must be made for patients in the teaching hospital. As a matter of expediency, I doubt the wisdom of the proposal. We will send you our comments as soon as we have analyzed the bill.[49]

In the follow-up letter two days later, Leake explained his reasoning a little further:

> If indigent patients were to be referred to the hospital with the approval of a county judge, there would be certain to be delay, and there would also be every possibility for political interference, and for the imposition of undesired patients in the hospital.
>
> It seems to me that the people of the State can realize much more effectively what first-class medical training entails if the people of the State assume the full responsibility for carrying out the program … To compromise with the principle is to lay ourselves open to all the difficulties and abuses which experience has shown in other states may follow from county participation in the cost of hospitalization for teaching patients at the State Medical School.[50]

The State Legislature took no action on this issue during the 1947 session. Painter revisits it in a letter to Leake after the Board of Regents met at UTMB on April 2 and 3,

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[48] Ibid.

[49] Chauncey D. Leake to T. S. Painter, April 5, 1947, letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[50] Chauncey D. Leake to T. S. Painter, April 7, 1947, letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

1948. The regents instructed Painter and Leake to arrive at a plan for charging the counties, to be presented at the next board meeting and, ultimately, to the legislature:

> [F]rom my intimate contact with the legislature, I believe that we have just about reached all that traffic will bear in the matter of hospital appropriations, and that if we do not devise some method of supplementing the appropriations we will be restricted in what we can do in the matter of hospitalization.[51]

Nevertheless, Leake appeared to get his way, for he wrote in a 1951 letter to a friend:

> Funds for the hospitalization of indigent patients who are referred to us from all parts of the state, are provided in appropriations by the legislature. It seems to me that this is a wise procedure and the best way to set up the picture.[52]

Unfortunately, the legislative appropriations for the indigent proved inadequate. By 1952, UTMB required patients in the Out-Patient Clinic to contribute to the cost of their care; yet, collecting even small amounts created a problem. In a letter dated October 15, 1952, to UT Chancellor James P. Hart, Leake lamented that "rigid enforcement of the rule that all patients pay in accordance with their" ability to pay has kept some of those "needed for teaching" from returning. Other patients, with venereal disease or tuberculosis, posed a public health risk when they chose not to return to the clinic for follow-up. Thus, he asked that a separate, $1,000 account be allocated from the UTMB Unappropriated Surplus to cover these patients.[53] Hart assented by initialing the letter, which he returned to Leake (date-stamped December 5, 1952), adding a postscript: "Comptroller Simmons Concurred with Leake."[54]

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[51] Theophilus S. Painter to Chauncey D. Leake, April 5, 1948, letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[52] Chauncey D. Leake to Dr. William Gibson, April 7, 1951, letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[53] Williamson: $1,000 = $7,356.

[54] Chauncey D. Leake to James P. Hart, October 15, 1952 (initialed by Hart and returned to Leake on December 5, 1952), letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

The situation did not improve. In July 1955, the regents raised the hospital rates by $1.50 per day for full-pay patients, effective the next fiscal year, and added a minimum $3 daily charge per patient to "localities referring indigent patients to the hospital." The board also authorized UTMB to invoice referring localities for services to those who did not pay. In a letter to 250 county judges and another 250 MDs in the Texas Medical Society, UT President Logan Wilson blamed these actions on "an operating deficit [at UTMB] of over $500,000 in 1954-55 … inadequate Legislative appropriations … [and restrictions on access] to usable funds…"[55] An accompanying news release indicated the Medical Branch received some 25,000 patients from 250 of Texas's 254 counties, admitted 12,504 patients, and had 142,329 outpatient visits.[56]

By December 1955, Galveston County Commissioners began authorizing admissions of indigent county residents to UTMB. St. Mary's Hospital, however, was the only one to submit bids for indigent care contracts—until 1959, that is. At that time, Commissioners Court minutes show St. Mary's submitted a bid of $11.50 per person per day for hospitalization of indigent residents; UTMB bid $11.[57] The commissioners voted to approve both. [58]

It is interesting to note here that Leake's concerns about county admitting processes delaying indigent patient care appear to be well founded. For a number of years, that was happening in Galveston County; each request for admission had to be taken before the Commissioners Court for approval. Only in 1960 did the court authorize the Welfare Department to "refer patients in need of hospitalization" for care; the

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[55] Williamson: 2005 dollar equivalent, $500,000 = $3,646,378.

[56] Logan Wilson, July 16, 1955, letter, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[57] Williamson: 2005 dollar equivalents, $11.50 = $77.02, $11 = $73.67.

[58] Patricia Jakobi, notes from minutes, Moody Medical Library Blocker Collection CHP, Box 29, #271, Minutes, Galveston County Commissioners Court since 1876, 25-29.

decision to admit patients was left to the physicians. After this time, the commissioners no longer voted on whether to admit (authorize the expense) case by case.[59]

Continuing in the Christian tradition of their forebears, voters in the City of Galveston passed a charter amendment in 1957 authorizing a property tax levy of $0.20 on each $100 valuation "to be devoted solely for the treatment and care of indigent sick persons" who live in the city. After which, payments to the hospital increased to $200,000 a year.[60]

Meanwhile, on the national level, President Lyndon B. Johnson was implementing his Great Society plan, which included the companion Medicare and Medicaid health care programs. Medicare covered those over age 65 through direct federal payments to hospitals, physicians and other providers. Medicaid, funneled through the states, paid for "medical care for old age assistance recipients, blind, disabled and indigent families with dependent children."[61] Johnson signed the two laws, approved by both houses of Congress, in 1965. While it took several years for the details to be worked out, Medicare and Medicaid funds addressed UTMB's deficits related to indigent health care—for a while.

In the meantime, Galveston County officials established a Committee to Study Indigent Care in September 1966. Its report was issued that December 27, but the Commissioners Court took no action. Another committee, composed of the County Welfare Board and four members from the Indigent Care committee, was charged with drafting a policy for indigent hospital care at John Sealy Hospital. The report, issued May 27, 1968, said the average cost to the county for each hospitalized patient was $47.92. A

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[59] Ibid.

[60] E. D. Walker to F. Lanier Cox, June 13, 1957, letter and attachment, Moody Medical Library Blocker Collection CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990; Williamson: 2005 dollar equivalent, $200,000 = $1,387,567.

[61] Burns, 87.

concurrent report said the county should not expect to pay the full cost of care, since the patients were used to train medical students.[62] The result ultimately was a memorandum of agreement with the Medical Branch to serve the county's medically indigent residents. It was signed March 17, 1969. The city thereafter discontinued its financial support of the hospital.[63]

1970-THE PRESENT: MEDICARE, MEDICAID, AND INDIGENT CARE

Partly, as a result of the county contract, Medicare, Medicaid, and state funding, the next decade saw UTMB hospital income grow by more than 900 percent, from $27.3 million in 1970 to nearly $250 million in 1990.[64] Most of that income was attributable to increased payments from the state and income for patient services, including Medicare and Medicaid dollars.[65] However, it must be pointed out that UTMB leaders, Dr. Truman G. Blocker, Jr., (1964-1974) and Dr. William C. Levin (1974-1987), "whirled in the political networks that included elected state officials, regents, UT System officers, and UTMB administrators," which undoubtedly contributed to UTMB remaining in good offices with the state.[66]

Despite the windfall of the 1970s, an economic downturn in the 1980s put a kink in the indigent lifeline, as unreimbursed costs escalated. Another factor that contributed to reduced income was the growth of health maintenance organizations (HMOs) in the late 1970s. The U.S. Department of Health and Human Services worked with Congress to enact the Health Maintenance Organization Act of 1973, which required that 1) businesses with twenty-five or more employees who provided health insurance must also

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[62] Brooks Keller, "Indigent Care Pay May Cost $460,000," *Galveston Daily News*, May 28, 1968.

[63] Burns, 87.

[64] Ibid., Appendices W and Y, 451-456; Williamson: 2005 dollar equivalents, $27,300,000 = $137,273,172, $250,000,000 = $373,565,417.

[65] Ibid., notes to appendices.

[66] Burns, 67.

offer an HMO plan (called "dual choice"), 2) that some state-imposed restrictions on HMOs were lifted if the HMOs were federally certified, and 3) provided grants and loans to plan, start, or expand an HMO. The program, in essence, gave HMOs entry to company-provided health insurance plans that previously were blocked. It took until 1977 for the federal agencies to draft and issue regulations and to certify plans. At that point, the snowball started rolling, and HMOs grew rapidly. The dual choice requirement expired in 1995.[67]

In spite of the best efforts of HMOs and managed care strategies that other commercial health insurance companies instituted to curb increasing expenses, the cost of a day in the hospital continued to rise. According to a study by the American Hospital Association, the average cost per day for an inpatient at what is termed a "nonfederal short-general and other special hospital" in 1965 was slightly over forty dollars. Only five years later, in 1970, the cost rose 55 percent to nearly seventy-four dollars. By 2005, in only forty years, the inpatient cost per day averaged $1,521.58 (before adjusting for inflation), thirty-seven and a half times the original amount (see Figure 1-2). When the dollars are adjusted for the increase in the Consumer Price Index, the cost in 2005 was more than 600 percent higher than the 1965 expense.[68] That average is much more than the estimated 6 percent annual medical inflation rate. UTMB does not have a historic record of inpatient cost per day.

Ideally, HMOs focused on preventive medicine—with the goal of a patient seeing a primary care physician (PCP) earlier in the illness cycle, when it is less expensive. The

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[67] Wikipedia, the Free Encyclopedia, "Health Maintenance Organization," http://en.wikipedia.org/wiki/HMO (accessed November 18, 2007).

[68] Health Forum, "Historical Trends in Utilization, Personnel, and Finances for Selected Years from 1946 through 2006," *AHA Hospital Statistics: The Comprehensive Reference Source for Analysis and Comparison of Hospital Trends* (Chicago, IL: American Hospital Association, 2008): 2-4; Williamson: in 1965, $40.56 = 250.99; 1970, $73.73 = $482.66; 1975, $133 = $483; 1980, $245 = $580; 1985, $460 = $835; 1990, $686 = $1,025; 1995, $970 = $1,243; 2000, $1,170 = $1,327.

physician or his/her clinic, however, signed a contract with an HMO for a fixed amount, based on the number of patients who enrolled in the practice. It did not matter how many of those patients the physician saw, the reimbursement remained the same. The doctor (or, in many cases, the nurse practitioner or physician assistant in the clinic) became the gatekeeper for further patient care, referring patients for tests or specialists or even hospitalization only when necessary. But the HMO placed a step, called "pre-certification" in between the PCP and the specialist. If the referral did not meet all the pre-determined requirements the insurance company had established for the patient's condition, the HMO employee (usually not medically trained) who pre-certified the procedure often refused the referral because she or he determined that it did not fit the company's pre-established authorization criteria. At the same time the HMOs negotiated physician contracts, they established limits on the total they would allocate for any given patient (capitation). As a result, PCPs, specialists, testing organizations, and hospitals—among others—began having to pare expenses because the HMOs were reimbursing less and less.[69]

According to Dr. Ben G. Raimer, Vice President and Chief Executive Officer, Community Health Services, the 1980s and 1990s were a chaotic time, largely due to the advent of HMOs and managed care, which "put up more ways to keep patients out, and caused problems at UTMB." The "largess at the state level … brought substantial funding for the hospital," as a result of the efforts of Drs. Blocker and Levin, along with others. Otherwise, he said, the hospital would have encountered severe financial problems.[70]

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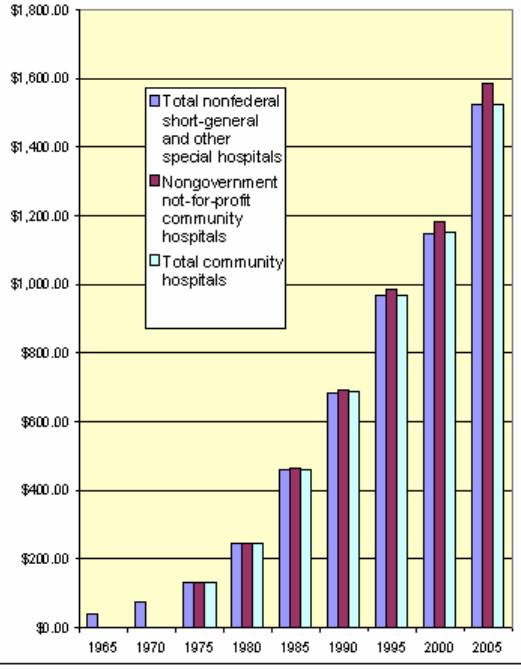
[69] NetIndustries, LLC, "Health Maintenance Organization," http://www.faqs.org/health/topics/71/Health-Maintenance-Organization.html (accessed November 18, 2007). The item is undated, but its most recent reference is to information from 1997.

[70] Ben G. Raimer, M.D. (Vice-President and Chief Executive Officer, Community Health Services), interview by Joanna Bremer in his office in the UTMB Administration Building, October 15, 2007.

Figure 1-2. Adjusted Cost per Inpatient Day by Hospital Type



Year	Total nonfederal short-general and other special hospitals	Nongovernment not-for-profit community hospitals	Total community hospitals
1965	$40.56		
1970	$73.73		
1975	$133.06	$133.36	$133.81
1980	$244.44	$245.74	$245.12
1985	$459.57	$462.69	$460.19
1990	$681.52	$692.36	$686.83
1995	$966.79	$984.39	$967.69
2000	$1,147.99	$1,182.32	$1,149.40
2005	$1,521.58	$1,585.34	$1,522.42

Source: American Hospital Association c. Health Forum LLC

In fiscal year 1987, UTMB officials signed contracts with eight Texas counties similar to what they had negotiated with Galveston County, paying for care to indigent patients who were not enrolled in Medicaid. By 1991, contracts with sixteen counties and three hospital districts contributed $5.8 million toward indigent care.[71] In January 2007, UTMB had contracts with forty-four counties and four hospital districts for indigent care.[72] Income from these contracts amounted to approximately 2.4 percent of UTMB unsponsored care revenues and expenses revenues for 2006.[73]

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[71] Burns, 94; Williamson: $5.800,000 = $8,316,740.

[72] Office of Community Health Services, "County Contract Status—Effective January 2007," Galveston: University of Texas Medical Branch, http://www.utmb.edu/osainfo/CountyInfo/CountyContracts.htm (accessed July 3, 2007). Link accessible only to UTMB internal users. The contracts are for managed care for these patients. The other counties in the state whose indigent patients seek care at UTMB have hospitals of their own, where these patients are supposed to go first. They are referred to specialists at UTMB.

[73] Office of Finance, Decision Support, "The University of Texas Medical Branch Unsponsored Care Revenues and Expenses for Fiscal Year August 2006 (in millions)," December 18, 2007; obtained from the UTMB Finance Department; and Office of Community Health Services, "The University of Texas Medical Branch at Galveston Indigent Health Care and Treatment Act County Indigent Care Contract

One recommendation of Galveston County's Indigent Hospitalization Policy Committee in May 1968 was that county officials look into a federal grant for indigent care in a "ghetto area" through Public Law 89479.[74] Taking that suggestion one step further, and recognizing that primary care prevents many emergency department visits, Galveston County and UTMB proposed two County Coordinated Community Clinics (4Cs), funded largely by the Department of Health Education and Welfare (HEW), as a model for the nation (now, in a revised form, known as the Federally Qualified Health Care clinics). Texas Senator Ralph Yarborough announced the five-year grant for the $7 million program in April 1970. Some $4.1 million of the clinics' proposed budget came from HEW.[75] The first clinic opened in 1972 in Texas City, the Galveston facility six months later.[76]

The clinics, still in operation, are staffed by family medicine physicians, along with UTMB residents and students, plus nurses, technicians and social workers. The clinics triage and treat patients, but also refer them to UTMB specialty clinics for secondary and tertiary services, as necessary. Patients pay the 4Cs clinics on a sliding scale based on their household incomes. Social workers also attempt to help them enroll in programs that will pay for or contribute to the costs of their medical services.[77] The question remains, however: When 4Cs patients have conditions that require surgery or more intensive treatment (cancer, for example) for which they are referred to UTMB, who pays their health care expenses if they do not have insurance? In many cases, that is a problematic issue. Galveston County reimburses UTMB for secondary and tertiary care

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Services," September 1, 2005, through August 31, 2006; obtained from the UTMB Office of Community Health Services.

[74] Keller.

[75] Pat Faour, "$800,000 Grant Announced for Indigent Clinic Plan," *Galveston Daily News,* April 17, 1970; Williamson: 2005 dollar equivalents, $7,000,000 = $35,198,249, $4,100,000 = $20,616,117.

[76] *Galveston Daily News*, "New Clinic Slated, Opens Monday," July 15, 1972.

[77] Faour.

of patients up to 50 percent FPL (up to a maximum of $2 million), but those above that threshold must find other resources. Many of them, unfortunately, end up contributing to UTMB's costs of uncompensated care.[78] Another question to ask is, should a national health insurance plan be implemented after the 2008 presidential election, for example, whether these patients still would come to 4Cs for their care.

Although the 4Cs have experienced financial ups and downs over the years, they continue to be an integral part of the health care system in Galveston County for uninsured patients, some of whom do pay something for their care. In fact, patient payments amount to about 22 percent of the clinics' income—depending, of course, on what the total collections are. The clinics also receive around 22 percent of their budget from federal sources, and approximately 56 percent from Galveston County.[79]

Galveston County Community Health Access Program

More recently, UTMB's Office of Community Health Services (OCHS) took the concept one more step, establishing the Galveston County Community Health Access Program (GCHAP). A group Raimer mobilized applied for a Community Access Program (CAP) grant after the Galveston County Commissioners Court reduced Medicaid eligibility to such a level that only 900 souls in the county qualified for the program.[80] Some 17 percent of the residents of Galveston County in 2000 were uninsured.[81] Formally organized in 2002 with the $900,000, one-year grant from the

[78] Curtiss Brown (Director, Community Services, Galveston County, Texas), interview by Joanna Bremer in his office in Shearn Moody Plaza Building, Galveston, TX, July 9, 2007.

[79] Patrick Butler (Compliance Auditor, Galveston County Health District) e-mail message to Joanna Bremer, August 24, 2007.

[80] Galveston County Health Access Program, "Our History—G CHAP," Galveston County Health Access Program, http://www.som.utmb.edu/e-NEWS/2001/e-NEWS-July01.htm (accessed May 28, 2007).

[81] City-Data.com, Galveston County, TX, http://www.city-data.com/county/Galveston_County-TX.html (accessed January 7, 2008).

Health Resources and Services Administration (HRSA),[82] GCHAP is a coalition of 24 local organizations (including the 4Cs clinics) which aim to "bridge gaps in access to health care in Galveston County … [for] all persons at or below 200 percent of the federal poverty level who are … uninsured or underinsured."[83] The grant was renewed for three more years, expiring August 31, 2005, after a no-cost extension. The program received a 2004 award from the Community-Campus Partnerships for Health. During its first year, GCHAP:

- Increased the number of trips to medical appointments, helping reduce the rate of claims denials for clients;
- Created an interface among social services, religious ministries and medical providers to coordinate access for the uninsured;
- Formalized coordinated, community-based care for the uninsured;
- Coordinated and enhanced community-based prevention programs;
- Expanded web-based record collection to monitor and evaluate service delivery; and
- Implemented ongoing evaluation, resource coordination, project development and quality assurance systems.[84]

The Jesse Tree, a Galveston organization that coordinates community services for the indigent and others, is one of the key partners in the GCHAP coalition. In keeping with Galveston's Christian roots, the Jesse Tree was established in 1995, after a series of meetings at Moody Memorial First United Methodist Church, where participants identified the need for an organization that could readily identify "resources for those

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[82] Office of the Dean, School of Medicine. "Major Grants and Awards," *SOM eNews* online newsletter (July 2001), http://www.som.utmb.edu/e-NEWS/2001/e-NEWS-July01.htm (accessed May 28, 2007).

[83] Community-Campus Partnerships for Health, "2004 Community-Campus Partnerships for Health Award Recipient," Seattle, WA: University of Washington, http://depts.washington.edu/ccph/awards2004GCHAP.html (accessed May 30, 2005).

[84] Ibid., 2.

seeking social services, medical care and ministry." This need was met by expanding the responsibilities of Ted Hanley, director of Our Daily Bread, in Galveston. With seed grants from the church's Permanent Endowment Fund and a private donor, the Jesse Tree was planted. Its name comes from a biblical passage: "A shoot will come up from the stem of Jesse; from his roots a branch will bear fruit . . ." (Isaiah 11:1). [85]

Through GCHAP and its own measures, the Jesse Tree efforts toward improved health care for the indigent and uninsured in 2004 resulted in:

- 24,676 screenings on Galveston County's Webcare site
- 3,035 unique clients entered into the program and
- 7,634 referrals from 6,838 visits.[86]

Through the Jesse Tree, with the assistance of GCHAP affiliated ministries and other health care providers, such as St. Vincent's Episcopal House, the Luke Society Medical Mission and the 4Cs clinics, individuals and families are "assigned medical homes, screened for chronic diseases, and signed up for appropriate programs.…An adherence plan guides the progress and provides incentives" for clients to follow the plan. At GCHAP, a Direct Assistance Fund, supported by churches, a Community Development Block Grant through the City of Galveston, and local agencies, provided $38,100 to "expand access to medications" in 2004.[87] Although one intention of the program is ultimately saving money for UTMB, its real mission is enrolling low-income and indigent residents into some kind of medical home and addressing their health needs before they reach a crisis point.

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[85] The Jesse Tree, "Orientation and Overview," http://www.jessetree.net/The percent20Jesse percent20Tree percent20Overview percent20and percent20OrientationVersion percent203 percent20October2006.pdf (accessed May 25, 2007).

[86] The Jesse Tree, "A Community Response to Disparity," Health Disparities Panel presentation at the University of Texas Medical Branch on May 5, 2005, 3.

[87] Ibid.

These programs are important because the Galveston County Commissioners Court authorized funds for indigent health care services only to county residents whose incomes are equal to or less than 21 percent of the federal poverty level,[88] or $1,955.10 per year for an individual or $3,958.50 per year for a family of four.[89] While about 2,000 individuals (or about 0.77 percent of the 260,000 population) qualify for the program today, the average weekly enrollment in the Galveston County indigent care contract is about 350 persons.[90]

Demand and Access Management Program

Whether from Galveston County or counties in the rest of the state, many of those uncovered by insurance of any sort have been showing up at the UTMB Emergency Room, often when they could be treated at clinics and hospitals closer to home. In a letter in 1998 introducing cost-containment measures, President John D. Stobo explained the reasons:

> Last year alone, we provided more than $119 million in indigent care costs and we anticipate a $24 million increase in indigent care expenses for fiscal year 1998. The reason? The number of indigent patients we cared for rose 20 percent between fiscal years 1997 and 1998.
>
> This increase in volume is for two reasons: first, with the state's robust economy more people are employed, making them ineligible for federal and state support. At the same time, many of them now work for employers who do not provide affordable health insurance. (In fact, a recent article in the *Houston Chronicle* noted that almost one-third of the Houston-area population has no health insurance, the highest percentage of uninsured among the nation's largest metropolitan areas.) Second, many health providers who have in the past given of

[88] Galveston County Health Access Program, "A Health Partnership with the Community," February 2004, http://www.galvestonchap.org/Publications/presentations.asp (accessed July 2, 2005), 5.

[89] United States Department of Health and Human Services, "2004 Federal Poverty Guidelines." http://aspe.hhs.gov/poverty/04poverty.shtml (accessed July 2, 2005).

[90] Curtiss Brown, e-mail message to Joanna Bremer, July 6, 2007.

> their time and services freely find this impossible to do within the financial constraints of managed care. Instead, they send these patients to UTMB.[91]

Effective October 1, 1999, UTMB implemented the Demand and Access Management Program (DAMP), intended to relieve the financial drain:

- Pre-registration by trained administrators or financial screeners to determine payment method will take place before any patient receives an appointment.
- Payment status or third-party-payer coverage will be verified before a patient's visit.
- Co-payments or deductibles for insured patients will be expected when services are provided.
- UTMB's indigent county contract process will be refined to ensure simplicity and uniformity throughout the state.
- Charity (medically indigent) patients from counties contracting with UTMB will be asked for a $12 co-pay when they visit the clinic or a $100 co-pay when they are admitted to the hospital. All indigent patients must have a referral from a primary care physician or clinic and an indigent care card provided by the county indigent care coordinator.
- Patients not covered by any payer or county contract, those requesting services that are not covered, or patients from contract counties seeking primary care services at UTMB will be asked to pay 25 percent of the standard reimbursement amount prior to care if their income is documented to be below 250 percent of the poverty index. If their income is above 250 percent of the poverty index, they will be asked to pay half of the standard reimbursement amount prior to care.

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[91] John D. Stobo, "A Message from President John D. Stobo: The Demand and Access Management Program" (Galveston: University of Texas Medical Branch, 1998), http://www.utmb.edu/president/damphome.htm (accessed May 1, 2005).

- More rigorous screening of transfer requests and referrals will determine whether or not a trip to Galveston is medically appropriate. Can the medical service be provided in the patient's community, where family and friends will be closer at hand? Is UTMB in a position to provide the needed service?[92]

Although the steps assure the university will not go bankrupt caring for those without resources, the patients may well go bankrupt themselves in attempting to deal with their ailments. In fact, about half of personal bankruptcies in the United States in 2003 were due to medical debt.[93]

On the other hand, UTMB's Office of the President is seeking a solution for many of those who live and work in Galveston County but whose employers do not currently provide health insurance. This solution, a plan called Three-Share, will be addressed in chapter 3.

Navigant and UTMB's Sustainable Financial Plan

In March 2006, Stobo announced UTMB was contracting with Navigant Consulting, Inc. (NCI), of Chicago to identify strengths and weaknesses, and develop a sustainable financial plan. "Programs and people are the essence of our greatness," he told the campus at a town meeting. "We must have sufficient financial resources to attract and support them, and to construct the facilities to further their work. [Unfortunately, f]or a number of years, we have been going from crisis to crisis," he said.[94] Although UTMB, with an annual budget of about $1.4 billion, succeeded in addressing financial challenges,

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[92] Ibid., 2-3. DAMP has undergone a number of revisions since it was first implemented, but these policies still generally apply.

[93] David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* Web Supplement 5 (February 2, 2005): 63-73.

[94] John D. Stobo, "From Very Good to Great: Setting an Ambitious Course for the Future" (Galveston, TX: University of Texas Medical Branch, 2006), http://www.utmb.edu/townmeeting/March2006.htm (accessed May 30, 2007).

the administration decided it was time to be proactive, to identify and earn enough operating income to cover depreciation.[95]

Including depreciation, the university was spending $20-$30 million more than its operating revenue each year, making up the difference with donations, money from endowments and other non-operating funds.[96] NCI found that the institution was "projected to lose a total of $101 million in FY 2007, $117 million in FY 2008, and $148 million in FY 2009," unless it changed its ways. The goal was a 3 percent operating margin at the end of FY 2007, from a projected negative 5.7 percent margin for FY 2006, or $140 million in expense reductions or revenue improvements.[97]

The plan resulting from Navigant's recommendations was intended to:

- Increase the part of the UTMB patient base with private insurance. Currently, 85 percent of the institution's income from patients comes from such government sources as Medicare, Medicaid, the Department of Corrections and state appropriations. With those sources expected not to keep pace with medical inflation, UTMB is seeking to find more patients with private insurance, which pays better.
- Erase about $20 million in annual operating deficits and create a 2 to 4 percent operating surplus.
- Increase the portion of UTMB's $1.4 billion annual revenue for research from 10 percent to close to 20 percent. [98]

Among the steps NCI recommended were to "achieve labor expense saving opportunities" in the hospitals and clinics ($22 million), institutional support ($12

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[95] Ibid.

[96] Marty Schladen, "UTMB Reorganization Prompts Fears of Layoffs," *Galveston County Daily News*, May 26, 2006.

[97] Navigant Consulting, "UTMB—Overall/Institutional Support, Confidential Draft, Executive Summary" (UTMB computer printout, Office of the President, May 17, 2007), 14.

[98] Marty Schladen, "UTMB Changes Are Due by August," *Galveston County Daily News*, June 5, 2006.

million), School of Medicine ($31 million), Correctional Managed Care ($2.7 million), and other schools ($1.1 million); "achieve supply expense savings" of $11 million; enhance revenue by about $16 million via "tightening financial screening policies, improving accuracy of information collected, monitoring contract compliance and reducing accounts receivable."[99]

At a Town Meeting on May 7, 2007, to introduce his successor as president, Stobo said the university's financial situation had improved in the first half of fiscal year 2007 (as of March 1, 2007) to a positive margin. He also said he hoped to have a positive report about UTMB's funding from the State Legislature after its session ended May 28, 2007.[100] The role of the State Legislature in addressing indigent health care at UTMB will be discussed in chapter 2.

CONCLUSION

This report demonstrates that, from the middle of the nineteenth century to the present, Galveston has taken care of the sick and the frail and the penniless to the best of its ability—whether they were from the across the street, across the state, or across the ocean. The costs were borne by those with the financial capacity to do so—from taxpayers, to paying patients, to churches, to philanthropists. Nevertheless, UTMB, except for a short time in the 1960s and 1970s, always has operated at a deficit in its efforts to meet their health care needs. While the Medical Department, from the beginning, never was mandated to do so by decree or legislation, the state's support in this endeavor, over the course of 117 years, often has been inadequate.

In order to address the problem, the university has adopted a variety of measures over the years that increase revenue, reduce costs, or reduce the number of unsponsored

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[99] Navigant, 28-29.

[100] John D. Stobo, "Town Meeting" (Galveston: University of Texas Medical Branch, May 7, 2007), Webcast: http://www.utmb.edu/townmeeting/#webcast (accessed May 13, 2007).

patients—with mixed results. The next chapter will examine the Texas State Legislature, its role in meeting the needs of the state's uninsured population, currently 25.1 percent,[101] the highest proportion in the nation, and some of the programs legislators have devised in an effort to allow UTMB to continue serving the people of Texas.

[101] Neal Lane and John D. Stobo, "Code Red: The Critical Condition of Health Care in Texas [The Summary]," Task Force for Access to Health Care in Texas, April 17, 2006, www.coderedtexas.org (accessed April 25, 2007).

Chapter 2: Texas Legislature's Role in Indigent Care Funding

INTRODUCTION

The University of Texas Medical Branch (UTMB) always has served patients from every corner of Texas, many of them without the resources to pay for their care. Although the State Constitution assigns the "care of paupers" to the counties, because UTMB is the only full-service hospital wholly owned by the state, one would think the State Legislature would provide it with adequate funding.[1] In fact, as discussed in the previous chapter, the record reveals much less than that. From the beginning, University of Texas (UT) officials, members of the UT Board of Regents, and UTMB executives have had to use every tactic at their disposal to obtain enough money from legislators. This chapter will review the State Legislature's role in providing adequate funds for UTMB to serve the indigent, during the eras of 1891-1940, 1941-1969, and 1970 to the present.

During the university's first decade, Galveston took a back seat to Austin, where the main UT campus absorbed the bulk of the allocations. In fact, were it not for the Sealys building and supporting the hospital for its first 50 years, the academic medical center may well have been displaced. The City of Galveston managed the hospital throughout this period, as well. Costs were contained, in part because patients primarily were local residents. The regents assumed management responsibility for the hospital in 1941. With that move, the university encouraged doctors and county officials to refer patients from throughout the state, which brought costs the regents had not anticipated.

[1] Three hospitals are operated by the University of Texas System: UTMB, UT M.D. Anderson Cancer Center, and UT Health Center at Tyler, which started out as a tuberculosis or "chest" hospital and has broadened its scope in recent years. Two other state-owned chest hospitals are located in Harlingen and San Antonio, and a number of psychiatric hospitals are operated by the Texas Department of Mental Health and Mental Retardation, including one on the UTMB campus.

After the Great Depression, through the World War II years, and into the 1960s, although UTMB was growing, its leaders still battled for adequate finances to care for the number of indigent patients who came through its doors.

With the advent of Medicare and Medicaid in the late 1960s and an improved national and state financial climate into the 1980s, the medical campus blossomed, with an infusion of state, UT System, and Sealy & Smith Foundation investments in buildings and patient resources. Even so, the once-bright financial picture began to darken, as indigent care issues that had hounded UTMB from the beginning were being felt in hospitals throughout the state. The State Legislature assembled a task force to examine the issues and present solutions, which provided only temporary relief. By the 1990s, managed care siphoned off what slim margins had been available for indigent care, and advancing technology meant more—and more expensive—tests and procedures. At the same time, the economic situation became more conducive to small businesses and individual entrepreneurs (without the means to pay for health insurance for their workers or themselves). The resulting flood of costs overwhelmed the state, the counties, and the academic health centers, not the least of which was UTMB.

That brings us to today. The State Legislature is testing a variety of solutions, in hopes that at least one of them will bring some kind of insurance coverage to the one-fourth of Texans currently without it. Should that happen, it presents a good news–bad news scenario for UTMB. The good news will be that all of the unsponsored patients who currently come to Galveston for their health care will have insurance to pay for it. The bad news is that these patients will not *need* to come to Galveston because their community doctors will take them—and the insurance dollars they will bring along.

1891-1940

During UTMB's first decade and, in reality, until after it acquired control of the John Sealy Hospital complex in 1941, the state considered indigent health care a local expense. The institution's first chief business officer, Provost James P. Johnson, counted on several sources of income in addition to state allocations for that first ten years: student fees, Sealy family donations, other gifts, payments from private patients, and "contributions from the city for the care of indigent patients."[2] Nevertheless, an outside observer would find it hard to make a case for the Medical Department benefiting excessively from the Legislature's largess. In a June 1897 letter to Dr. T. C. Thompson, a Galvestonian and member of the University of Texas Board of Regents, UT President George Winston wrote,

> [T]he House of Representatives is acting very badly. The Finance Committee has cut down the appropriation for the Main University to $25,000 and that for the Medical University to $30,000, knocking off $8,000. The Senate Committee recommends $38,000 as heretofore. I am using every possible effort and shall continue to do so to prevent any reduction below the $38,000, but it is impossible to say what the result will be.… This legislature is certainly a hard body to deal with, and we shall be very fortunate if we pull through without serious damage to both branches."[3]

For the biennium 1900-1901, UTMB received $35,000 each year, after a request for $54,909 for 1900 and $46,249 for 1901.[4] The Medical Branch appeared lucky to get even that amount after hours of speechifying on behalf of appropriations ranging from $75,000 (defeated 66-41) to $40,000 (defeated 56-51). In an article headlined: "Funds for

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[2] Chester R. Burns, *Saving Lives, Training Caregivers, Making Discoveries: A Centennial History of the University of Texas Medical Branch at Galveston* (Austin: Texas State Historical Association, 2003), 26.

[3] George Winston to Dr. T. C. Thompson, letter, June 2, 1897, T.C. Thompson Papers (Galveston & Texas History Center, Rosenberg Library, Galveston); Samuel H. Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1790-2006," MeasuringWorth.Com, 2006 (accessed December 3, 2007). Equivalent value in 2005 dollars, using the Consumer Price Index (CPI) is $38,000 = $911,720.

[4] Williamson: 2005 dollar equivalent: $35,000 = $839,742.

University, Appropriations for the State University Productive of Time-Killing Speeches, Two Elements Are Present, One the Graduates of the University and the Other the Boys from the Creek," an unidentified legislative reporter/commentator wrote:

> The appropriation for the university is always a demand for what might be called a healthy appropriation for the institution, and there is always an element in the legislature which does not believe it is entitled to a cent from the general taxes.… It may be denied, but...there is a jealousy between the different institutions.… [A] great number do believe that every dollar that can be given to the university ought to be given to the schools they favor. Hence the quarrel which always breaks out when the proposed appropriation for the university comes up.… [A]fter the matter was brought up in the senate, if not before,… the members had made up their minds, but then the speeches had been prepared and had to be uttered.[5]

An accompanying article about activities in the House of Representatives said in 1899 that one member, John Samuel Shropshire, "was not unfriendly to the university...[and] considered it as important as the common free schools of the state. But he did not believe the framers of the constitution ever contemplated that the institution should be maintained by appropriations from the general revenue."[6]

That year, the legislature allocated half the total state budget to "the state's eleemosynary institutions (blind, deaf, retarded, insane), $674,355 for the first year and $520,795 for the second year; [and] the state's courts and judiciaries,… $689,990 for the first year and $689,540 for the second." [7]

After the 1900 hurricane devastated Galveston Island and much of the university, the House Speaker J. S. Sherrill appointed a committee to visit the UT and UTMB campuses and report on their status. Committee members were Oscar F. McNally, Pat Neff, M. T. Lively and George W. McKnight. "In this enraged whirl of storm and flood, the property of the State was caught, and, along with others, suffered considerable

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[5] *Galveston Daily News*, "Funds for University," May 2, 1899.

[6] *Galveston Daily News*, "Twenty-Sixth Legislature: The House," May 2, 1899.

[7] Burns, 26; Williamson: 2005 dollar equivalents, $674,355 = $16,179,549; $520,795 = $12,495,241; $689,990 = $16,554,674; $689,540 = $16,543,877.

damage," they wrote. The report acknowledged the legislature's inadequate response to financial requests:

> Money appropriated for the equipment of laboratories and to supply facilities for demonstrations has at all times been inadequate, a result largely due to the pressing demands made upon the State from other sources. In consequence of this the Faculty, one of the ablest obtainable, have been greatly handicapped in their work.[8]

Furthermore, the committee complimented the accomplishments of the Medical Branch and its faculty. They noted that, even after the storm, "the attendance this term has been but few short of that of the previous years, showing conclusively the esteem in which the institution is held throughout the State." The delegation also pointed out that the Sealy family, "at an expense of several thousand dollars," donated the cost of repairs to the John Sealy Hospital, which, while owned by the state, was "supported by the city of Galveston, mainly as a charity institution." The committee outlined the need for "$55,000, in round numbers, which represent necessary and absolute immediate needs, and should be appropriated." The legislature became more generous, responding to the report and the regents' request for $60,000 for repairs and $45,000 for salaries for the biennium 1901-1903 by allocating all of it, but for $5,000 in salaries.[9]

Some 87 percent of UTMB operating income came from state general revenues between 1901 and 1940. However, uses of the legislative allocations were limited to "maintenance and support," while money for erection, repair, maintenance and support of

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[8] Oscar F. McNally, Pat Neff, M. T. Lively, and George W. McKnight, "Report of Special Committee Appointed to Visit the University of Texas and Medical Branch," Journal of the House of Texas of the Twenty-Seventh Legislature, February 26, 1901, http://www.lrl.state.tx.us/scanned/interim/27/27_0_UnivTX&UTMB.pdf (accessed June 12, 2007).

[9] Ibid. The repair costs outlined in the report: $23,495.54 for the Medical College building; $4,947.08 for Anatomy, Pathology, Chemistry, Physiology, Pharmacy, Obstetrics and Gynecology; $10,456.85 for University Hall; $1,435.12 for furniture; and $13,000 to reimburse costs for temporary repairs to allow the school to reopen for the term; Williamson: 2005 dollar equivalents, $55,000 = $1,319,595; $60,000 = $1,439,558; $45,000 = $1,079,668; $5,000 = $119,963.

the university and its branches was to come from the Available University Fund.[10] In other words, costs for care of indigent patients were borne mostly by the city, private pay patients and their insurance carriers, and philanthropy. Although counties throughout the state were authorized by the state constitution to take care of their paupers, including their health care, it neither mandated the action nor spelled out measures to pay for it.

The State Constitution prohibits general revenue from being used to build or maintain educational facilities for state universities; that is what the Available University Fund is for.[11] Unfortunately for UTMB, the hospital was where teaching took place, but it was separate from the educational enterprise. That changed in 1941. Gov. W. Lee "Pappy" O'Daniel assured Chief Executive Officer and Dean John Spies in 1940 that he would "support a major increase in state dollars if UTMB acquired complete control of the John Sealy Hospital complex."[12]

Thus, for the next five months, Galveston City Commissioners, the John Sealy Hospital Board of Managers, Sealy & Smith Foundation board members, and university officials "negotiated a dissolution of the hospital board and the transfer of complete authority for operating the hospital complex to the regents."[13] In a letter to the Galveston City Commission requesting it abrogate the lease, the Hospital Board of Managers said the situation made it "impossible to establish any single and definite authority for a unified management" because responsibility for the patients and facilities was divided inconsistently. At the same time, the board believed that state management of the facilities would "permit of a greater efficiency in operation, create a greater interest in our medical college by the state at large, expand our medical center in Galveston, and

[10] Burns, 77 and 17. The Available University Fund derives from interest received on bonds and fees from sales of lands the university used to capitalize itself—the Permanent University Fund.

[11] Ibid., 505, n. 9.

[12] Ibid., 51.

[13] Ibid.

bring to fruition the dream of those who would cure and care for those who could not help themselves."[14]

Throughout the negotiations, the city appealed to the state to take care of its indigent patients. But city commissioners finally agreed to pay $40,000 a year, along with an annual supplement (primarily from the Sealy & Smith Foundation) of $75,000 in 1941 and $60,000 after that for a guaranteed 58,000 patient days in the hospital (which averages out to $1.04 per patient per hospital day) and an unlimited number of patient visits to the outpatient clinics.[15] The number of inpatient days was determined by averaging totals for the previous five years. In the contract, the city was required to determine whether an individual qualified as indigent but the hospital received the authority to determine whether the person should be admitted and when he/she should be discharged.[16]

Although the commitment of $60,000-$75,000 annually by the Sealy & Smith Foundation for uncompensated care sounds like a huge burden, it actually saved money for the foundation over what it had previously paid. "The Sealy & Smith Foundation is making up a...deficit generally higher than $100,000 per year [and]...cannot continue to meet such a deficit due to reduced income," Mayor Brantly Harris told the *Galveston Daily News*.[17] The move was viewed as a positive for all parties, Harris said, and particularly for the regents because "this will permit the university to start its expansion program." The expansion program to which he referred was implied in a statement by UT President Homer P. Rainey that "a building and expansion program to make Galveston

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[14] *Galveston Daily News*, "Hospital Board Asks City to Abrogate Lease: City Commission to Receive Letter at Meeting Tomorrow," January 15, 1941.

[15] Williamson: 2005 dollar equivalents, $40,000 = $530,346; $75,000 = $994,399; $60,000 = $795,519.

[16] *Galveston Daily News*, "Cancellation of Hospital Lease Ordered by Board: University Regents Are Given Exclusive Control by City," March 7, 1941.

[17] Ibid.; Williamson: 2005 dollar equivalents, $100,000 = $1,325,866.

the outstanding medical center of the South is being planned by the university." The *Galveston Daily News* quoted him as saying: "At the present time there is no outstanding medical center in the South. Galveston is the logical place for such a program and the university intends to carry out the plan." [18]

1941-1969

Although the following biennium saw increased budget support from the legislature and growth in the number of patients from throughout the state,[19] the advent of new medical centers in Houston and Dallas in the next decade saw waning interest in UTMB—not only by the lawmakers but also on the part of University of Texas President Theophilus S. Painter. In a 1946 letter to Dr. Chauncey D. Leake, UTMB's vice president and dean, Painter wrote that he thought:

> [M]ore and more of the time of the men at Galveston, in the clinical years, is going to be spent in Houston, where clinical material is abundant. The result will be that...our primary considerations [in Galveston]...will be to provide an adequate laboratory and class building so as to take care of the teaching needs.[20]

To which Leake responded by seeking salary increases for the next biennium, accompanied by the justification that they were only "in accordance with the second and third rate medical schools." He warned that unless they were "progressively raised,… Texas will have to be satisfied with [that], since the quality of a medical school depends largely on the quality of its professional personnel." State pride would not let that happen, and budget increases followed.[21]

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[18] *Galveston Daily News*, "Statement to Be Made Later on Hospital Change: Conference Held by Local Officials with University Head," January 31, 1941.

[19] Chauncey D. Leake to Homer P Rainey, letter, February 21, 1944, CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990. Attached to the letter is a list of Texas counties and the number of patients from each, totaling 1,275 patients from 124 counties.

[20] Burns, 81.

[21] Ibid.

Having recently acquired the hospitals, the regents were surprised in early 1946 by a projected operating deficit of $198,000, which Painter blamed on the cost of charity care. The board took a number of actions, including granting a $75,000 loan to meet urgent expenses, increasing room charges, and freezing the budget. Leake also appealed to the city, which raised its budget allocation for indigent care by 87.5 percent, from $40,000 to $75,000, as of July 1, 1946.[22]

With diligent and tenacious attention to the Board of Regents and the State Legislature, leaders of Galveston's academic health center witnessed budget increases over the next several biennia. The Galveston Chamber of Commerce and UTMB officials in early 1947 conducted tours of the facilities for state representatives and senators, who left the island "greatly impressed by the size of the medical plant, not realizing its massiveness or potentialities. They were especially interested in the hospital and the service to indigents, and the cost per patient per day." In a presentation to the group, Leake said the cost of caring for indigent patients "had risen from $350,000 to $430,000 from 1942 to 1946...[and that] the cost per patient per day at John Sealy Hospital...is $6.25 compared with $9.53 in other general hospitals in the state."[23] Shortly after their visit, the House and Senate approved an emergency appropriation to UTMB of $328,067 until the end of the 1947 fiscal year.[24] Recognizing that their stewardship efforts with the legislators would be beneficial, in a letter to Painter in April 1948, Leake wrote: "It is my opinion that if the situation is put clearly before the legislature, sufficient funds will be

[22] Burns, 82.

[23] Lillian E. Herz, "Texas Senators Are Impressed with Size of Medical Branch and Opportunities Offered," *Galveston Daily News*, March 14, 1947.

[24] Stuart Long, "Approval Seen for Emergency Medical Appropriation," *Galveston Daily News*, April 6, 1947; Williamson: 2005 dollar equivalents, $350,000 = $350,000; $430,000 = $5,152,085; $6.25 = $74.88; $9.53 = $114.18; $328,067 = $2,868,016.

appropriated...for the State indigents referred to our hospitals, and which thus become available for teaching purposes."[25] And that happened.

Meanwhile, groundbreaking for a new John Sealy Hospital took place in May 1949, and the hospital opened in January 1954. The R. Waverley Smith Pavilion, for which Jennie Sealy Smith had left a bequest after her death in 1938, opened in December 1953. And a third new building, the Ziegler Hospital, with 60 beds for "patients with diseases of the chest," opened in February 1954. Funds for the facility were bequeathed to the university by Rose M. Ziegler, who died in January 1948, and were matched by the Texas State Board of Health.[26]

By summer 1955, UTMB had a $500,000 deficit, partly as a result of opening these hospitals and adding 100 more beds for which the state had not allocated enough operating funds.[27] Again the regents used the Available University Fund to cover the loss, and raised room charges. They also appealed to "local communities to assume a minimum portion of the costs of care for their indigent patients." In a letter to 250 county judges and 250 members of the Texas Medical Society, UT President Logan Wilson blamed "inadequate Legislative appropriations for the next biennium, together with restrictive provisions as to usable funds" for increases in room charges to individuals and referring localities that were perceived as the only way for UTMB to stay in business:

> Local communities, through relatives or friends of indigent patients or through private or public welfare agencies, will simply have to raise the minimum required if the hospital is to continue to serve the state as the only state general hospital in Texas.[28]

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[25] Chauncey D. Leake to T. S. Painter, April 14, 1948, CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[26] Burns, 113.

[27] Williamson: 2005 dollar equivalents, $500,000 = $3,646,378.

[28] Logan Wilson to county judges and physicians, July 16, 1955, CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

He also enlisted their "cooperation in explaining the situation at the Medical Branch to interested citizens and agencies" in their communities. A news release issued about the rate increases the same day noted that private physicians in 250 of the state's 254 counties referred "some 25,000 patients...from every corner of the state...where local facilities are not comparable or available." As of the end of the 1954 fiscal year, 12,504 patients had been admitted to the hospital, and 142,329 were treated in the out-patient diagnostic and treatment clinics.[29] Meanwhile, the Sealy & Smith Foundation augmented its budget in 1956 and 1957 to make up for the losses.[30] Contributions from the foundation, other organizations, and gifts amounted to 3 percent of hospital operating income between 1941 and 1968.[31]

Dr. John Truslow, who became dean and chief executive officer of UTMB in April 1956, approached Galveston city commissioners for another increase in charitable care contributions. After voter approval of a property tax of twenty cents per one hundred dollars of evaluation for "treatment and care of the indigent sick persons, resident of the City of Galveston" in a special election May 14, 1957,[32] the city raised its annual UTMB allotment to $200,000. Between 1941 and 1968, this amounted to about 2 percent of UTMB's operating income. Truslow also pressed the state between 1958 and 1963 for substantially larger budgets, first to increase salaries, next to support $13 million in campus improvements, and then for operating expenses.[33] Although the state allocations

[29] Ibid.

[30] Burns, 83-84.

[31] Burns, 84.

[32] Mrs. Mary Quiroga, Secretary of the Board of Commissioners, Certification of Election, June 6, 1957, CHP, RF49, HEALING: Care of Indigent Patients, 1911-1990.

[33] Burns, 84.

for indigent care are not specifically identified, hospital operations included some uncompensated care costs.[34]

Under the leadership of charismatic Dr. Truman G. Blocker, Jr., appointed CEO in 1964 and UTMB's first president in 1967, operating income continued to escalate—from the legislature and from the regents. "UTMB was now receiving more tangible support from state government than ever before."[35]

Meanwhile, another charismatic Texan, U.S. President Lyndon B. Johnson, led his Great Society program through Congress, and he signed Public Law 89-97, establishing Medicare and Medicaid in July 1965. As a result, millions of federal dollars became available to the states for health care for the elderly, for the blind and disabled, and for indigent families with dependent children. By 1969, UTMB saw dramatic increases in its income.[36]

At the same time, the UT Board of Regents, with approval of the State Legislature, converted the disparate components of the university throughout the state into the University of Texas System, between 1967 and 1970. That move created economies of scale and efficiencies of organization that enabled the campuses, including UTMB, to better use their financial allocations.[37]

1970 TO THE PRESENT

For the most part, indigent care seems to have been less of an issue for UTMB throughout the 1970s, because the UT Board of Regents, and effective UTMB executives

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[34] Williamson: 2005 dollar equivalents, $0.20 = $1.44; $100 = $719; $200,000 = $1,437,086; $13,000,000 = $93,410,596.

[35] Burns, 84.

[36] Ibid., 87.

[37] Vernon E. Thompson, interview by Chester E. Burns, April 1986, Part 4, UTMB Centennial Oral History Collection, Moody Medical Library, Galveston, Texas, http://ar.utmb.edu/areas/informresources/collections/blocker/oralhistorychild.asp (accessed November 11, 2007).

were working closely and harmoniously together—and the state had the wherewithal to provide the finances. The state was riding an economic high tide:

> UTMB benefited from significant increases in state revenues during the 1970s.… For example, state revenues increased from $4.4 billion in fiscal year 1973 to $7.4 billion in fiscal year 1977, a 68 percent increase.… Biennial appropriations for medical education in Texas from general revenue and federal revenue sharing between 1972 and 1979 increased 251.4 percent (from $167,041,522 to $586,962,357). [38]

In his annual reports to the regents and the Legislative Budget Board between 1964 and 1974, Blocker discussed progress of new hospitals, research buildings, and other facilities under construction on the campus. He thanked the regents and state legislators for their vision and support as he reported on the good works their financial assistance enabled the university to undertake. None of his reports revealed difficulty affording care for any patients who sought treatment they could not pay for. In fact, the state "was very affluent as a result of tax revenue from the energy industry" in the 1970s, said V.E. "Jack" Thompson, Vice President for Business and Hospital Affairs from 1967 to 1986, in an interview in 1990.[39]

That does not mean, however, that indigent care was not on the legislative radar screen. The introduction to a 1980 report by the Texas Advisory Commission on Intergovernmental Relations said, "Since the early 1970s, a number of state legislative committees, agencies, and other groups have examined the general problems and issues related to the provision and financing of medical care in Texas."[40] The report, in essence, reaffirmed that the Texas Constitution assigns counties the responsibility for "provid[ing] medical treatment for indigents." Moreover, if a county has a public hospital, its

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[38] Burns, 94; Williamson: 2005 dollar equivalents, $4,400,000,000 = $19,332,283,465; $7,400,000,000 = $23,844,580,102; $167,041,522 = $779,527,103; $586,962,357 = $1,579,629,989.

[39] V. E. Thompson, interview with Chester R. Burns, January 1990, Part 7.

[40] Jose Jorge Anchondo, "Medically Indigent Costs Affecting Local Governments: Background and Issues," Intergovernmental Report No. VIII-1 (Austin, TX: second printing, October 1983), Texas Advisory Commission on Intergovernmental Relations, June 1980.

commissioners court "shall provide for sending the indigent sick of the county to such hospital."[41] The report recommended, among other solutions, county hospitals seeking payment from other counties when they treat uncompensated patients from those counties. However, no mechanism for enabling that was suggested. UTMB is unique, however, in that it is a state hospital, not supported by county or hospital district funds, and outside the bounds of the legislation. However, a mechanism for requiring counties to pay for their residents' uncompensated care would have benefited UTMB, as well.

In 1981, a survey by the Department of Human Resources found that 28 percent of the poverty population in the state had no health insurance of any kind. Not long after, the State Legislature established the Task Force on Indigent Care, including elected officials, physicians, other health professionals, business and labor leaders, representatives of advocacy organizations, consumers, and representatives of state health agencies. Chaired by Mrs. Helen Farabee and Rep. Gordon Arnold, vice-chair, the task force issued a comprehensive report in December 1984. In its introduction, the report lays out the crux of the problem:

> Indigent health care is an issue which affects all Texans, not just poor individuals in health crisis. The longer the problem is ignored, the more expensive the consequences become for everyone.… Ambiguous state statutes regarding county responsibility and restrictive state and federal programs have resulted in great disparities in the tax burden in different parts of the state. The inequities among health care providers threaten the viability of certain types of hospitals, and create disincentives to providing services to the poor and uninsured.[42]

The task force made 50 recommendations, divided into three categories that represent major issue areas by the Executive Committee, identified after 11 hearings and a number of site visits across the state: "allocation of responsibilities for providing and

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[41] Ibid, 2.

[42] Helen J. Farabee, Gordon Arnold, Chet Brooks, et al., "Task Force on Indigent Health Care: Final Report, December 1984," www.lrl.state.tx.us/scanned/interim/68/in2.pdf (accessed June 12, 2007), 1.

financing indigent health services;...priorities for those services which should be included in the responsibilities of governments and providers;...and proposals for addressing issues requiring further consideration." In a summary statement, the task force said:

> The major recommendations...propose including many more individuals in tax-supported programs, which would finance a greater portion of the demand for free care, with additional revenues derived from federal income taxes, state general taxes, as well as local property taxes.… [And that] the balance of indigent care costs remaining after the expansion of private and tax-supported insurance programs should be more equitably distributed among public and private hospitals.[43]

The task force also derived seven themes for its overall approach and objectives:

- Expand health insurance coverage for the medically indigent;
- Improve statewide uniformity in defining eligibility for charity care;
- Provide greater equity in distributing the burden of providing and financing indigent health care;
- Maximize the utilization of existing health-care facilities in order to improve the geographical access to care;
- Increase the availability of maternity and primary care services in order to reduce unnecessary utilization of high-cost care (see County Contracts below for how UTMB addressed the problem);
- Preserve the ability of public hospitals and private nonprofit hospitals to provide high quality care to indigent Texans; and
- Improve the availability of information on the nature and scope of indigent health-care needs and on efforts to meet those needs in order to improve statewide monitoring and coordination.[44]

[43] Ibid., 3-4.
[44] Ibid., 4-5.

The task force also received survey responses from 277 nonfederal, non-psychiatric, general acute-care hospitals in the state, representing 51.5 percent of the hospitals and 65 percent of the hospital beds in the state. In 1983, those hospitals received $5.9 billion in total gross revenues, 24 percent ($1.4 billion) of which they reported as uncompensated or under-compensated care. In other words, in the mid-1980s indigent health care was a statewide problem.[45]

Thompson's successor, E. J. "Jere" Pederson, confirmed that indigent care had always been part of the university's mission, and that the operating budget (which included federal and state allocations, individuals' and insurance company payments, and philanthropy) included costs related to caring for patients who could not pay the bills. In fact, he said, UTMB had enough money that the John Sealy Memorial Endowment for Biomedical Research was created in 1986, using gifts from the Sealy & Smith Foundation matched by undesignated UTMB dollars. Initially $10 million, the match doubled in two years and was invested for a conservative, yet high yield; today, the endowment is valued at more than $135 million.[46] Pederson's point was that uncompensated care was not really a big problem during this time because the hospitals generally had enough income to cover the costs.[47]

Pederson said a "perfect storm" in the mid-1990s caused indigent care to become the issue it is today. Health maintenance organizations (HMOs), exemplified by Kaiser-Permanente and CIGNA, both originating in California, held down premiums—and provider reimbursements—by capping payments to physicians and hospitals, leaving little room to shift costs to uncompensated care. Taking cues from HMOs, other health

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[45] Ibid., 14.

[46] Williamson: 2005 dollar equivalent, $10,000,000 = $17,819,343.

[47] E. J. Pederson (UTMB Executive Vice President for Business Affairs, 1985-2005), interview with Joanna Bremer, in his office in the Bank of America Building, November 28, 2007.

insurers instituted managed care policies, also driving down reimbursements. Meanwhile, Medicare created diagnosis related groups (DRGs) under which it paid hospitals and doctors, capping the amount it would pay based on the patients' diagnoses, no matter what extenuating circumstances increased costs. And Medicaid rates and coverage established by the State Legislature were generally set at the federal minimums, following Texas' traditional low-tax, low-service patterns, because government officials wished to use their budgets in ways that would be more visible to the taxpayers who elected them.[48]

Meanwhile, the state and national economies from the early through the mid-1980s were faltering, and governments had less money. For example, Congress enacted the Balanced Budget Act of 1997, which stipulated cutbacks for Medicaid. The state also instituted Medicaid reductions. The number of uninsured rose because small businesses were dropping expensive health insurance in order to keep going. Some individuals who had lost their industry and corporate jobs started their own companies—without enough wherewithal for health coverage for themselves and their employees. All of these factors, whose momentum had started a decade or two earlier, accumulated and crashed down on UTMB—and other health-care institutions—all at one time.[49]

"The advent of technology and the expense of that technology have driven up the cost of indigent care," said Dr. James C. Guckian, Executive Associate for Health Policy and Planning at UT System in 1988-1999. "During the 1970s and 1980s (and earlier), the cost remained relatively low, and was sustainable by UTMB with state appropriations and Sealy gifts. Costs really began to escalate in the 1990s."[50] In addition to the costs of the technology itself, said Dr. Alvin L. LeBlanc, Vice President for University Hospitals

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[48] Ibid.
[49] Ibid.
[50] James C. Guckian, e-mail message to Joanna Bremer, November 27, 2007.

at the time and currently Associate Dean Emeritus for Graduate Medical Education, "liability risks for not using all the technology available increased the number of tests done," which also raised expenses related to patient care.[51]

County Contracts

Indigent health care had come to the political forefront in the early 1980s, when a nationwide recession struck, represented by, among other things, deep layoffs in the automotive and oil industries, particularly affecting Texas. In 1983, a television reporter asked UTMB President William C. Levin, questions about indigent health care, which he answered in a letter. Part of the response included comments from LeBlanc, who wrote:

> [T]he numbers of individuals unable to afford personal health care has increased markedly in the last year, reflecting the general worsening of the economy and the increased unemployment rate. Federal program coverage of such individuals has been significantly restricted, with more of the same assured by recent congressional action. County hospitals throughout the state, subjected to increasing numbers of patients, reduced reimbursement rates, and increasing costs, have tightened their eligibility requirements and have been forced to refuse services to non-residents. Because of these changes, UTMB at Galveston, which has traditionally provided significant services to indigent patients from throughout the state, has been increasingly asked by county officials, hospital administrators, and physicians in its catchment area to define its policies and capabilities in regard to indigent patient transfers.… Although [UTMB] is a state supported institution, it is neither mandated to serve as the indigent hospital for the State of Texas, nor is it capable of doing so...What the State of Texas does do is provide funding which allows us to accept a finite number of indigent patients appropriate to our basic educational mission.[52]

The groundwork for eventual UTMB contracts with counties for care of their indigent population had been laid out in the 1960s by the chairman of the Department of Obstetrics and Gynecology, William J. McGanity, M.D., who, with another outstanding ob/gyn specialist LeBlanc as his agent, established satellite prenatal clinics in adjacent

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[51] Alvin L. LeBlanc, M.D. (UTMB Associate Dean Emeritus for Graduate Medical Education), personal communication, December 2007.

[52] William C. Levin to Sylvia Komatsu, April 29, 1983, the William C. Levin, M.D., Papers, File 2, Box 49, Blocker History Collection, Moody Medical Library, Galveston, Texas.

counties, the first being Jefferson County. The clinics cost the county only for a public health nurse, which it already had, and a facility in which to house a clinic—existing county public health facilities for which the county already was paying anyway. UTMB provided health-care teams, including physicians, which conducted prenatal exams and provided nutritional counseling, family planning information and prescriptions, and screening for potential gynecological surgical procedures. "The outcome was healthier mothers and babies, a benefit for the county, financially and politically," said LeBlanc. "The UTMB teams were compensated by the county only for travel. Eventually, UTMB secured some grant support for this project."[53]

When, in the 1980s, it appeared important to obtain county support for their other indigent patients, LeBlanc was tapped, because he had established the prenatal care network under McGanity's tutelage. The administration offered to provide residents, who would care for Medicaid-eligible patients, for which UTMB would receive the standard Medicaid reimbursement; and they would care for county patients who do not qualify for Medicaid but cannot afford to pay for their diagnosis and treatment, for which UTMB would bill the counties at one-third the customary rate.

Again, LeBlanc started with Jefferson County, because he had a relationship with the county judge and other officials. "County judges have close relationship among themselves and a very efficient network, including the Texas Association of Counties and the County Judges & Commissioners Association of Texas," said LeBlanc.

> It was very interesting. Once we signed the contract with Jefferson County and a few others, we began getting calls from all over the state—even West Texas. These are small counties; and they did not have that many patients coming here. But they could afford to pay one-third of the regular cost for those who did. And the Legislature and UT System liked it, because it helped defray a significant amount of the costs of indigent care provided by UTMB, and extended the

[53] Alvin L. LeBlanc, M.D. (UTMB Associate Dean Emeritus for Graduate Medical Education), interview with Joanna Bremer in his office in the Jennie Sealy Hospital, November 27, 2007.

> entitlement criteria used by a number of contracting counties to a more reasonable level than required of them by state law.[54]
>
> Unfortunately, as time passed and the cost of medical care escalated, the new county judges found it more and more politically difficult to maintain these more realistic entitlement levels, and the source of funding for indigent care provided by UTMB began to be much less available. The issue of illegal alien residents and their health care has become a much more significant issue in recent years, and greatly adds to the complexity of funding health care for the unemployed and uninsured.[55]

The Prison Hospital

The prison hospital came about largely as a result of a 1972 class action lawsuit, officially *Ruiz vs. Estelle,* by prisoner David Ruiz against William J. Estelle, then director of the prison system. The suit, in essence, claimed cruel and unusual punishment in Texas prisons because of overcrowding, inadequate health care, inadequate security, unsafe working conditions, and severe and arbitrary disciplinary procedures. The suit, as it related to health care, said the TDC had "too few medical professionals for the number of prisoners...uncredentialed individuals [delivering] medical care, and limited therapy for psychiatric patients." Federal Judge William Wayne Justice of the U.S. Fifth District Court in Tyler heard the case, and ordered a wide range of changes throughout the Texas prison system, including health care.[56]

As the state hospital, UTMB had long provided medical care to Texas prison inmates, an extension of the hospital's mission of care for the indigent. The prisoner care at UTMB existed for many years before the Texas Department of Corrections Huntsville Hospital was condemned in 1973. In fact, 10 years before that, Blocker had proposed building a prison hospital at UTMB, using prison materials and labor. But it was rejected

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[54] LeBlanc, personal communication subsequent to November 27, 2007, interview.

[55] Ibid.

[56] David Theis, "Big House Health Care: Why and How UTMB Treats the Incarcerated," *UTMB Magazine* 9, no. 1 (Fall 2007): 6-11.

as outside the university's five-year plan, already in place.[57] According to LeBlanc, the state did not pay for any prisoner care or treatment; UTMB just provided it as one state agency to another. That changed after the Texas Criminal Justice System Hospital opened at UTMB in June 1983. The state spent $40 million on the prison hospital, linked by a bridge to the John Sealy Hospital Annex, and when it found it necessary to clarify expenses, the legislature created a TDCJ budget for UTMB.

> Because of the complexity of maintaining TDC control of hospitalized inmates' security, and avoiding duplication of such very expensive UTMB services as the operating room, recovery room, intensive care units, and specialty labs/support services, the original budgets were best guesses, and did not include the development of UTMB physician coverage of outpatient service delivery at the various TDCJ units. This initial budget did not contain a UTMB faculty compensation plan for services rendered inmates.
>
> Eventually, these budgets became more accurate for both UTMB and TDCJ, as we gained experience in providing comprehensive care to all inmates, introduced a managed care type contract approach, and developed a mechanism to reimburse faculty for their services to the TDCJ inpatients and outpatients. As the TDCJ expanded its units and population, a comparable approach was developed between TDC and Texas Tech Health Service Center for TDCJ inmates housed in units in West Texas. The original UTMB-TDC hospital was designed to be physically connected to the UTMB hospital complex to satisfy Judge Justice's requirement that inmate care must be equivalent to that of other patients, and at the same time, provide security to protect the non-inmate population.
>
> As it became evident that there were logistical problems in getting inmates to Galveston for special clinics and procedures and then back to their units after hospitalization, especially if surgery or delivery were involved, a second step-down infirmary and clinic unit was developed in Texas City, and separately budgeted.[58]

"The TDCJ hospital was a big deal for us," LeBlanc said. "It allowed us to increase the number of residents because we had more case material." LeBlanc credited State Representative James Hury, with working with UTMB President Levin, Lt. Governor William Hobby, and members of the governor's staff, to compensate UTMB

[57] Burns, 520, n. 30.
[58] LeBlanc, personal communication.

faculty for the time they were spending with incarcerated patients. LeBlanc had been visiting with Hury regularly over the years, seeking legislative support for this. He said that:

> In accordance with our indigent care contracts with counties, faculty received 33 percent of usual charges. Hury said he believed the sticking point was that the Appropriation Committee chair and the House Speaker Gib Lewis thought the faculty wanted to be paid as if the inmates were private patients. Finally, Hury said one day, "Let's go get this settled." He walked me into the chairman's office, where he explained the situation in "East Texas straight talk." The chair replied that the state's financial situation precluded a fee-for-service approach, but that UTMB could get $2 million for faculty compensation for the year—take it or leave it. Since the faculty were receiving nothing, this was clearly "found money" for services already being rendered, and became a base to build a more reasonable faculty compensation plan on. All of us were under the gun because of Judge Justice.[59]

Legislative Actions

Throughout the 1980s and 1990s and into the early 2000s, the Texas Legislature grappled with the growing numbers of uninsured Texans and the spiraling costs of health care, especially as these affected state costs in the Medicaid program. Innumerable studies by special leadership-appointed task forces, standing legislative committees, legislative agencies, comptroller performance review teams, and state health and insurance agencies looked at all aspects of the indigent care problem. Among other things, they evaluated Medicaid, health insurance adequacy and availability, managed care, trauma care, chronic illnesses, local and state government responsibilities, provider reimbursement and responsibility, and accessibility to specialty care. Every session during this period, the legislature enacted several measures that either positively or negatively affected UTMB's ability to address the increasing needs of low income and uninsured patients seeking care—either through actions specific to UTMB and/or the

[59] Ibid.

three UT state-owned hospitals (UTMB, UT M.D. Anderson, and UTHC-Tyler), or through actions that affected many or all providers, including UTMB. It should be noted that, "until very recently, perhaps at the time of appropriation of lottery funds [below], the state never explicitly appropriated funds for indigent care," Guckian said. "Funds were appropriated for the hospital with the legislative understanding that they were to be used for training, which allowed for care of non-paying patients."[60] Nevertheless, the legislature cut this amount in half (from $20 million to $10 million) in 2003, when it also halved the allocation from unclaimed lottery proceeds (also $20 million down to $10 million) (Table 2-2). The same year, the Legislature imposed a three-month waiting period and changed income rules for the Children's Health Insurance Program (CHIP), dropping 40,000 children from the program. In January 2004, revised eligibility rules and six-month coverage periods resulted in a loss of enrollment of another 78,000 children; and implementation of new asset tests for eligibility the following September cost coverage for an additional 34,000 children, equaling a reduction of more than 150,000 children insured by CHIP in one legislative biennium.[61] That single Legislative session (the 78th) cost UTMB some $50 million (Table 2-2), which it has yet to recover. Other key legislative actions from 1985 through 2007 are outlined in Table 2-1.

Table 2-1. Major Legislative Actions with Impacts on UTMB Health Care Funding

Year	**Affected all/most providers OR Mainly affected UTMB**	**+ or - impact on UTMB's ability to serve indigent and low-income patients**	**Legislative Action**
1985	All	+	Legislature passed Indigent Care and Treatment Act – first time county responsibility was formalized (set at

[60] Guckian, e-mail message.
[61] Heber Taylor, "Help Spread the Good News," *Galveston Daily News*, July 11, 2007.

Year	Affected all/most providers OR Mainly affected UTMB	+ or - impact on UTMB's ability to serve indigent and low-income patients	Legislative Action
			AFDC levels, about 18% of the federal poverty level)
1987	UTMB	+	UTMB started earning additional federal Medicaid funds through the disproportionate share program ($2.3m total for 1988, '89, and '90); *initiated by UT System. No legislative action involved.*
1991	All	+	Legislature raised Medicaid eligibility for pregnant women and newborns to 185% of FPL (a few years later, this became the federally mandated minimum.)
1991	UTMB	-	Legislature swept some of the federal DSH funds earned by UTMB and the other state-owned hospitals into the state general revenue fund.
1993	UTMB	-	Legislature increased UTMB hospital appropriation by $30m per year (to $97M), but began sweeping all federal DSH funds earned by UTMB into the state general revenue fund ($150M per year at this time; since 1993, state GR gain from UTMB DSH has ranged from $50M-$150M per year—see Figure 2-1)
1993	UTMB	-	Legislature directed Medicaid managed care pilot for Galveston, Jefferson and Chambers counties
1997	UTMB	+	Legislature increased UTMB hospital appropriations by about $17M per year (starting FY '98)
1997-8	All	-	Medicaid cuts due to U.S.Balanced Budget Act of 1997
1999	All	+	Legislature implemented CHIP program to provide coverage for low-income children in families above Medicaid income eligibility
1999	All	+	Legislature appropriated Tobacco Settlement proceeds to start CHIP and provide trust funds for counties, health science centers, and health-department funded services
1999	UTMB	+	Legislature first appropriated $20M per year in unclaimed lottery funds for UTMB indigent health care (to start in FY 00)
1999	All	+	Legislature increased county responsibility for indigent health care to 21% of the federal poverty level
2001	UTMB	+	Legislature appropriated $4M per year in new special item for UTMB indigent health care
2001	UTMB	-	Legislature failed to pass bill that would have increased sales tax in Galveston County to fund indigent care
2003	UTMB	-	Legislature cut $20M lottery appropriation for UTMB indigent health care in half—to $10M per year, and reduced indigent care special item by about $200,000

Year	Affected all/most providers OR Mainly affected UTMB	+ or - impact on UTMB's ability to serve indigent and low-income patients	Legislative Action
			per year
2003	All	-	Legislature eliminated state general revenue funding for the Medicaid Graduate Medical Education program ($10M per year loss to UTMB)
2003	All	-	Legislature eliminated Medicaid Medically Needy program, which was the only program that provided funds for non-pregnant, non-disabled low income adults
2003	All	-	Legislature reduced Medicaid and CHIP provider rates
2005	All	+ -	Legislature restored some Medicaid provider rates, but not for hospitals
2005	All	-	Legislature established Medicaid Upper Payment Limit program which provided substantial supplemental federal funds to safety net hospitals, but swept all of UTMB's, MD Anderson's, and UTHC-Tyler's gains into the state general revenue fund.
2007	UTMB	+	Legislature appropriated $13M in one-time funding to replace UTMB hospital losses due to 2005 Hurricane Rita evacuation
2007	All/UTMB	+	Legislature appropriated $150M to increase all hospital Medicaid rates starting FY 09, and started UTMB's, MD Anderson's, and UTHC-Tyler's rate increases earlier—in FY 08.
2007	UTMB	-	Legislature restricted UTMB's use of the $10M /yr lottery funding, prohibiting UTMB from using it to serve patients from Galveston, Brazoria, Harris, Jefferson, Montgomery, and Fort Bend counties unless those counties' indigent care programs set their income eligibility levels above the statutory minimum (21% FPL)
2007	UTMB	-	Legislature denied UTMB requests for: 1) restoration of lottery funding, 2) funding to address increased costs of health care, and 3) allowing UTMB to retain some of the federal DSH and/or hospital UPL gains earned from UTMB services. As a result, total *appropriated spending level for UTMB health care* for FY 08 and for FY 09 is **about $5M below the level for FY 01.** Even more significant, a*ctual general revenue spent by the Legislature on UTMB health care*, after taking into account UTMB's payback to the state general revenue fund via DSH and UPL ($80-90M per year over the last

Year	Affected all/most providers OR Mainly affected UTMB	+ or - impact on UTMB's ability to serve indigent and low-income patients	Legislative Action
			two biennia), will probably be **no higher than the $63M GR spent by the legislature in FY 1990**.
2007	All	?	Legislature directed Health and Human Services Commission to implement substantial Medicaid reform. Results to be determined.

Disproportionate Share Hospital and Upper Payment Limit Programs

In 1986, financial officer Thompson said he feared that a reserve fund UTMB had been able to accumulate would be appropriated by the State Legislature in order to accomplish the business of the state.[62] In fact, "in 1985, Legislative appropriations to UTMB were cut," said Guckian, chairman of the Internal Medicine Department at the time. "About $20 million [of these] reserve funds were transferred by the Board of Regents to UT Austin, as were similar amounts from UT M.D. Anderson. State appropriations to clinical departments also were cut. I don't think [these actions] in 1985-86 were in any way related to indigent care; it was the down-turn in the economy and state revenue." The effect, however, was a reduction in UTMB's budget, which did affect its levels of patient care, particularly in relation to indigent and low-income patients.

Although Texas, like many states, did not begin to receive Disproportionate Share Hospital reimbursements to UTMB for its costs for indigent care until 1987 or later, the Omnibus Budget Reconciliation Act (OBRA) that Congress passed in 1981 contained the Boren Amendment, establishing the reimbursement system to compensate hospitals for revenues lost from serving a disproportionately large number of Medicaid and other low-

[62] Thompson, interview with Burns, 1986, Part 4.

income patients. Called the Disproportionate Share Hospital Program (DSH), the benefit resulted from Congress's repeal of the requirement that states pay hospitals for Medicaid patients at the same rates the federal government pays for Medicare patients, allowing states to pay any rates they deem "reasonable and adequate."

Because Congress realized this practice would cost money for these indigent-serving hospitals, it approved the Boren amendment to replace lost income. In the early 2000s, because Medicaid reimbursements are lower than those for Medicare, a second class of reimbursement, called Upper Payment Limit (UPL), was created in an attempt to close this gap, as well.[63]

In order to receive federal DSH and UPL funds for its teaching hospitals, the state must demonstrate that it is providing matching funds, which most states obtain via intergovernmental transfers (IGT) from counties, hospital districts, and indigent-serving hospitals, and from taxes on health-care providers. Texas does not levy provider taxes. Its match comes from IGTs from eight hospital districts, one municipal hospital and from 14 state-owned hospitals, including UTMB. To make this work:

> [These] hospitals transfer to HHSC an amount equal to their unreimbursed costs for Medicaid and uninsured patients, and the federal matching funds obtained with these funds are withheld by HHSC and transferred to the state general revenue fund. The hospitals [in the program] are reimbursed at 100 percent of their federal cap amounts.[64]

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[63] David C. Warner, Lauren R. Jahnke, and Kristie Kimbell, "Medicaid and the State Children's Health Insurance Program in Texas: History, Current Arrangements, and Options," *Code Red,* Appendix B (April 2005), B-8, B-18–B-19.

[64] Ibid, B-18, from House Select Committee on State Health Care Expenditures, "Interim Report 2004: A report to the House of Representatives, 79th Texas Legislature," November 2004, Austin, Texas, http://www.house.state.tx.us/committees/reports/78interim/healthcareexpenditures.pdf, accessed January 1, 2005.

"The 14 state hospitals that transfer money for matching funds are the University of Texas Medical Branch at Galveston, the University of Texas M.D. Anderson Cancer Center, the University of Texas Health Center at Tyler, The Texas Center for Infectious Disease in San Antonio and 10 mental health facilities."

Guckian, who held a number of administrative positions at UTMB, including Vice President for Medical Professional Affairs and Director of the Faculty Group Practice between 1986 and 1988, was Executive Associate for Health Policy and Planning at UT System in 1988-1999, when DSH started to take hold across the country. He was working on managed care issues with a health-care consultant, based in Washington, D.C., who told Guckian he had found a way for the UT System to receive federal money (DSH) to reimburse indigent care costs at its academic medical centers (UTMB, UT M.D. Anderson Cancer Center and UT Health Center Tyler). Guckian called in the Executive Vice Chancellor for Business Affairs, R. D. (Dan) Burck, a UT System lawyer, and Executive Vice Chancellor Dr. Charles Mullins, who agreed to sign a nondisclosure agreement with the consultant because he was providing proprietary information. Subsequently, the consultant's contingency fee was negotiated. They expected it to be small change; but it was far bigger than anyone expected. The DSH reimbursements to UT System for its hospitals went on for a total of seven years (1987-1993), contributing from $50,000 to more than $1.8 million per year. (Table 2-2).[65]

In about 1990-1991, the office of Lieutenant Governor Bob Bullock learned of the federal DSH income for UT System Hospitals. The lieutenant governor's staff and legislative staff members had been trying to find every possible avenue to maximize federal dollars to the state. The officials could not understand UT System obtaining federal money without informing them. They also were upset about the contingency arrangement, and blocked payments to the consultant. In the meantime, state leadership offices (including the governor, the lieutenant governor, and the speaker of the house)

[65] Laura Smith, telephone conversation with Dr. James C. Guckian, November 20, 2007, as told to Joanna Bremer by telephone, November 20, 2007. Guckian confirmed this in an e-mail message to Joanna Bremer, November 27, 2007; Williamson: 2005 dollar equivalent, $50,000 = $78,750; $1,800,000 = $3,094,542.

called in UT System officials, and worked out an arrangement for the federal dollars to go to the state General Revenue Fund, from which UTMB, UT M.D. Anderson Cancer Center and UTHC Tyler would receive their usual state allocation, plus some extra to support indigent care. For UTMB at the time, the additional allocation was $30 million, which was about the amount it had been receiving. Since that time, however, UTMB has received none of the DSH reimbursement from the state; but the state allocation in lieu of DSH has not been near the amount the hospital actually spends on indigent care and which is reported to CMS via the state. Any net gain through DSH goes to the general revenue fund, rather than to UTMB (see Figure 2-1).[66]

In the meantime, counties with public hospitals and hospital districts process their IGTs because they represent a major revenue stream: when DSH and UPL payments arrive from CMS, the Department of State Health Services (DSHS) returns the IGT amounts, plus a certain percentage more. At the same time, the DSHS also sends payments to private hospitals in the state that serve indigent patients, even though they do not have to contribute to IGTs. The state provides this funding, Guckian said, because, "Some private non-profit hospitals are members of the Texas Association of Public and Non-Profit Hospitals, and are politically influential." As a result, the state has maxed out DSH dollars with allocations to other hospitals and claims on general revenue dollars.[67]

CMS currently is planning to change the federal DSH and UPL programs dramatically. The agency published a proposed rule on January 18, 2007, entitled "Medicaid Program: Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State-Financial Partnership." In essence, the rule would take four major steps:

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[66] Smith.
[67] Ibid.

> 1) Impose a cost limit on Medicaid payments to public providers; 2) impose a new federal definition of public provider status; 3) greatly restrict the sources of non-federal share funding through intergovernmental transfers and certified public expenditures; and 4) require providers to receive and retain the full amount of Medicaid payments received.[68]

These changes would severely limit federal funding to hospitals and states across the nation. For Texas, the changes would reduce federal funding by an estimated $500 million, primarily owing to the redistribution of cost limits. States, hospital associations, and many others have objected strenuously to these proposed CMS rates. As a result, Congress placed a one-year moratorium on implementation of the policy. Some groups want to permanently prohibit implementation because of the devastating funding losses it would cause for states' health-care safety nets.

Partly in response to the understanding that CMS was likely to drastically change the DSH and UPL programs, the Texas Legislature passed Senate Bill 10 (SB10) in 2007. This bill sets the framework for comprehensive Medicaid reform that is intended to reduce costs in the Medicaid program, expand health-care coverage options for Texas' large uninsured populations, and preserve federal funding as much as possible. To the extent this effort leads to reducing the numbers of uninsured in Texas, it could help UTMB with its indigent care expenses. Senate Bill 10 and the states whose model programs it incorporates are discussed more fully in the next chapter.

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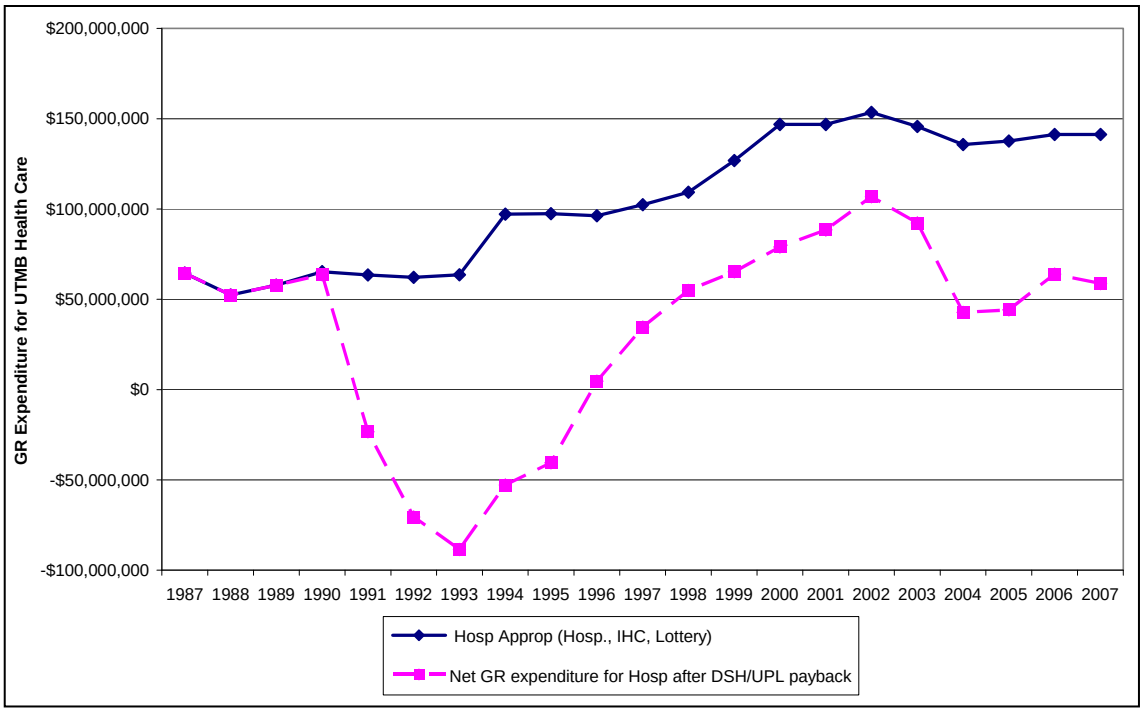
[68] Powell Goldstein, "Memorandum Regarding 'Proposed Rule Regarding Cost Limit for Public Providers and Defining "Public" Status'" (Washington, D.C: National Association of Public Hospitals and Health Systems, January 19, 2007), http://www.naph.org/Content/ContontGroups/Policy_Priorities/Medicaid_and_SCHIP/Summary_of_Proposed_Rule_1-19-07.pdf (accessed November 23, 2007).

Figure 2-1. UTMB Health Care Appropriations: Impact of DSH/UPL Payback



Source: UTMB Disproportionate Share Hospital I and II tables, from the office of Nancy Gast, Institutional Compliance

Over the last decade, realizing they could not depend upon the Texas Legislature to come up with solutions to Galveston's indigent care issues, UTMB officials hunted for some alternatives they could propose. Of all the plans they found, two stand out for their ability to address the problem of indigent care costs. The first, the Hillsborough County model from Florida, is discussed here. The second, called Three-Share, is based on a program implemented in Muskegon County, Michigan. It will be discussed briefly below and in more detail in chapter 3. Another funding source, identified by Galveston State Rep. Craig Eiland, is unclaimed lottery winnings. That plan also is discussed below.

Table 2-2. UTMB: DSH/UPL Deposits to State GR and UTMB Appropriation History

						UTMB Hospital/HealthCare Appropriations				Total GR App.	Net GR expenditure (Approp less DSH/UPL payback)		
						UTMB Art III Approps		DSHS Art II Approps	Subtotal Hospital/ Healthcare	Total GR*** (Including lottery)			
	DSH II	UPL	DSH 1	TOTAL to State GR	Retained by UTMB*	Hospital GR D.1.1	SuppforIndigntCare Spec Item E.2.4.	Lottery DSHS Indigent Care B.3.3.			Net Hospital GR	Net Total GR	
FY 09	TBD	TBD		TBD	$0	$ 127,815,298	$3,508,761	$10,000,000	$141,324,059	$238,794,181	TBD	TBD	**FY 09**
FY 08	TBD	TBD		TBD	$0	$ 127,815,298	$3,508,761	$10,000,000	$141,324,059	$238,954,955	TBD	TBD	**FY 08**
FY 07**	$52,410,270	*$30,146,880*		*$82,557,150*	$0	$ 127,727,579	$3,508,761	$10,000,000	$141,236,340	$229,132,099	$58,679,190	$146,574,949	**FY 07****
FY 06	$25,076,993	$52,244,508		$77,321,501	$0	$ 127,727,579	$3,508,761	$10,000,000	$141,236,340	$229,104,957	$63,914,839	$151,783,456	**FY 06**
FY 05	$93,432,210			$93,432,210	$0	$ 123,774,009	$3,838,108	$10,000,000	$137,612,117	$225,861,455	$44,179,907	$132,429,245	**FY 05**
FY 04	$92,997,798			$92,997,798	$0	$ 121,978,506	$3,779,691	$10,000,000	$135,758,197	$222,291,006	$42,760,399	$129,293,208	**FY 04**
FY 03	$53,416,323			$53,416,323	$0	$ 121,674,981	$4,000,000	$20,000,000	$145,674,981	$233,771,866	$92,258,658	$180,355,543	**FY 03**
FY 02	$46,808,939			$46,808,939	$0	$ 129,563,154	$4,000,000	$20,000,000	$153,563,154	$244,858,227	$106,754,215	$198,049,288	**FY 02**
FY 01	$58,369,067			$58,369,067	$0	$ 126,774,906		$20,000,000	$146,774,906	$238,076,646	$88,405,839	$179,707,579	**FY 01**
FY 00	$67,800,071			$67,800,071	$0	$ 126,819,391		$20,000,000	$146,819,391	$237,426,859	$79,019,320	$169,626,788	**FY 00**
FY 99	$61,613,761			$61,613,761	$0	$ 126,899,983			$126,899,983	$213,090,263	$65,286,222	$151,476,502	**FY 99**
FY 98	$54,462,621			$54,462,621	$0	$ 109,352,663			$109,352,663	$212,999,722	$54,890,042	$158,537,101	**FY 98**
FY 97	$67,816,516			$67,816,516	$0	$ 102,415,666			$102,415,666	$205,469,221	$34,599,150	$137,652,705	**FY 97**
FY 96	$91,598,185			$91,598,185	$0	$ 96,237,684			$96,237,684	$204,640,691	$4,639,499	$113,042,506	**FY 96**
FY 95	$137,917,076			$137,917,076	$0	$ 97,415,298			$97,415,298	$226,467,174	($40,501,778)	$88,550,098	**FY 95**
FY 94	$150,045,876			$150,045,876	$0	$ 97,160,438			$97,160,438	$227,050,318	($52,885,438)	$77,004,442	**FY 94**
FY 93	$143,993,528		$8,150,000	$152,143,528	$2,467,835	$63,567,258			$63,567,258	$178,891,015	($88,576,270)	$26,747,487	**FY 93**
FY 92	$124,555,382		$8,150,000	$132,705,382	$1,822,889	$62,135,717			$62,135,717	$180,595,828	($70,569,665)	$47,890,446	**FY 92**
FY 91	$78,716,534		$8,150,000	$86,866,534	$1,338,684	$63,485,300			$63,485,300	$176,400,210	($23,381,234)	$89,533,676	**FY 91**
FY 90			$1,630,000	$1,630,000	$1,840,329	*$65,288,182*			$65,288,182	*$180,732,866*	$63,658,182	$179,102,866	**FY 90**
FY 89					$49,871	$ 57,819,600			$57,819,600	$166,017,592	$57,819,600	$166,017,592	**FY 89**
FY 88					$470,886	$ 52,386,646			$52,386,646	$164,341,848	$52,386,646	$164,341,848	**FY 88**
FY 87					$1,830,514	$ 64,471,784			$64,471,784	$147,904,653	$64,471,784	$147,904,653	**FY 87**
TOTAL	$1,348,620,880	$52,244,508	$26,080,000	$1,426,945,388	$9,821,008	$ 2,064,676,324	$22,635,321	$120,000,000	$2,207,311,645	$4,822,873,652	$1,660,476	$2,835,621,978	**TOTAL**

**In earliest years of DSH, UTMB's hospital retained some of the increased funding. But after 1993, all net gain went to the state GR fund rather than to UTMB. Also, state match for program is provided through intergovernmental transfer (except in FY 87-89 when state GR was appropriated to the Department of Human Services, then the state's Medicaid agency, specifically to provide state match for DSH.)*

*** Estimated*

Source: UTMB DSH 1 and DSH 11 tables, NG

*** Does not include Higher Ed Group Insurance State Cont.

italics indicates "estimated" or "budgeted" rather than"expended"

HILLSBOROUGH COUNTY MODEL

With its health-care costs increasing at 17 percent each year, in 1990 the State of Florida required each county to devise a plan for local taxpayers to pay medical expenses of their indigent neighbors. The Hillsborough County Commission created a comprehensive managed care program, which the legislature approved in 1991. Financing ranged from $26.8 million in property taxes to state-federal Upper Payment Limit and Disproportionate Share Hospital funds, and the key: a one-half cent county sales tax. Initially aimed at those with incomes up to 100 percent FPL (which increased yearly in 10-percent increments to 150 percent), Hillsborough HealthCare (HHC) provided primary care, specialty care, outpatient and inpatient hospital care, pharmacy, dental and vision coverage, as well as social services assistance and case management.[69]

The plan expanded coverage from 15,000 to more than 25,000 residents while saving taxpayers $100 million in 10 years by reducing the cost per enrollee from $600 to $250 per month. The current program, serving residents at 100 percent FPL who do not qualify for other Medicaid coverage (capped at 33 percent FPL), is divided into five managed care networks, three run by local hospitals. It includes six hundred primary care physicians, twelve clinics and five hospitals.[70]

The county identified that chronic diseases (asthma, cardiovascular disease, and diabetes) were responsible for two-thirds of its payments. Thus, HHC case managers implemented disease management programs that also addressed weight-loss and smoking cessation. For diabetes patients, a pilot personal responsibility plan, including a "play or co-pay" feature, was created. Enrollees who complied with their treatment plans received disease-linked benefits, such as vision and dental coverage, and were not charged co-

[69] Communities Joined in Action, "Hillsborough County Health Care Plan," http://www.cjaonline.net/Communities/FL_Hillsbourough.htm (accessed September 8, 2007).

[70] Ibid.

payments. Patients who did not comply with their treatment regimens received case management through the program, encouraging them to follow their doctors' orders.[71]

Money-saving administrative aspects of the program include:

- A comprehensive, online medical records system;
- Provider reimbursement linked to outcomes, for which the base is guaranteed, 10 percent may be added after the first year, up to a 24 percent increase after five years;
- Streamlined overhead to maintain a 4.7 percent rate for expenditures, compared with a median state managed care expense ratio of 10.9 percent, according to the Florida Hospital Association HMO Indicators Report.[72]

HHC was so successful that county commissioners in the late 1990s reduced the half-cent sales tax to one-quarter cent because it had accumulated a surplus of nearly $140 million. By 2001, however, the rate returned to one-half cent because the program experienced a $4 million deficit. Facing another $6 million shortfall in 2005, the county cut dental and vision benefits, and instituted a one dollar co-pay for prescription drugs that had been free.[73] The program restructuring worked.

In September 2007, the program had $91.9 million in reserves, what HHC calls a trust fund. But the trust fund is not expected to remain so large. Hillsborough County Health and Social Services Director David Rogoff fears hard times ahead, saying enrollment is rising and the state is forecasting reduced sales tax collections. At the same time, "he expects the state to force counties to dramatically increase the portion of money

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[71] Dennis Penzell, "Hillsborough County Florida (Tampa), Partners for a Prosperous Athens," http://www.prosperousathens.org/initiatives/health/images/Hillsborough%20County%20Florida%207-13.pdf (accessed September 8, 2007). Penzell, affiliated with the Association of Clinicians for the Underserved, is identified as the contact person and appears to be the author of the two-page report.

[72] Ibid.

[73] Phil Galewitz, "Local Governments Find Ways to Assist with Care for Uninsured," *Palm Beach Post*, July 31, 2005, http://kff.org/about/upload/fellow-7_31-pkg.pdf (accessed September 8, 2007).

they provide to treat people in some Medicaid programs, [which] also comes out of the health plan."[74]

Currently, HHC's five regional managed-care plans provide primary care and preventive services, education, and early detection. The networks of physician groups, hospitals and clinics are selected based on their ability to serve participating patients at reduced rates, to provide short waiting times for non-urgent visits, and on their locations near public transportation. Clinics also are open evening and weekend hours for working patients, who may have small co-payments. Beneficiaries select a primary care physician who refers them to specialists or for emergency care when it is appropriate. Before HHC, the county's costs for inpatient hospital services equaled 60 percent of its 1992 indigent care budget; by 1994, it was 32 percent. In the same time frame, indigent use of the emergency department fell by 27 percent.[75]

Beyond health-care services, the program has case managers and social workers who advise whole families, linking them with a full range of county social services and job training. Rogoff estimates that helping beneficiaries find jobs "adds a productivity value of $15 million per year to the economy."[76]

Hillsborough Comes to Galveston

Phyllis Busansky, a member of the Hillsborough County Commission in 1991 and driving force for the development of HHC, came to Galveston in June 2000 to discuss the program with UTMB and city and county leaders. She also gave the lecture at the UTMB Health Policy Forum, "The Hillsborough Plan for Indigent Care: How We Mobilized the

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[74] Bill Varian, "Indigent Care's Reserves Healthy: But Hillsborough's Health Care Fund Is Wary of Hard Times and Growing Enrollment," *St. Petersburg Times,* September 2, 2007.

[75] Government Innovators Network, "Hillsborough County Health Care Plan, 1995 Winner," http://www.innovations.harvard.edu/awards.html?id=3688 (accessed September 13, 2007).

[76] MaryAnn Lando, "Innovative Programs Provide Access to Care," *HealthCare Executive* 19, no. 1 (January/February 2004): 16-22.

Community to Provide Primary Care Clinics for the Indigent." At that time, she encouraged Galveston and UTMB officials to pursue a similar approach.[77]

In 2001, Rep. Patricia Gray (D), the Galveston Representative to the State Legislature, drafted and presented a bill to the Texas House of Representatives (HB 2456) that would allow Galveston County to create a program similar to Hillsborough's. The bill requested permission for the county to call an election to add up to one cent of sales tax to support a pilot program to support indigent care. Provisions of the program, as written, included:

- Secondary and tertiary level services for residents up to 100 percent FPL;
- Primary level services for residents up to 200 percent FPL;
- Case management services, utilization review, patient outreach services, patient education, and transportation.[78]

Of importance to the Legislature, the Legislative Budget Board's fiscal note, dated April 18, 2001, said flatly: "No fiscal implication to the state is anticipated."[79] The bill passed in the House on May 3, 2001, and went to the Senate, where it was read and sent to the Senate Finance Committee. The committee did not act on the bill. Former Senator Bill Ratliff, chair of the Finance Committee at the time, said he did not place it on the agenda because the bill would have exempted Galveston from the 2 percent statutory limit on local sales and use tax rates. It would have been a first for any locality

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[77] Phyllis Busansky, "Prescription for Change: UTMB Health Policy Forum: The Hillsborough Plan for Indigent Care: How We Mobilized the Community to Provide Primary Care Clinics for the Indigent," Health Disparities Lecture, the University of Texas Medical Branch, June 27, 2007, http://www.utmb.edu/healthpolicy/busansky.htm (accessed September 13, 2007). Videotape obtained from the Office of University Advancement.

[78] Patricia Gray, HB 2456, 77th Regular Session of the Texas Legislature, 2001, http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=77R&Bill=HB2456 (accessed September 16, 2007).

[79] Legislative Budget Board, "Fiscal Note, 77th Regular Session" (Austin, TX: State of Texas, April 18, 2001), http://www.capitol.state.tx.us/tlodocs/77R/fiscalnotes/html/HB02456.htm (accessed September 16, 2007).

in the state, and Ratliff said he felt it would have opened the flood gates for other communities to exceed this limit. Ratliff's action was unrelated to funding UTMB's indigent care, *per se,* but rather to the taxation principle.[80]

The Texas state sales and use tax rate is 6.25 percent, but local taxing jurisdictions (cities, counties, special purpose districts, and transit authorities) may also impose sales and use tax up to 2 percent for a total maximum combined rate of 8.25 percent. The City of Galveston has imposed the maximum 2 percent local tax. The statutory limit on city and county sales and use tax rates was established many years ago to preserve state tax capacity; that is, if localities had higher tax rates, the state would be limited in what it could earn through sales and use taxes—because the perception is that people would buy what they need somewhere else, where the taxes are lower. [81] Although the Internet did not exist at the time this legislation was enacted, sales tax for goods purchased online is charged only if the purveyor operates in the state where the purchase is being made. Thus, in the face of a high sales tax, more people may turn to the Internet—at least, until the online tax exemption changes.

Unclaimed Lottery Winnings

Senator Ratliff has been very supportive of providing funding for UTMB's indigent care. In fact, in the previous legislative session, as Finance chair, he approved

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[80] Laura Smith, telephone conversation with Bill Ratliff, e-mail message to Joanna Bremer, November 20, 2007.

[81] Smith, the section of HB 2465 that relates to this is on lines 3-4 and 3-5: "*c) Sections 323.101(b), (d) and (e) do not apply to the tax imposed under this subchapter.*" Those references are to Sec.323.101 of the Tax Code:

d) A county may not adopt a sales and use tax under this section if as a result of the adoption of the tax the combined rates of all sales and use taxes imposed by the county and other political subdivisions of this state having territory in the county would exceed two percent at any location in the county.

e) If the voters of a county approve the adoption of a sales and use tax at an election held on the same election date on which a municipality having territory in the county adopts a sales and use tax or an additional sales and use tax and as a result the combined rate of all sales and use taxes imposed by the county and other political subdivisions of this state having territory in the county would exceed two percent at any location in the county, the election to adopt a county sales and use tax has no effect.

sending $20 million per year in unclaimed lottery winnings to UTMB for indigent care. As he recalls it, Galveston Representative Craig Eiland and Representative Jim Pitts came up with the idea. Pitts found the untapped source of funding, and Eiland had the idea to direct it to UTMB. Eiland asked Ratliff to put this in the budget and Ratliff agreed—he thought it was a good use for the money.[82] The allocation from lottery proceeds has since been reduced to $10 million per year.

In an important step, the Legislature, in its 2007 session, specified that the $10 million in lottery proceeds are predicated on UTMB requiring the six local counties (Galveston, Brazoria, Fort Bend, Harris, Jefferson, and Montgomery) from which most of its patients come to increase the income cap of 21 percent FPL that indigent patients may not exceed in order for Medicaid reimbursements take effect. Unfortunately, the counties have no incentive to increase that level because it will require them to pay more out of their budgets, which most elected officials are loath to do. The reality is that UTMB provides more than $10 million in care to enough patients from outside those six counties that the requirement is moot. However, university officials are developing plans for the counties to support their indigent patients in other ways. These plans will be discussed in chapter 4.

Before the 2003 legislative session, UTMB sent an application to CMS for the Three-Share Plan (borrowed from another successful program, in Muskegon, Michigan) under the direction of President John D. Stobo and stewarded by Dr. Barbara Breier, Director of the Center to Eliminate Health Disparities. Under the plan, employers pay one-third of the premium, workers pay one-third, and state and federal Medicaid funds flow through UTMB for the last third. This program is discussed more fully in chapter 3.

[82] Smith.

CONCLUSION

As Guckian pointed out, "UTMB never has had a constitutional or statutory requirement to provide indigent care. [And,] while John Sealy's original gift was to provide hospital care to the poor in Galveston, the provision of indigent care has been more cultural than legal. Caring for the poor also was a way for students and residents to experience excellent clinical training."[83] Thus, except for providing the economic support for UTMB's educational mission, it has not been incumbent upon the legislature to pay the health-care expenses of those who cannot afford to pay for them, themselves. However, as noted above, when the university did find the resources to cover those uncompensated costs, via the federal DSH allocations, the legislature appropriated those funds for the General Revenue Fund without adequately returning the favor. While counties have a constitutional obligation to attend to the needs of paupers within their borders, they are not mandated to do so, and no enforcement vehicles are in place, even if they were. As a result, the six counties that comprise UTMB's primary service area (70 percent of its patients come from those counties) provide Medicaid reimbursement for their residents whose incomes are below 21 percent of the Federal Poverty Level. Galveston County pays secondary and tertiary expenses for those patients up to 50 percent FPL, but that leaves the university holding the empty bag in terms of caring for the other indigent residents.

Several local and legislative measures are being investigated in an attempt to reduce indigent care costs, not only for UTMB but also statewide. Those measures are discussed in the next chapter.

[83] Guckian.

Chapter 3: What Other States Are Doing

INTRODUCTION

The Texas Legislature ended the 2007 session passing Senate Bill 10 (SB10), authorizing new Medicaid and indigent health-care programs and pilots. Most of those programs derived from those implemented by other states, in their attempts to increase the number of insured residents or enhance benefits for those already covered by state and federally financed health-care programs. This chapter will discuss those states' initiatives, as they are reflected in the Texas legislation. It should be noted that most of the other programs were instituted since 2005, which is not enough time to determine whether they are accomplishing their expected goals. It is not within the scope of this thesis to evaluate the programs in those terms. Rather, they are discussed as models. However, SB10 established most of its initiatives as pilots, with reports to the Legislature and other state officials due before the 81st session, which begins in January 2009.

Consultant Sellers Feinberg conducted an evaluation of SB10 and its provisions for the Texas Health and Human Services Commission, and delivered its report, "A Vision for Texas Health Care Reform," on May 8, 2007. The report notes that the state's total health-care expenditures in 2004 of $107 billion put Texas' spending at third in the nation. Yet, the state still has the highest rate of uninsured residents, 24.6 percent, or 5.5 million individuals. For the most part, these people do not seek primary or preventive health care, which means they wait until their ailments are at a critical point, when they seek attention at (and often admission to) a hospital, which leads to higher costs. It is a vicious cycle:

> Given the high numbers and cost of care for the uninsured, Texas employers pay higher insurance premiums to support the cost of care for the uninsured. These high premiums, in turn, make it increasingly difficult for small businesses to

> provide health insurance to their employees, contributing to the high rate of uninsured and creating a greater challenge for Texas businesses to compete economically.[1]

Thus, among the goals of SB10 is increasing employer-sponsored insurance (ESI), adding new business opportunities for individual and small group insurance plans, enhancing the state's high-risk pool and other coverage, while emphasizing beneficiaries' sense of personal responsibility by providing incentives to improve their health.[2] These two themes undergird the points that follow. Furthermore, the provisions follow key points of President Bush's "Affordable Choices" program, including supporting the commercial insurance market by also subsidizing premiums for private policies, diverting beneficiaries to a more limited benefit package while encouraging cost-sharing and personal responsibility, and improving management and coordination of care for Medicaid recipients.[3]

In interim reports before the 80th Session of the State Legislature (January through May 2007), Texas Health and Human Services Commission (HHSC) staff members pointed to other states' actions in outlining suggestions for lawmakers to consider. From those reports and other sources, this chapter will compare Texas' provisions with the other programs. As will be explained below, a number of these are pilots for which the Legislature has requested data before the end of 2008, in order to determine whether they should be continued. At the same time, other segments of the reform package require approval of a section 1115 Waiver from the Centers for Medicare and Medicaid Services (CMS) before they can be enacted. According to Section 1115 of the Social Security Act, states may seek a waiver from the U.S. Department of Health and Human Services in

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[1] Sellers Feinberg, "A Vision for Texas Health Care Reform," (Austin, TX: Texas Health and Human Services Commission, May 8, 2007), http://www.hhs.state.tx.us/medicaid/HealthCareReform.pdf. (accessed September 13, 2007), 7.

[2] Ibid, 5.

[3] Ibid, 10-11.

order to pursue pilot or demonstration projects that accomplish the goals of the Medicaid program in a novel way, but without changing the original budget amount. Without the waivers, these new projects—which expand eligibility to new groups of people, change rules related to care delivery, or modify the benefits packages, for example—would not be permitted. The waiver review process may take a long time and often requires delicate negotiations with CMS.[4] The HHSC expected to prepare and file the waiver request in January 2008.[5]

HIGHLIGHTS OF SB10

The Texas Health and Human Services Commission highlights provisions of SB10 on its welfare reform website:

> Senate Bill 10 directs improvements to the Texas Medicaid program by focusing on prevention, better planning, and helping Texans to live longer, healthier lives. Highlights of the bill include:
>
> 1. Establishing the Texas Health Opportunity Pool Trust Fund to provide premium subsidies to eligible Texans and help offset uncompensated care costs for providers who implement innovative measures to provide primary and preventive care.
> 2. Improving health outcomes and increasing consumer choice and responsibility through pilot programs such as positive incentives for healthy lifestyles, health savings accounts, and an incentive program to encourage regular health-care visits.
> 3. Increasing employer-based insurance options through the Medicaid Health Insurance Premium Payment reimbursement program and allowing individuals to opt out of Medicaid and use employer-sponsored insurance in some cases.
> 4. Using tailored benefits packages for children with special health care needs to better meet the complex needs of this population, reduce costs, and simplify program administration.

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[4] Texas Health and Human Services Commission, "State Coverage Initiatives: Matrix Glossary: Medicaid, SCHIP, and Federal Authority," http://www.statecoverage.net/matrix/saivers.htm (accessed September 8, 2007), 2.

[5] Texas Health and Human Services Commission, "Next Steps and Timelines," http://www.hhs.state.tx.us/medicaid/Timelines.shtml (accessed August 24, 2007).

5. Allowing cost sharing for non-emergency use of emergency rooms to support appropriate emergency room utilization.

6. Using outcome-based performance measures and incentives in health maintenance organization contracts to increase access to appropriate health-care services.[6]

The states and the models from which the pilot programs are borrowed and discussed below are:

■ California, Florida, Massachusetts	Low Income Pool
■ Florida, Idaho, Kentucky, West Virginia	Positive Incentives
■ Indiana	Health Savings Accounts
■ Florida, Illinois, Iowa, Rhode Island, Pennsylvania	Premium Reimbursement, Assistance
■ Florida	Opt-Out Plans
■ Michigan (Muskegon County)	Three-Share/Multi-Share
■ Idaho, Kentucky, West Virginia	Tailored Benefit Packages
■ Arkansas, Arizona, Hawaii, Kentucky, Minnesota, Oregon, Utah	Cost-Sharing
■ California, Massachusetts, Michigan, New York	Pay for Performance
■ Twenty-three states	Consumer-Directed Programs

The programs that seem to have the most favor among Texas leaders are the Health Opportunity Pool Trust Fund (Low Income Pool), the insurance premium reimbursement and opt-out plans, and the three-share/multi-share program that the University of Texas Medical Branch (UTMB) introduced. According to a HHSC official who preferred to remain anonymous in discussing expected outcomes for programs that still are in the pilot stage, these three plans are preferred because participants, their employers, or both, take some decision-making responsibility and pay some of the costs. Another program the official pointed out, which does not require federal approval, is the Positive Incentives plan, which officials like because it encourages and rewards health-seeking activities and healthy lifestyles. The HHSC hopes to work with health

[6] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage for Health Care Reform," http://www.hhs.state.tx.us/medicaid/SB10Highlights.shtml (accessed August 24, 2007).

maintenance organizations (HMOs) that currently have programs through HHSC to identify their recommendations for incentives they can offer members to pursue healthy activities. The Florida program failed, the official observed, because the incentives were not robust enough. At the same time, the department is leveraging more community interaction, with such organizations as the Young Men's Christian Association, to generate health promotion activities; for example, educating chronic disease patients about self-care steps that will prevent their diseases from reaching the crisis stage.

HEALTH OPPORTUNITY POOL

The Health Opportunity Trust Fund would combine federal, state, and public and private money in a pool from which premium subsidies to individuals and uncompensated care cost reimbursements to providers are disbursed (Figure 3-1). From the HHSC web page, the first reform would be:

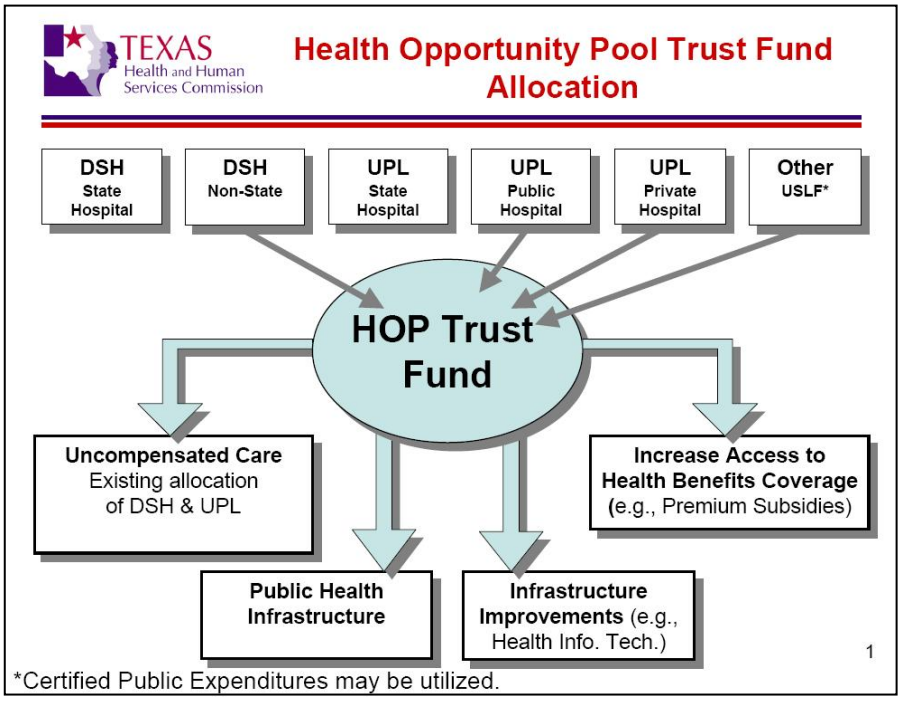
1. *Establishing the Texas Health Opportunity Pool Trust Fund (HOP) to provide premium subsidies to eligible Texans and help offset uncompensated care costs for providers who implement innovative measures to provide primary and preventive care.*[7]

HHSC has several goals for HOP. Primarily, the commission aims to provide health coverage to those who are now uninsured, through subsidies and other means, with the intention of reducing "the need for uncompensated care." The program also will reimburse providers for a portion of the uncompensated care they provide in hopes of protecting Texas' safety net. Assuming approval of the 1115 Medicaid Waiver, the state will create the pool using federal contributions of Disproportionate Share Hospital (DHS) dollars to non-state owned hospitals, Upper Payment Limit (UPL) to public (non-state owned) and private hospitals (DSH and UPL are additional forms of Medicaid financing often used to help support uncompensated or poorly compensated care), along with other

[7] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage."

state and local health-care funding that currently is not matched by federal funds.[8] (Figure 3-1.) DSH funds are allocated by CMS to each state to reimburse hospitals that serve a disproportionately large number of Medicaid and low-income patients. The money covers uncompensated costs of serving un- and underinsured patients. UPL is another CMS program that reimburses hospitals and providers "for the difference between what Medicaid pays for a service and what Medicare would have paid." Because Medicare pays higher rates, this difference is called the "Medicaid upper payment limit" (UPL).

Figure 3-1. Health Opportunity Pool Trust Fund Allocation



SOURCE: Health and Human Services Commission, Medicaid Reform Division

UPL, separate and distinct from DSH, is financed with both state and local funds, as is the rest of Medicaid. "Texas has had a limited UPL plan that makes payments to

[8] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Health Opportunity Pool Trust Fund," http://www.hhs.state.tx.us/medicaid/HOP.shtml (accessed August 24, 2007).

public hospitals in rural counties under 100,000 population, as well as to the nine large urban public hospital districts."[9]

Low-income pools have been adopted by several states. Three examined by the HHSC for its report "Medicaid Reform Strategies for Texas" are California, Florida and Massachusetts. California's proposed program appears to be similar to what Texas hopes to enact. California is negotiating for its Safety Net Care Pool (SNCP) a maximum of $3.83 million in federal funds over five years to design pilot programs that will provide "for 1) payments to providers for uncompensated medical services and 2) a new … initiative to expand insurance coverage in the last three years of the waiver."[10] The uncompensated care payments will be made only to state, county, city or other government providers for medical services to the uninsured. In the last three years of the demonstration program, $180 million from SNCP will expand coverage to uninsured individuals in five geographic areas. The governmental entities receiving these grants must match them with local dollars or intergovernmental transfers. To qualify, programs define their eligibility criteria, develop a screening and enrollment process, establish a medical records system, and include a benefits package that features preventive and primary care services. In other words, they may design their programs to meet the needs of the residents of their communities. DHS also will monitor each local program and evaluate its initiative. [11]

Florida's Low Income Pool (LIP) was established July 1, 2006, "to ensure continued government support for the provision of health-care services to Medicaid,

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[9] Neal Lane and John D. Stobo, "Code Red: Medicaid and the State Children's Health Insurance Program in Texas," Task Force for Access to Health Care in Texas, http://www.coderedtexas.org/files/Report_Chapter04.pdf (accessed September 9, 2007), 68.

[10] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Low-Income Pools," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/LowIncomePools.pdf (accessed August 24, 2007), 1-2.

[11] Ibid.

underinsured and uninsured populations." The pool has a capped annual allotment of $1 billion total, computable for each year of the five-year demonstration period.[12] LIP is financed by contributions from counties, hospital districts, and state agencies, who contribute 41.24 percent of the total, and Federal Matching Assistance, via Title XIX funding, of 58.76 percent. In addition to reimbursing hospitals, clinics, and other providers for uncompensated care, LIP may assist un- or underinsured patients with "payments for provider access systems and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS." [13]

Massachusetts made national headlines in 2006, when, under its Republican Governor Mitt Romney, the state enacted legislation to require every person in the state to have health insurance, either through their employers or on their own. More than a decade earlier, however, the state created the Uncompensated Care Pool (UCP) in 1985

> to help ensure access to needed health-care services to individuals with no other source of health-care coverage. The pool makes payments to acute care hospitals and community health centers for eligible services provided to low-income uninsured and underinsured individuals,

in much the same way Texas' HOP would do. Through the state's 2006 health reform program, the state expects "funds from the uncompensated care pool will be shifted into premium subsidies for the uninsured."[14] Even before the rules went into full effect, 20 percent of those who had been using the UCP enrolled in Commonwealth Care between 2006 and 2007.[15]

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[12] Florida Agency for Health Care Administration, "Low Income Pool (LIP)," http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml (accessed August 19, 2007).

[13] Ibid.

[14] Robert Wood Johnson Foundation, "Coverage Profile: Massachusetts, Overview of Medicaid and SCHIP Coverage," December 2006, http://statecoverage.net/profiles/massachusetts.htm (accessed August 26, 2007).

[15] Academy Health, "Implementation Work Continues in Massachusetts," *Stateside*, July/August 2007, http://newsmanager.commpartners.com/proofs/proofs/?id+ahstsd20070731&articlenumber=3.pdf (accessed August 19, 2007).

The state may not see quite the savings it expects, however. In a review of Massachusetts' reform program, Laure E. Felland et al. said in their introduction:

> Market observers believe many small firms may be unaware of specific requirements [for their employees' coverage], and some could prove onerous. Moreover, the largest impact on small employers may come from the individual mandate for all residents to have a minimum level of health insurance. This mandate may add costs for firms if more workers take up coverage offers, seek more generous coverage, or pressure employers to offer coverage. Despite reform of the individual and small group markets, including development of new insurance products, concerns remain about the affordability of coverage and the ability to stem rising health-care costs.[16]

Massachusetts' Commonwealth Care program, which took effect January 1, 2007, seemed to be creating problems for subscribers only six months into its creation. According to an article in *The Wall Street Journal* in July, the "550,000 people whom Massachusetts hopes to rescue from the ranks of the uninsured … will be seeking care [in the face of] a 'critical shortage' of primary care physicians." A study by the Massachusetts Medical Society quoted in the article said 49 percent of internists and 95 percent of doctors in general practice in three of Boston's top teaching hospitals have stopped accepting new patients. " 'Health reform won't mean anything for the state's poor if they can't get a doctor's appointment,' says Elmer Freeman, director of the Center for Community Health, Education, Research and Service in Boston."[17]

Massachusetts is not alone in its dilemma, but it is exacerbated there by the health-care reform. Between 2001 and 2005, the number of primary care physicians in the United States fell 6 percent, relative to the general population, says the article, quoting a study by the Center for Studying Health System Change in Washington. Only

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[16] Laurie E. Felland, Debra A. Draper, and Allison Liebhaber, "Massachusetts Health Reform: Employers, Lower-Wage Workers and Universal Coverage," Washington, DC, Center for Studying Health System Change, *Issue Brief* 113 (July 2007), http://www.hschange.org/CONTENT/939/ (accessed September 9, 2007).

[17] Zachary M. Seward, "Doctor Shortage Hurts a Coverage-for-All Plan," *Wall Street Journal*, July 25, 2007, B1-2.

20 percent of third-year medical students selected primary care specialties in 2005, versus 54 percent in 1998, according to the study.[18]

As these types of reforms take shape across the country, the situation does not look good. In addition to the shortage of primary care physicians, the safety net hospitals, which usually are teaching hospitals like UTMB, will see their patient bases erode because private physicians, who had been referring uninsured patients to the safety net hospitals, will begin to accept them because of their newfound insured status. This issue, and possible solutions, will be discussed further in chapter 4.

The staff evaluation of low-income pools for consideration by the Texas Legislature pointed out that a Massachusetts-type plan "would enable Texans throughout the state to participate," while a California-type program "allowing local communities to develop and implement programs" would facilitate innovations "that best meet their community needs."[19]

POSITIVE INCENTIVES

While providing health coverage is an important step in reducing costs, it is well established that people who have insurance see their doctors more often. As a result, it makes sense to give them incentives to stay healthy, and see their physicians when they are truly ill. Thus, the next highlight includes:

2. *Improving health outcomes and increasing consumer choice and responsibility through pilot programs such as positive incentives for healthy lifestyles, health savings accounts, and an incentive program to encourage regular health-care visits.*[20]

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[18] Ibid.

[19] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Low-Income Pools," 4.

[20] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage."

Among its key health-care reform goals, HHSC wants to "Focus on Keeping Texans Healthy."[21] The steps to do that include promoting primary and preventive care measures that keep individuals from resorting to expensive emergency room visits; providing "efficient care management," via "enhanc[ing] care management models;" and requiring beneficiaries to exercise "consumer choice and personal responsibility."[22] These are embodied in the moves to implement positive incentives. Four states' models were cited in the document, "Medicaid Reform Strategies for Texas: Enhanced Benefit Accounts."[23] They are Idaho, Kentucky, West Virginia and Florida.

Through the Preventive Health Assistance (PHA) program in Idaho, qualifying Medicaid recipients who complete a weight-loss program or smoking cessation clinic receive points they can use with specified vendors for goods or services that support their healthy behaviors. The benefits include gym membership fees, tobacco cessation products, and healthy lifestyle classes, among others. Participants, who first fill out health questionnaires, may earn up to 200 points per year for healthy improvements in their lifestyles.[24]

Kentucky's Get Healthy Accounts (GHA) apply to beneficiaries with chronic diseases, such as diabetes, pulmonary disease and cardiac conditions. Points for completing disease management programs are credited to their GHAs, and may be "used for co-pays, alternative therapies, exercise, and weight-loss or smoking cessation programs."[25]

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[21] Texas Health and Human Services Commission, "Texas Health Care Reform Goals," June 2007, http://www.hhs.state.tx.us/medicaid/ReformGoals.shtml (accessed August 24, 2007).

[22] Ibid.

[23] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Enhanced Benefit Accounts," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/EnhancedBenefitAccounts.pdf (accessed August 24, 2007) 2.

[24] Ibid.

[25] Ibid.

Beneficiaries in Florida earn enhanced benefits credits by taking part in healthy behaviors offered via their health plans, at local community centers, or through other not-for-profit organizations. The program records participation through:

- The health plan, which reports doctor visits or approved healthy behaviors (e.g., mammogram, colorectal screening, keeping appointments) to earn credits; or
- An Enhanced Benefits Universal Form completed after accomplishing an approved healthy behavior (e.g., weight-loss program, smoking cessation clinic, physical fitness class) at some other location and then forwarded to the health plan.

Points earned in the Enhanced Benefits Accounts Program may be redeemed at the beneficiary's pharmacy for everyday items, such as multivitamins, dental products, and shampoo, or over-the-counter medications, such as antacids, pain relievers, and laxatives. Rewards range from $7.50 to $25 per activity, and may accumulate to a maximum of $125 per person (adult or child) per year.[26]

West Virginia recipients, however, face a carrot-and-stick approach under the state's Healthy Rewards Accounts. Participants sign a personal responsibility agreement with their primary care physicians or health plans. If they adhere to the agreement, points are granted toward optional health-care services (the carrot). On the other hand, if they do not sign agreements or do not fulfill their commitments on time, not only do they not receive optional services, their coverage may be reduced (the stick). These reductions may affect chronic diseases, such as diabetes or cardiovascular disease, as well as dental or mental health or substance abuse treatment.[27] The staff report says that the punishment in this case subverts the goals of the program, because people with these diseases, if they go untreated, end up in the emergency room. Not only that, but thereafter their care,

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[26] Florida Medicaid, "Introducing the Enhanced Benefits Account Program," State of Florida, August 2007, http://ahca.myflorida.com/Medicaid/Enhanced_Benefits/enhanced_benefits_brochure-english-08-07.pdf (accessed August 19, 2007).

[27] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Enhanced Benefit Accounts," 2.

much of which would end up being paid by Medicaid despite the restriction on certain benefits, may cost far more than it otherwise would have.

Health Savings Accounts

Beyond incentives for healthy behaviors, SB10 provided a pilot for Health Savings Accounts (HSAs), which create an awareness of health-care costs and, ideally, a more responsible use of Medicaid services. Designed to accompany policies with low-cost premiums but high deductibles, HSAs are good vehicles for working Medicaid recipients, whose employers cannot afford large premium payments. Once created, the accounts have no ceiling and travel with individuals, as they change jobs, for example.

According to the HHSC report, only Indiana has an HSA initiative, which it calls a Personal Wellness and Responsibility (POWER) account. The state, which received a CMS 1115 waiver for this demonstration program in December 2007, manages the accounts, into which the state and the beneficiary (up to 5 percent of gross family income), along with employers who choose to help, make contributions up to a total of $1,100 per adult. For those considered high-risk, the state may increase the total. Participants, whose incomes may be no more than 200 percent of the FPL, receive POWER cards, which are debit cards for medical services approved under the health plan. At the end of each year, unspent funds up to $500 may be rolled over to offset the next year's contributions, if they undertake preventive health measures.[28]

As pointed out by the staff evaluating the program, "enrollees in HSAs may delay or avoid necessary health care, thereby potentially leading to increased costs for late interventions and poor health outcomes." Another disadvantage in the report is the

[28] Office of Public Affairs, "HHS Approves Medicaid Waiver to Create New Indiana Health Plan for Uninsured Hoosiers," (Washington, DC: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, December 14, 2007), http://www.hhs.gov/news/press/2007pres/12/pr20071214a.html (accessed January 26, 2008).

likelihood of higher out-of-pocket expenses for individuals with chronic diseases, which may encourage those patients to stay in traditional plans while healthier ones switch to the HSAs. Should that adverse selection occur, premiums would likely increase for the traditional plans.[29]

INSURANCE PREMIUM REIMBURSEMENT AND OPT-OUT PLANS

Under this program, an individual would have the option to enroll in his or her employer's health insurance plan, and the worker's portion of the monthly premium would be paid by Medicaid, up to the projected amount that otherwise would be assigned to that person. The report of SB10 features this program as:

3. *Increasing employer-based insurance options through the Medicaid Health Insurance Premium Payment reimbursement program and allowing individuals to opt out of Medicaid and use employer-sponsored insurance in some cases.*[30]

Under the Medicaid Health Insurance Premium Payment System (HIPPS), HHSC currently reimburses some premiums, deductibles and other cost-sharing expenses for Medicaid-eligible workers whose employers offer health insurance plans. Through a program known as "opt out" in SB10, the health commission will seek a section 1115 waiver that will use Medicaid funds to reimburse workers who buy health insurance through their employers (Employer-Sponsored Insurance, or ESI) and "opt out" of Medicaid. The amount of the reimbursements would be as much as the state projects their Medicaid premiums to be. If the private premiums are higher than the projected Medicaid amount, however, the employees pay the difference. For example, if the projected Medicaid premium were $75 and the total ESI premium were $90, the employee would pay the $15 difference—a more affordable figure. Furthermore, any additional costs for the ESI, such as co-pays and deductibles, also would come from the worker's pocket. A

[29] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Enhanced Benefit Accounts," 4.

[30] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage."

complication with opt-out is that "Medicaid neither provides nor pays for wrap-around health care … benefits that are not available through the employer's health insurance plan."[31] However, a benefit for workers who have private insurance is that finding and getting an appointment with a doctor should be easier and less time-consuming than it is through a Medicaid clinic.

Florida's Agency for Health Care Administration (AHCA) is piloting its 2006 waiver-approved "Medicaid Opt-Out Program" in Broward and Duval counties. Under the plan, employed beneficiaries may choose, in conjunction with their choice counselors, to use their defined contributions toward the premiums for their employers' health insurance programs, rather than enrolling in Medicaid.[32] The counselor will steer the participant through the maze of the various health-care plans, comparing the benefits between Medicaid and the ESI, to ensure the individual—and the state—gets the best value for the investment. For example, benefits are limited to the employer's package, whether or not they meet the Medicaid minimums. For the eligible employee and family, one cited advantage of the program is that the private insurance usually offers a broader choice of physicians. Among advantages for the state, the program supports the private insurance market, saves money, and potentially covers family members who are not eligible for Medicaid, thus insuring more individuals.[33] Another benefit for the state is that it would no longer need to prove the cost-effectiveness of the program.

Another Texas program that would provide premium assistance for ESI is through the Children's Health Insurance Program—Premium Assistance program (CHIP-PA), in

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[31] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Medicaid Opt-Out," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/MedicaidOptOut.pdf (accessed August 21, 2007), 1.

[32] Florida Medicaid, "Florida Reform Implementation Plan," November 29, 2005, http://ahca.myflorida.com/Medicaid/medicaid_reform/implementationplan/implementationplan_11-29-05.pdf (accessed August 19, 2007), 35-37.

[33] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Medicaid Opt-Out," 2.

Senate Bill 240 of the 78th Legislature in 2003. In fact, HHSC filed a Health Insurance Flexibility and Accountability (HIFA) waiver with CMS in November 2006 that is currently under review. The HIFA waivers, in place since August 2001, are intended to inspire states to devise comprehensive, state-wide, initiatives that maintain current Medicaid and SCHIP levels while encouraging low-income residents to obtain health insurance coverage. The CMS promise for these types of 1115 waivers is that they provide more flexibility for the states and will receive expedited reviews, so the states can implement them sooner.[34]

"HHSC anticipates approval because the program is consistent with the current administration's priorities and with CMS's public/private strategies," according to the staff report.[35] The state expects to see CHIP savings because premium supplements for employed family members of CHIP-eligible children are likely to be lower than the cost of covering the children individually. At the same time, parents and spouses of parents would be covered for the same state investment. The only caveats are that the employer must contribute at least 40 percent of the premium total, and the CHIP-PA family pays any remaining premium obligation, as well as cost-sharing, such as co-pays and deductibles.[36]

A program in Illinois similar to CHIP-PA received CMS approval in September 2002. The program, called Family Care/All Kids Rebate, allowed the state to use the state's unspent SCHIP allocation to expand eligibility to 185 percent FPL over five years. Illinois had financed a premium assistance program for families between 133 and 185 percent FPL, which it switched over to federal funding. Highlights of the Family Care/All

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[34] Texas Health and Human Services Commission, "State Coverage Initiatives," 3.

[35] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: CHIP Premium Assistance," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/CHIPPremiumAssistance.pdf (accessed August 21, 2007), 2-3.

[36] Ibid., 1.

Kids Rebate are that the family receives $75 per person per month toward ESI and must pay any additional costs itself; employers do not have a minimum contribution requirement; the health plan must cover at least physician and inpatient hospital services; and the state provides immunizations not included in the health plan.[37]

Many other states have premium assistance programs under section 1115 waivers, including Arkansas, Idaho, Maine, Massachusetts, New Jersey, New Mexico, Oklahoma, Oregon, Utah, Virginia, and Wisconsin.[38] Iowa, Pennsylvania, Rhode Island, and Texas use HIPP funds for their premium assistance programs.[39] Whether the programs save money for every state is unclear. But Iowa and Rhode Island estimate that they do. "Pennsylvania—one of the largest PA programs with over 23,000 enrollees—estimates that savings for fiscal year 2003 reached $76.3 million," report Cynthia Shirk and Jennifer Ryan in a National Health Policy Forum brief.[40]

Several strategies appear to generate the most success. Covering whole families, using incomes instead of Medicaid eligibility, streamlines administration and increases the pool of beneficiaries. Communicating directly with employers improves employee education and recruitment. Committing significant resources to developing and operating the program allows states to obtain data about coverage and cost effectiveness. Keeping enrollment high is important not only because of the increased insured population but also because the state spreads administrative costs among a larger group, thus saving state and federal dollars.[41]

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[37] Ibid., 2-3.

[38] Ibid., 3.

[39] Cynthia Shirk, Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?," National Health Policy Forum, *Issue Brief* 812 (July 17, 2006), http://nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf (accessed September 3, 2007), 4.

[40] Ibid.

[41] Ibid, 10-13.

In testimony before the U.S. House Education and Labor Committee, Joan C. Alker, deputy executive director of the Center for Children and Families at Georgetown University, said enrollment in premium assistance programs has not been as high as many states had hoped, primarily because employers of low-income workers often do not offer health insurance coverage. Alker also pointed out that private insurance for families is much higher because public programs achieve savings through economies of scale, reduced administrative costs, and reduced payments to providers. For example, she said:

> In 2004, the average cost of covering a family of four through Medicaid nationwide was $7,418, whereas the cost of the average employer-sponsored insurance package for a family of four was $9,950—34% higher. This annual cost of almost $10,000 for private coverage does not include significant additional costs families will incur—such as co-payments, deductibles and other coinsurance. Similarly, a recent study conducted by the Urban Institute for the state of Illinois found that predicted medical spending would be 31% higher if children were covered by private insurance as opposed to covering them through Medicaid/SCHIP.[42]

Also a senior researcher at Georgetown's Health Policy Institute, Alker questioned the advisability of withholding benefits available through public programs or requiring these low-income families to pay higher cost-sharing—for which they otherwise would be eligible. Her report recommended using private coverage only "when it is a cost-effective use of public funds,"[43] in other words, when it saves the states money and provides equal or better care to the recipients.

Three-Share/Multi-Share

While not spelled out in the state's highlight, a demonstration waiver from UTMB for Galveston County is under consideration by the CMS, and similar pilots were approved in SB10 for what is called Three-Share/Multi-Share Programs. They are

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[42] Joan C. Alker, "Premium Assistance Programs: Do They Work for Low-Income Families?" Georgetown University Health Policy Institute, Center for Children and Families, March 15, 2007, http://edworkforce.house.gov/testimony/031507JoanAlkertestimony.pdf (accessed January 26, 2008), 4.

[43] Ibid., 4-5.

designed for small businesses and their employees, who tend to receive low wages, and may become part of the CHIP-PA program discussed above. Under the Three- or Multi-Share Program (Three-Share), the employee pays one-third of the premium, the employer one-third, and the community, state, federal or some combination the last third. In the reform strategies report, HHSC staff point out that "these programs provide increased health-care coverage, [but] they do not necessarily provide what most people think of as health insurance." The programs are more affordable, although benefits typically are limited, including requiring enrollees to see only local providers. However, members of the community are consulted about what benefits they would like the plan to provide. At the same time, premiums are low enough that employers and employees can afford their shares, approximately $150-$180 total per participant per month (or $50-$60 each). By comparison, Texas Employee Retirement System health insurance premiums are $270-$360 per person per month.[44]

Of the 256,067 residents of Galveston County, 99,670 are employed persons over age 16. More than a quarter of them (29,950) are employed or self-employed—and uninsured.[45] The Center for Health Disparities (CHD) in UTMB's Office of the President has been working with Galveston chambers of commerce, local businesses, and state and national government officials to implement a limited health insurance program for the working uninsured, called Three-Share. Based on a successful program in Muskegon, Mich., Three-Share requires an equal investment in premiums by the employee, the employer, and the state/federal SCHIP program. Businesses are not eligible to sign up for the program unless they have not provided health insurance benefits for twelve months or

[44] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Three-Share/Multi-Share Programs," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/ThreeShare_MultiSharePrograms.pdf (accessed August 21, 2007), 1-2.

[45] Barbara Breier, "Galveston County 3 Share Plan Proposal," (Galveston, TX: University of Texas Medical Branch, draft dated April 27, 2005), 17.

more. This is to prevent companies from discontinuing existing plans with private insurers.[46]

Dr. Barbara Breier, director of UTMB's Center to Eliminate Health Disparities (CEHD), along with Patricia Gray, Galveston attorney and former state representative, and Aurora Mitchell, president of UTMB HealthCare Systems, investigated the Muskegon program and began laying the groundwork for a plan to use unspent SCHIP dollars in Texas. On behalf of the Texas Health and Human Services Commission, employers, employees and itself, the university applied for a section 1115 Health Insurance Flexibility and Accountability waiver of the Social Security Act. The waiver would "expand employer sponsored health insurance coverage to certain disadvantaged, low-income working parents of children enrolled in the SCHIP program and working adults without dependent children with income at or below 200% of the federal poverty level for a family of four ($38,700)."[47]

According to Breier, the waiver would apply statewide (see below). The Three-Share Program in Galveston would be a demonstration model, which other counties could adopt if it proves successful, which she believes it will be, based on preliminary data. From June through December 2004, CEHD conducted a feasibility survey of 1,500 small businesses (fewer than 50 employees) in Galveston County. Some 13% responded, of whom 85% said they would be interested in the plan.[48]

Working with those interested businesses, the study team conducted focus groups with 100 of their employees, whose average annual salary is $24,000. The team was somewhat surprised by the result. Rather than the anticipated low co-payments, the

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[46] Barbara Breier (Director, Center to Eliminate Health Disparities), interview with Joanna Bremer in Breier's office in the UTMB Administration Building, April 29, 2005.

[47] Breier, "Galveston County 3 Share Plan Proposal," 1.

[48] Breier, interview.

respondents selected higher co-pays and improved benefits, including major medical. Breier said their rationale was they would rather spend slightly more for office and emergency department visits in order to not to bankrupt themselves in case of catastrophic illness or injury. A telephone survey achieved similar results, she said.[49]

The focus groups used an interactive computer program developed by the University of Michigan, called Choosing Healthplans All Together (CHAT). In brief, CHAT consists of several rounds of a game in which individuals, then small groups, then one large group, receive a given number of tokens to allocate to specific types of health benefits. Facilitators explain the benefits and their associated costs before, during and after each round of the game, and lead discussions throughout, so the participants have a thorough understanding of how their decisions relate to real-world health-care scenarios.

After several individual and group discussions and explanations of benefits by team members, the participants arrived at the following ranking of top priorities:

1. Pharmacy
2. Primary care
3. Hospitalization
4. Specialty care
5. Tests
6. Other medical (ambulance, equipment)
7. Long term care[50]

The lowest on the priority scale were:

15. Infertility
14. Complementary/alternative care
13. Uninsured care (This asks the participants to set aside a certain amount of their money in a pool to provide for members of the plan that lose their jobs, etc. not unlike COBRA. This was a very low priority.)
12. Vision
11. Home health services
10. Mental health

[49] Ibid.
[50] Breier, "Galveston County 3 Share Plan Proposal," 11.

9. Last chance (transplant services)[51]

Three-Share's proposed benefits, then, would include inpatient and outpatient hospital services, physician services, pharmacy services, laboratory and X-ray services, and ground ambulance services.[52]

Some may express concern that the expanded benefits package of this program may jeopardize other, minimal-benefit plans offered or being considered in other states or regions. Because the University of Michigan CHAT program is designed for any entities considering low-cost health-care programs to use in determining the needs and wishes of their proposed markets, the entities would be smart to use CHAT in laying the groundwork for their proposals.

Another aspect of the plan that costs nothing, but benefits the individuals as much as possible by taking advantage of community resources is a web-based community asset map on the Jesse Tree home page that

> provides an online, searchable resource inventory containing in depth, detailed information about Galveston County resources (i.e., exact services provided, requirements for service, payment forms accepted, etc.) …[which] complements the efforts of the Three-Share Plan. … [The map] contains many programs and services that promote prevention or wellness, such as a low-cost community smoking cessation program. These types of programs could help improve the health of the subscriber and make him/her less costly to insure."[53]

The plan also would include low-cost access to the Commit to Fit worksite wellness program instituted in recent years at UTMB.[54]

As evidenced by the study participants' choices, a number of exclusions will be required in order to maintain costs at a reasonable level. As included in the draft

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[51] Ibid.
[52] Ibid., 23.
[53] Ibid., 24-25.
[54] Ibid., 25.

proposal, they are: neonatal services, transplant services, bariatric surgery, allergy testing and treatment, hearing aids, glasses and contacts, home health, DME/prosthetics, out of network treatment, out of area treatment, infertility treatment, implant TMJD, dialysis treatment, and blood and blood products.[55] (Because adults covered under this plan likely will have SCHIP-eligible children, these services will be covered by SCHIP and not Three-Share.)

Breier, who said Three-Share must enroll 3,000 participants in its first three years in order to break even, will conduct research from the beginning to determine whether it is achieving four measurable outcomes:

- Decreasing the rate of uninsured workers in Galveston County
- Increasing access to health care for subscribers
- Improving quality of care by comparison to previous medical care, and
- Not displacing employer contribution levels or beneficiary enrollment in private health plan coverage.[56]

With the program's emphasis on primary care, preventive services and health education, Breier hopes the participants will take control of their own and their families' health, that employers will experience increased productivity and reduced turnover, and that UTMB will see decreased health-care expenditures for all of them. "People's mindset in the past has been that insurance pays for everything," Breier said. "Through this program, we hope to educate people about how costs relate to care, and how lifestyle decisions relate to health."[57] The strong health education component teaches individuals to be responsible for their own primary care by planning for care, making and keeping doctor's appointments, and having a health-care home, so problems are addressed right

[55] Ibid., 23.
[56] Ibid., 27.
[57] Breier, interview.

away, without waiting for ailments to get so bad they require care in the emergency department.

"When people are spending their own money, making better choices about their health, rationing their own use of the health-care system," Breier said, "they will begin to use health-care services better."[58] The premise here is that if participants pay something toward the cost of their care, it will have more value to them. [Table 3-1.]

Table 3-1. Proposed Three-Share Benefits, Limitations and Cost-Sharing

Benefits	**Limitations**	**Cost Sharing**
Inpatient Hospital	30 days maximum/year	$200 co-pay/admission
Outpatient Hospital		$75 co-pay/visit
Emergency Room		$75 co-pay/visit
Lab & X-ray		No co-pay
Physician	12 visits/year	$15 co-pay/PCP $30 co-pay/specialist
Psychiatric or Substance Abuse Therapy	20 visits/year	$30 co-pay/visit
Pharmacy		$10 co-pay/generic $20 co-pay/brand
Ground Ambulance		No co-pay

SOURCE: Proprietary information in Three-Share proposal [Not to be published until plan is accepted]

The Three-Share program has a number of advantages. It promotes health-seeking activities, provides care when members are sick, and covers limited hospital costs for a segment of the population for whom health insurance has not been an affordable option. In the bargain, some employers could offer a fringe benefit they had not been able to afford in the past. And, for UTMB, the plan provides payment for services that have been uncompensated. The biggest advantage is a healthier community, at least among those in the plan.

While the plan needs only 3,000 members to break even, they represent only 10% of the 29,950 Galveston County workers without health insurance. The survey was

[58] Ibid.

answered by only 13% of the 1,500 or so qualified small businesses identified by the chambers of commerce in the county. That leaves a large number of employers who showed no interest in attempting to cover their workforce, even at a reasonable cost. That is not to say they might not buy in after the program is up and running, and they learn about its success from colleagues and competitors. But it still leaves a large gap.

At the bottom of another gap are the homeless, the unemployed and the marginally employed (part-time, minimum-wage). Some of these are caught in the vicious circle of being too sick to work and not getting better because they do not have the resources to see a doctor or pay for prescriptions because they cannot work. And that does not include the children whose parents don't know about SCHIP, cannot afford even the small premium the state requires to enroll in the program, or get caught in the paperwork mill.

In addition to Galveston's waiver proposal, which "would cover 2,170 working parents of Medicaid and CHIP children under 200 percent FPL," several metropolitan areas proposed similar programs. Houston/Harris County's is aimed at about 100,000 (10 percent of the area's uninsured) working uninsured whose incomes are below $50,000. Dallas hospitals grouped together to offer a non-insurance, indemnity three-share program for 35,000 working uninsured. The program does not include hospitalization. El Paso and Austin have similar programs in the works for small businesses in their communities.[59]

While Muskegon provided the model for UTMB's Three-Share proposal, two versions of the program have been adopted by Wayne County, in which the City of Detroit is located. Muskegon covers more than 3,500 individuals from 526 small businesses with its program; Wayne County's has 4,310 participants. The county also

[59] Ibid, 2.

recently implemented the Four Star Health Program, administered by local health systems working with the county. Between the two plans, the county aims to cover 10,000 to 15,000 uninsured, or about 5 percent of its uninsured population of 250,000.[60]

"In Illinois, counties/cities that have three-share programs certify Medicaid loss for local health departments (which are paid less than cost), and the resulting additional federal funds are used to finance the program," according to the staff report.[61]

New Mexico and Oklahoma have state-wide programs with some three-share characteristics, using HIFA waivers that were implemented in 2005. By mid-2006, about 4,700 people had enrolled in New Mexico's program, available to businesses with fewer than 50 employees for workers with qualifying incomes of up to 200 percent FPL. The employers pay $75 per person monthly; individuals contribute $0-$35, based on their wages; and the state finances the balance. In Oklahoma, 440 small companies (fewer than 50 workers) signed up for the plan, and 803 workers whose wages were less than 185 percent FPL had enrolled by June 2006. Oklahoma employers contribute at least 25 percent of the premium; workers pay the lower of 15 percent of the premium or 3 percent of their gross income; and the state pays the balance.[62]

The HHSC evaluation notes that more than 2.3 million working Texans between ages 18 and 64 (over 25 percent) lack health insurance. And nearly half of them work in companies with fewer than 25 employees, according to the U.S. Census Bureau. "Three-share programs often target those in this group … but could cover some employees in the other income brackets as well."[63]

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[60] Ibid, 3.
[61] Ibid.
[62] Ibid.
[63] Ibid, 4.

Using the low-income pool (above), along with the insurance reimbursement, the state could choose either a community-based three-share program, which covers working uninsured, or a state-wide program, which covers working and non-working alike, to increase the number of individuals with some kind of health-care coverage.

TAILORED BENEFIT PACKAGES

Texas is looking at creating benefit packages specifically tailored to children with special health-care needs. The summary of highlights of the bill includes:

4. *Using tailored benefits packages for children with special health-care needs to better meet the complex needs of this population, reduce costs and simplify program administration.*[64]

Although several states (e.g., Idaho, Kentucky, and West Virginia) have implemented tailored benefit packages, called "benchmark plans" in the Deficit Reduction Act 2005 (DRA), for their entire Medicaid populations, Texas is focusing its version of the legislation only on children with special needs.[65] However, under SB10, HHSC "may not implement a package … before September 1, 2009."[66] Once it does get implemented, though, because the DRA changed the law, states that comply with the relevant DRA requirements will not need to apply for a waiver for their benchmark plans.

The Idaho Department of Health and Welfare (DHW) benchmark plan, one of those the Texas HHSC evaluated, will group populations by a) health needs, b) specific goals, c) benefits, d) service delivery systems, and e) performance measures. Three programs will be offered, in which the beneficiaries have similar health needs: low-income healthy children and working-age adults; special needs and disabled patients

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[64] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage."

[65] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Benchmark Plans (Tailored Benefits)," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/BenchmarkPlans_TailoredBenefits.pdf (accessed August 21, 2007), 1.

[66] Texas Senate, Senate Bill No. 10, http://capitol.state.tx.us/tlodocs/80R/billtext/pdf/SB00010F.pdf (accessed July 21, 2007), 8.

whose health care is more complicated; and the dual-eligibles, Medicare recipients who also qualify for Medicaid.[67]

The first group will be enrolled in the Benchmark Basic Plan, offering standard Medicaid benefits, but it omits long-term care, intensive mental health care, and organ transplants. A health promotion feature includes an option for a personal health account. Providers also will receive incentives for preventive services, such as well child check-ups and immunizations.[68]

The Enhanced Benchmark Plan, for individuals with disabilities or special health needs, makes no changes in the existing program, funded under Title XIX, including long-term or institutional care. According to the concept summary, Idaho "will reform service delivery systems to better meet needs." The idea is to allow those who have the capacity to manage their own care. At the same time, the program aims to enhance mental health and recovery benefits.[69]

Increased Medicaid coverage will be provided for workers who have disabilities. At the same time, the DHW, in concert with the state Division of Vocational Rehabilitation, plans to create three Disability Resource Centers, where qualified individuals may obtain information and counseling about work incentives and opportunities.[70]

The third program, Coordinated Benchmark Plan, is designed for residents who qualify for Medicare and Medicaid, who will receive "cost-effective individualized care integrated … with Medicare coverage." Beneficiaries are required to enroll in Medicare

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[67] National Conference of State Legislatures, "Idaho State Plan Amendment," http://www.ncsl.org/programs/health/idmedicaid.htm (accessed July 21, 2007).

[68] Dirk Kempthorne. "Modernize Medicaid: Prevention, Wellness, Responsibility, Value-Based Reform, Concept Summary," (Boise, ID: State of Idaho, November 15, 2005), http://dfm.idaho.gov/cdfy2007/OtherDocuments/Modernize-Medicaid-Report.pdf (accessed March 31, 2006) 7.

[69] Ibid, 8-9.

[70] Ibid.

Part B, outpatient coverage, and Part D, the prescription drug benefit. The state also will pay for transportation to participating pharmacies to obtain the drugs, which is a major problem for many elderly patients. However, in order to achieve its goal of increasing non-public financing for long-term care, the state will promote use of reverse mortgages and commercial insurance.[71]

Kentucky's program, somewhat like Idaho's, has four plans, based on need. Family Choices and Comprehensive Choices resemble Idaho's Basic Benchmark and Coordinated Benchmark plans, respectively. Kentucky's middle two, Global Choices and Optimum Choices, split the special needs populations. Global Choices is for "pregnant women and parents, foster children, medically fragile children, SSI-related groups, and women with breast and cervical cancer. … [While, Optimum Choices is aimed at] individuals with mental retardation and long-term care needs." Features of the Global plan include basic medical services, higher cost-sharing and benefit limits than the regular state Medicaid plan. Optimum Choices has the same features as Global and provides three levels of individualized, long-term care: basic, targeted, and high-intensity, which includes institutional care.[72]

West Virginia's customized programs are tailored for those without special needs. According to the Texas HHSC report, "people who are elderly or have disabilities will continue with the current Medicaid benefits under the state plan."[73]

COST-SHARING

The most expensive use of Medicaid dollars is for patients who go to the emergency department when their ailments are not emergencies. As a result, the

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[71] Ibid, 10.

[72] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Benchmark Plans (Tailored Benefits)," 4-5.

[73] Ibid, 5-6.

Legislature wants to discourage the practice by asking patients to pay a portion of the expense. Highlights of the bill reflect:

5. *Allowing cost sharing for non-emergency use of emergency rooms to support appropriate emergency room utilization.*[74]

The Deficit Reduction Act of 2005 (DRA) allows states to charge premiums and cost-sharing for some Medicaid beneficiaries above 100 percent FPL. Texas may see limited savings, however, because of legislative and legal restrictions for most Medicaid populations in the state. As it stands now, premiums or cost-sharing may be charged only for infants between 133 and 185 percent FPL, pregnant women (cost-sharing for services unrelated to their pregnancies), youths younger than 21 years old who are transitioning from foster care, and some elderly. In SB10, the Legislature raised the age for transitioning foster children to 23, if they are still in college. [75]

The DRA also prohibits cost-sharing for children's preventive services (e.g., immunizations), family planning, and emergency services. Co-pays on prescription drugs may be imposed under the act, which also permits higher co-pays for prescriptions not on the state's Medicaid formulary, unless the prescribing physician stipulates that a non-formulary drug would work better, not have an adverse effect on the patient, or both. Cost-sharing also is permitted for non-emergency use of emergency rooms when the beneficiary has a medical home or primary care physician. After screening, if the emergency department determines the medical condition is not an emergency, but the patient demands care anyway, the hospital may require payment of a cost-sharing amount before the patient is treated. Before taking this step, the hospital must first advise the

[74] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage."

[75] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Premiums and Cost Sharing," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/PremiumsandCostSharing.pdf (accessed August 21, 2007), 1 and 4-5.

patient of another, non-emergency, provider who is available and accessible; identify a provider whose services will not require cost-sharing; and offer to provide a referral, indicating the treatment the patient needs.[76]

According to the HHSC report on premiums and cost sharing, Kentucky's DRA reforms included a cost-sharing provision. Several other states sought and received 1115 Research and Demonstration Waivers from CMS. Among them are:

- Arkansas, whose limited cost-sharing package is designed for adults up to 65 years old at 200 percent FPL or below;
- Arizona, which provides Medicaid benefits to parents of children enrolled in Medicaid and CHIP;
- Hawaii, providing comprehensive benefits to adults up to 300 percent FPL and requiring monthly premiums or cost-sharing equal to 50 percent of the cost of their coverage;
- Minnesota, covering parents of children enrolled in Medicaid, up to 275 percent FPL who pay premiums based on their incomes;
- Oregon, whose program for adults up to 100 percent FPL offers comprehensive benefits, for premiums between $9 and $20 per month; and
- Utah, which has one plan, equal to the state employee package, that requires Medicaid-eligible enrollees above age 19 to pay a maximum of $500 annually; and a second preventive and primary care plan for the same age group whose incomes are up to 150 percent FPL, for whom the maximum out-of-pocket expenses for health care are set at $1,000 per year.[77]

[76] Ibid, 1-2.
[77] Ibid, 2-3.

The same report indicates that Medicaid beneficiaries' limited incomes may cause them to "delay or reduce their use of care, [which] may lead to poor health outcomes and increased costs. [Some] states reported drops in Medicaid enrollment after implementing cost sharing…" Another concern the report raised is that administrative costs may eliminate any potential savings.[78]

PERFORMANCE MEASURES AND INCENTIVES

The Legislature identified pay for performance (P4P), which sets certain expectations for providers, as a way to enhance quality and improve outcomes. Thus, this highlight includes:

6. *Using outcome-based performance measures and incentives in health maintenance organization contracts to increase access to appropriate health-care services.*[79]

A variety of pay for performance measures were implemented over the years in private health-care organizations, and more recently in public programs (including Medicare and Medicaid), because of their promise of improving access, quality and outcomes for patients. The staff reform strategies report on P4P noted that Medicare has had programs in place since October 2003, providing bonuses and penalties to more than 260 Medicare hospitals in 38 states, including 21 in Texas. Although UTMB is not one of them, along with all Medicare providers nationally, it is required to submit reports of its quality measures to CMS, and failure to do so results in a reduction in Medicare payments. There are no penalties based on the measures themselves, just for failure to

[78] Ibid, 4.
[79] Texas Health and Human Services Commission, "Senate Bill 10 Sets Stage."

report.[80] In December 2006, Congress ordered CMS to add providers to the program. CMS included Medicaid and SCHIP in P4P programs in April 2006.[81]

In recent years, Texas has written performance-based principles into its contracts with Medicaid and SCHIP health maintenance organizations (HMOs). HHSC has an External Quality Review Organization that has been gathering Health Plan Employer Data and Information Set (HEDIS) information since January 2007. Senate Bill 1188 of the 79th Texas Legislature directed HHSC to "develop a proposal for providing higher reimbursement rates to primary care case management (PCCM) providers" who use national standards of care and best practices in treating beneficiaries.[82]

The Robert Wood Johnson Foundation (RWJ) implemented a P4P initiative in 2002, long enough ago to evaluate results. The program, "Rewarding Results," focused on financial and non-financial incentives to private entities for improvements in access, preventive care, chronic diseases, information technology, and provider report cards. Among the lessons it cited were:

- Engage and collaborate with providers from the start;
- Use reliable data, valid measures, and scientifically based benchmarks. Simplicity is better at the beginning; add complexity as the program becomes more established;
- Financial incentives should be significant; such non-financial incentives as administrative simplification, staffing assistance, and enhanced technology have been effectively used, as well;
- Public reporting provides data for comparisons;
- Provider feedback, along with methods and advice for improvement, is essential;

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[80] David M. Connaughton (Chief Financial Officer, UTMB Hospitals and Clinics), e-mail message to Joanna Bremer, January 27, 2008.

[81] Texas Health and Human Services Commission, "Medicaid Reform Strategies for Texas: Pay for Performance," February 2007, http://www.hhs.state.tx.us/medicaid/ResearchPapers/PayforPerformance.pdf (accessed August 21, 2007), 1.

[82] Ibid, 4.

- Providers in managed care environments seem more amenable to the P4P concept.[83]

Among the states with P4P experience, including those supported by the RWJ Foundation's Rewarding Results, California seems to be the oldest. The state's "Local Initiative Rewarding Results" (LIRR) includes seven Medicaid managed care plans. The focus areas of promoting access and preventive care for children and adolescents have improved. Allowing the plans to create their own incentives and having control over how to reach their goals have been effective strategies.[84]

Private programs in Massachusetts and Michigan show promise. Massachusetts' Health Quality Partners established a physician performance report on such preventive care measures as breast cancer screening and chronic disease care. Use of electronic medical records also seems to be increasing. The initiative implemented by Michigan Blue Cross Blue Shield for hospitalized cardiac patients realized improved care and a 45 percent decrease in life-threatening infections among patients in intensive care. BCBS is expanding the incentives to other diseases.[85]

New York's Excellus/Rochester Individual Practice Association (RIPA) provided performance reports, including action steps for improvement, for providers managing patients with chronic sinusitis, otitis, diabetes, asthma, and heart disease. P4P showed encouraging results. Meanwhile, Excellus/RIPA also "invested $1 million on health information technology and reduced health-care cost trends by almost $3 million."[86]

Recent RWJ Rewarding Results grants to Massachusetts, Ohio, Kentucky, and New York for "Bridges to Excellence" initiatives are spurring quality improvements by reducing mistakes, reducing waste and inefficiencies, and increasing accountability.

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[83] Ibid, 1-2.
[84] Ibid, 2.
[85] Ibid, 3.
[86] Ibid.

Medicare is using the model to create more P4P programs. A coalition of philanthropic, health-care oriented organizations—RWJ, Center for Health Care Strategies, and The Commonwealth Fund—awarded grant funding to Arizona, Connecticut, Idaho, Massachusetts, Missouri, Ohio, and West Virginia to develop and implement P4P programs within their Medicaid plans.[87]

As discussed in the HHSC reform strategies report, P4P motivates improved quality and patient monitoring among providers, helps the state build partnerships with providers, and facilitates incorporating information technology in provider practices. On the other hand, return on investment, size of financial reward, and additional appropriations are difficult to estimate.[88]

CONSUMER-DIRECTED PROGRAMS

Most of the programs described above rely on the Medicaid recipients to make decisions about their health-care coverage, healthy behaviors, expenditures from HSAs, and whether to opt out of Medicaid and sign up with their employers' health insurance offerings, among others. A study by Jessica Greene evaluated consumer-directed health strategies being employed by a number of states, including Texas. Her survey of forty-nine states found that twenty-three will have opt-out programs in place at the end of 2007.

> While these programs are popular with Medicaid agencies, it is noteworthy that they may be less so with recipients. In the first seven months of the Florida program, fewer than five families used the Medicaid "opt out" to purchase employer-sponsored coverage.[89]

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[87] Ibid, 3-4.

[88] Ibid, 4-5.

[89] Jessica Greene, "State Approaches to Consumer Direction in Medicaid," Center for Health Care Strategies, *Issue Brief* 113 (July 2007), http://www.chcs.org/usr_doc/State_Approaches_to_Consumer_Direction.pdf (accessed September 9, 2007).

In the conclusion, Greene pointed out several issues states need to keep in mind as they adopt these types of consumer-directed strategies. Essential to all the measures is the states' acknowledgement that "Medicaid recipients [have] relatively low health literacy levels [so they have] created structured supports to assist recipients (or their representatives), including home visits and monthly telephone calls." Thus, whatever types of education materials the states provide (print, audio, and video) must be accessible to them. "It will be important to test approaches and formats for presenting health plan comparisons…to see how best to present [this] information."[90]

The fact is, 90 million people in the Unites States—irrespective of their age, race, income or education level—"have difficulty understanding and acting upon health information," according to a study by the Institute of Medicine. Health literacy is defined as "the degree to which individuals can obtain, process, and understand basic information and services they need to make appropriate health decisions." The report goes on to emphasize that the level of health literacy among the population may have a great impact on "the ability of the health-care system to provide effective, high-quality health care."[91] While further exploration of health literacy is not within the scope of this thesis, it is important to recognize that complex choices about health insurance, primary care providers, available benefits, healthy lifestyle measures, and myriad other issues—along with their health and financial implications—must be clearly and carefully explained. And the recipient must fully understand the message (to the point of explaining it back to the interviewer in his or her own words). Otherwise, any hope of improving the health and welfare of Texans may be an exercise in futility.

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[90] Ibid.

[91] Institute of Medicine, "Health Literacy: A Prescription to End Confusion," *Report Brief* (April 2004) http://www.iom.edu/Object.File/Master/19/726/health%20literacy%20final.pdf (accessed September 9, 2007).

CODE RED REPORT AND ITS IMPACT

Neal F. Lane, Ph.D., Malcolm Gillis University Professor in the Department of Physics and Astronomy and Senior Fellow of the James A. Baker III Institute for Public Policy at Rice University in Houston, and John D. Stobo, M.D., then President of UTMB, in July 2004, convened what became the Task Force for Access to Health Care in Texas. Sponsored by the ten major academic health centers in the state: Baylor College of Medicine, Texas Tech Health Science Center, Texas A&M Health Science Center, North Texas, and the six health institutions of the University of Texas System, the 19 task force members represented large and small employers, hospitals, medical schools, health policy experts, and community and business leaders who are thoroughly knowledgeable about indigent health care. They "collected data, identified and assessed the magnitude of the problem of the uninsured in Texas, and made recommendations for consideration by policymakers."[92] After eighteen months, the task force released its final report, "Code Red: The Critical Condition of Health in Texas," on April 17, 2006. "The intent was to provide a high-quality analysis available to policy makers, interested groups and organizations and the public," the task force states on its website.[93]

The task force issued ten recommendations, most of which the 80th Texas Legislature acted upon, either in SB10 or other legislation. From the Code Red website, the recommendations and their legislative outcomes are:

Recommendation 1: The state should adopt a principle that all individuals living in Texas should have access to adequate levels of health care. Legislative actions provide:

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[92] Lane and Stobo, "Synopsis: Code Red: The Critical Condition of Health Care in Texas," Task Force for Access to Health Care in Texas, http://www.pdfdownload.org/pdf2html/pdf2html.php?url=http%3A%2F%2Fwww.coderedtexas.org%2Ffiles%2Fcode_red_synopsis.pdf&images=yes (accessed February 17, 2008).

[93] Task Force for Access to Health Care in Texas, "Access to Health Care in Texas: The Challenges of the Uninsured and Underinsured," http://www.utsystem.edu/hea/taskforce/homepage.htm (accessed February 17, 2008).

- CHIP program enhancements (HB109)
- Extensive Medicaid reform in Texas (SB10)
- Funding for resolution of FREW v. Hawkins lawsuit (HB15) [94]

Recommendation 2: Texas should provide more resources and aggressively seek more efficient and effective methods to support health care to the indigent and uninsured, with the goal of reducing rising health care costs. The outcome:

- Requires county participation above 21 percent—Six county region and UTMB (HB1 rider)
- Authorizes review of participation in regional programs (HB3154)
- Allows co-payment collection for emergency room usage for non-emergencies (SB10)[95]

Recommendation 3: A "Quality Assurance Fee" of 3 percent should be assessed on revenues of all hospitals and free-standing surgery centers in Texas in order to obtain a federal match to enhance overall finances for provider reimbursement and the quality and efficiency of health care. This recommendation resulted in no legislative action.[96]

Recommendation 4: The state should significantly increase its capacity and commitment to conduct experiments in health care delivery and funding (e.g. 1115 Waivers for R&D projects, funding pools, employer subsidies). Legislation provides for:

- Adoption of Three-Share subsidy program (SB10)
- Healthy Texas program for small employers (SB10)
- Numerous innovative pilot programs and studies on delivery of health care (SB10)
- Medicaid telemedicine reimbursement (SB24)

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[94] Task Force for Access to Health Care in Texas, "Code Red Recommendations: Legislative Review and Summary," http://www.coderedtexas.org/files/CROverview06-07.pdf (accessed February 17, 2008).

[95] Ibid.

[96] Ibid.

- Premium assistance for the uninsured (SB10, HB1, HB1751)
- Monthly health insurance subsidy to parents who adopt foster children who do not qualify for Medicaid (HB2701)
- 1115 Waiver for new and innovative programs (SB10)[97]

Recommendation 5: The concept of "virtual care coordination" for the uninsured (including them in a structured and connected system of care) should be developed by local communities and by the HHSC. The legislative result:

- Establishment of electronic health/medical records (SB204, SB40, SB10)
- Creation of the Texas Health Services Authority (HB1066)
- Provision of health information on drivers' licenses (HB1060)
- Authorization for HHSC pilot program for importation of eligibility information (HB321)[98]

Recommendation 6: Health care institutions and other providers must contribute to increasing community based ambulatory care, which includes integrating the latest developments in disease management and other cost effective models of health care delivery that seek to improve the quality of patient care while decreasing the cost of care. Behavioral health (both mental health and substance abuse) services should be accessible to all Texans with mental illness and additional public funding should be appropriated. The outcome:

- Additional funding provided for mental health services (HB1)
- Extensive reforms in Medicaid (SB10)[99]

[97] Ibid.
[98] Ibid.
[99] Ibid.

Recommendation 7: Texas must increase investment in the education and training of health professionals who will provide a significant amount of care to the uninsured and underinsured. Actions on the recommendation:

- Increase in graduate medical education funding (HB1)
- Increase in funding for professional nursing shortage program (HB1)
- Program for hospital-based nursing education partnerships (HB3443)
- Study of increase in medical residency programs and medical residents (SB10)
- Creation of incentive programs for retention and graduation of nurses (SB138)
- Tuition exemptions for nursing preceptors and their children (SB201)
- Funding for grants to address professional nursing shortage (SB289)
- Increase in funding for Joint Admission Medical Program (HB1)
- Study to improve nursing curricula (SB139)
- Loan incentive programs for first responders (HB618)

Governor Rick Perry vetoed a comprehensive higher education master plan (SB1234).[100]

Recommendation 8: Implementation of an integrated approach to school health including an emphasis on nutrition, exercise, dental health and disease management of such problems as asthma. Expansion of the School Breakfast Program, increase of physical activity requirements to 60 minutes a day in Texas schools, and adoption of asthma management education for affected school children and support staff will improve the health of Texans. The resulting legislation:

- Increases physical activity and requires physical assessments (SB530)
- Provides for healthy lifestyle incentives for Medicaid recipients (SB10)

[100] Ibid.

- Coordinates health programs for independent school districts in the border region (HB3618)
- Expands diabetes demonstration pilot program (HB3735)
- Creates diabetes registry (HB2132)
- Creates an interagency obesity council (SB556)
- Establishes Type Two Diabetes Risk Assessment Advisory Committee (SB415)
- Extends use of tobacco funds to fund nursing education (SB992)
- Establishes State Employee Wellness Program (1297)
- Establishes the Chronic Kidney Disease Task Force (HB1373)[101]

Recommendation 9: Academic health institutions, state and local governments, and communities, foundations, and the private sector should support the development of health science research programs to study cost-effective health care and other characteristics of a high-quality and efficient health system. The outcome:

- Creation of the Cancer Prevention and Research Institute of Texas (HB14)
- Funding and additions to the Texas Emerging Technology Fund (HB1188)[102]

Recommendation 10: Texas should adequately invest in public health programs, including research and community health, at the state and local level. The governor vetoed two of the four legislative actions:

- Healthy Lifestyle incentives for Medicaid recipients (SB10)
- Implementation of life-saving techniques and devices (HB92)

Vetoed were bills to provide funding for expansion of Schools of Public Health (HB1) and for extensive funding of special items to address public health issues (HB1).[103]

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[101] Ibid.
[102] Ibid.

The Legislature obviously heeded the message of Code Red, a signal to medical professionals that the patient is dying and requires immediate action.

CONCLUSION

As the HHSC examined other states' programs to extract models that could be applied here, they kept in mind one overarching goal: "Optimize investment in health care to ensure more efficient use of available funding and best health outcomes for Texans."[104] In the process, they identified these key goals:

- Focus on keeping Texans healthy;
- Reduce the number of uninsured Texans;
- Protect and optimize Medicaid funding; and
- Establish infrastructure to facilitate accomplishment of reform goals.[105]

By selecting a variety of other states' programs for testing in Texas, the Legislature will have at least an idea of whether one or several actions are worth continuing—either on a broader experimental basis or permanently—when the next session convenes. The act of reducing the number of uninsured Texans has pluses and minuses, as discussed above. On the plus side, the state's overall health and productivity should improve markedly; those who are uninsured now will have more access to care earlier in their illness cycle, when treatment is more effective and less expensive; and the state's costs for preventable hospitalizations will drop. On the minus side, when they have insurance, those currently uninsured will be likely to seek medical care more often;

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[103] Task Force for Access to Health Care in Texas, "Code Red Recommendations: Legislative Review and Summary," http://www.coderedtexas.org/files/CROverview06-07.pdf (accessed February 17, 2008).

[104] Texas Health and Human Services Commission, "HHSC Council Subcommittee on Medicaid Reform and Hospital Financing," October 30, 2007, http://www.hhsc.state.tx.us/about_hhsc/council/103007_PresentationPacket.pdf (accessed January 26, 2008), 8.

[105] Ibid.

the reduced number of practicing primary care physicians may be overwhelmed by the newly insured patients who seek them out; and, important for UTMB, patients previously referred to safety net hospitals will be accepted by private physicians because they no longer will be a drain on resources. That will result in a reduced number of cases for training students and residents.

This review of initiatives prescribed by SB10 that are modeled by other states illustrates an ambitious program of demonstrations to implement and review between Summer 2007 and Fall 2008, in preparation for the 81st Session of the Texas Legislature in January 2009. It is good to know state officials want to expand and enhance health-care coverage for low-income Texans. In the short run, this bodes well for UTMB, because the enactment of any of these programs means Galveston's academic health center will likely receive some payment for a higher percentage of the patients whose care today is uncompensated.

Unfortunately, even using models and data from other states to supplement the information the Texas pilot programs generate, it remains to be seen whether these initiatives will have enough time to be fully developed, implemented, and evaluated before the 2009 legislative session. The next, and concluding, chapter will present other options for consideration.

Chapter 4: Possible Solutions

INTRODUCTION

As mentioned in chapter 2, the University of Texas Medical Branch (UTMB) is not mandated by the state or any official body to attend to the health needs of every unsponsored patient who crosses its threshold. But many UTMB staff, faculty and students feel a personal obligation to take care of as many of them as time and resources permit.

Solutions to the issue of financing health care for those who cannot pay for it themselves must be addressed on a national level, because national policies affect local reimbursement for uninsured patients. For more than a decade, since the Clinton Administration's attempt to establish universal health care in the early 1990s, presidents and congressional leaders have implemented politically conservative health care measures (such as SCHIP, UPL, and HSA programs) that appease members on both sides of the aisle. But health care costs continue to rise at about 6 percent per year, and fewer employers and their workers can afford to pay the ever-higher health insurance premiums. As a result, more and more individuals and families find themselves without it. Witness: Texas has the highest rate of uninsured residents at 24.1 percent, or 5.5 million people.

Because any national solution is rife with politics (the President and Congress nearly allowing the State Children's Health Insurance Program to expire in 2007, for example), it is incumbent upon academic medical centers to devise their own means of dealing with unsponsored patients, while proactively structuring medical education "to include advocacy training regarding the financing of health care.…[or] they will find

themselves…constantly operating in the red if they try to take care of poorer and unsponsored patients."[1]

This chapter will examine suggestions for a national solution from the Commonwealth Fund (more general) and the Public Policy Institute (more specific). On a local level, creating a multi-county health district for the hospital that was proposed recently will be discussed. University leaders have taken some steps to address a crucial issue whose solution is beyond the scope of this thesis, but will be addressed to a limited extent below: changing UTMB's payer mix from 20 percent unsponsored and 15 percent commercially insured to 10 percent unsponsored and 25 percent commercially insured.[2]

Most of what follows discusses programs that have been undertaken and proposed in Galveston—primarily by the Office of Community Health Services, which has been working in concert with county government and local nongovernmental organizations—to save UTMB money and enable it to continue its mission.

I also will suggest some alternatives that may hold promise for at least reducing costs for the number of unsponsored patients who arrive at the emergency department (ED) because their ailments have advanced to crisis stage and they believe they have nowhere else to turn. None of these programs is the panacea that will insure large numbers of indigent patients, *and* make UTMB solvent, *and* still provide the number of medical cases the academic medical center requires to teach its students and train its residents.

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[1] Jason E. Glenn (Assistant Professor of History, Institute for the Medical Humanities), e-mail message to Joanna Bremer, February 16, 2008.

[2] John D. Stobo (Executive Director for Academic Programs, University of Texas System Office of Health Affairs), e-mail message to Joanna Bremer, February 7, 2008.

NATIONAL PROPOSALS

With the 2008 U.S. presidential race occupying the political focus, Democratic and Republican Party candidates are proposing ways to reconfigure the nation's health care system. Next to the economy, this may be the most important domestic policy issue in the race. Democratic candidates propose some type of universal health care paid for by a combination of restructuring Medicare and Medicaid and contributions from states, employers, and individuals, who may receive some form of federal reimbursement—through tax credits or income tax deductions. Republicans, on the other hand, are looking at market-based plans that individuals select and pay for, some with federal subsidies managed by the states or with income tax credits. Because the parties select nominees this summer, and the election takes place in the fall, it makes little sense to discuss their plans further, other than to point out the importance the candidates and their parties assign to finding a way to provide some kind of health insurance for the approximately 45.1 million people (15.3 percent of the U.S. population) who are uninsured.[3]

Suggestions for national coverage from The Commonwealth Fund Commission on a High Performance Health System (commission) and the Progressive Policy Institute (PPI) feature models in which the costs of health insurance are shared by individuals, employers, and state and federal governments. Both organizations tout state programs as potential models for the federal government to adopt or adapt. Several states' programs were discussed in the previous chapter.

[3] United States Census Bureau, "Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements, http://www.census.gov/prod/2007/pubs/p60-233.pdf (accessed December 19, 2007). This number is an average of 2004-2006 census figures.

Commonwealth Fund Proposes 'Agenda for the Next President'

Anticipating the 2008 presidential election, the Commonwealth Fund's Commission recognized that "health care reform has risen to the top of the domestic policy agenda," a development it welcomes:

> A window of opportunity appears to be opening: More than at any other point in recent history, there is agreement among key stakeholders that attaining universal coverage and reforming the delivery system are imperatives, and that "business as usual" is no longer acceptable.[4]

In November 2007, the fund issued a report, proposing "A High Performance Health System for the United States: An Ambitious Agenda for the Next President," for consideration by presidential aspirants. The agenda asserts that the president and Congress must provide leadership to "broker differences while keeping the ultimate goal" of a unified, if not universal, health care program "clearly in sight." It recommends five strategies for accomplishing this:

- Affordable coverage, by having "financing be a shared responsibility of federal and state governments, employers and individual households, and other stakeholders;"
- Aligned incentives and effective cost control, by rewarding high quality of care and prudent stewardship of resources; moving from provider fee-for-service to diagnosis-related accountability and total care of patients; and ending payment imbalances between specialty care and primary/preventive care, as well as behavioral medicine;
- Accountable, coordinated care, by creating electronic links among providers and with other services, and providing financial and non-financial incentives for collaborations that support one another and patients with "21st century care";

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[4] Commission on a High Performance Health System, "A High Performance Health System for the United States: An Ambitious Agenda for the Next President," (New York, NY: The Commonwealth Fund, November 15, 2007), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=584834&# doc58434 (accessed December 24, 2007).

- Aiming higher for quality and efficiency, via "public reporting, evidence-based medicine, and infrastructure that supports the health care system to…deliver the best care possible…in a culture of innovation and improvement;" and
- Accountable leadership, who set and provide the collaboration, coordination, and wherewithal to achieve a high performance health system, perhaps in the context of a national entity charged to do that.[5]

The commission recommends that, beyond "embracing coverage and access for all," the next president's health policy must contain costs, organize the health system to be easily accessible and navigable, implement a national health information system, and "establish national goals and do what it would take to reach them."[6]

Of course, not all solutions lie with the President and Congress. In its report "A Roadmap to Health Insurance for All: Principles for Reform," the commission points out:

> An estimated 10 percent to 40 percent of premiums is consumed by claims administration, underwriting, marketing, profits and other administrative costs. Costs of insurance administration are the fastest-growing component of U.S. national health expenditures.[7]

Thus, it seems incumbent upon the health care industry, itself, to identify and enact efficiencies, strategies, and cost-cutting measures that will curb their companies' administrative appetites, and return some of those costs to clients in the form of reduced premiums and cost-sharing.

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[5] Ibid.

[6] Ibid.

[7] Sara R. Collins, Cathy Schoen, Karen Davis, Anne K. Gauthier, and Stephen C. Schoenbaum, "A Roadmap to Health Insurance for All: Principles for Reform," (New York, NY: The Commonwealth Fund, October 2007), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=553840&#doc553840 (accessed December 24, 2007).

In the meantime, the commission's roadmap identifies how the current system "fails to promote high performance in the areas of access, equity, quality, efficiency and cost control," and explains that universal coverage is the answer for improvement:

- Unequal access results from inadequate insurance coverage;
- Poor access equates to poor quality of care because those without insurance do not have a regular provider, who would manage their conditions and prescribe preventive measures;
- Inefficient care delivery results in duplicate tests, missing results, and incomplete records because uninsured patients tend not to return to the same providers, and because medical records are not shared;
- The fragmented health insurance system makes it difficult to control costs;
- Financing indigent care is inefficient because private payers tend to be charged more (8-10 percent of premiums) to make up for uncompensated costs;
- Benefits and insurance markets lack incentives for patients and providers to seek effective services, reduce over-utilization and duplication, and eliminate waste.[8]

> The roadmap indicates this is not an easy task.
>
> Serious reform will require broad consensus and significant financial investment by federal and state governments, employers, households, and other stakeholders. A shared responsibility among all stakeholders will be needed to achieve the goals of reform in a way that is effective and fair.[9]

Progressive Policy Institute Report

The Progressive Policy Institute is more specific in its recommendations. The three essential principles of the PPI proposal, as discussed in its report "Health Coverage for All," are: 1) "an individual mandate," by which some states require their residents to

[8] Ibid.
[9] Ibid.

purchase private health insurance if they can afford it; 2) "financial assistance," using public subsidies, provided on a sliding scale based on a person's income, to help purchase private insurance; and 3) "choice and competition," using insurance pools based on the Federal Employee Health Benefits (FEHB) system, which provides a full array of health plans from dozens of different companies, the choices of which vary from one region to another.[10] The report suggests that, until a national health program can be implemented, Congress should open "FEHB to individuals and small businesses in states without an insurance pool." At the same time, the government "should supplement state health care subsidies with…tax credits for purchasing health care coverage." These credits, the report suggests, would be financed "in part by capping the current federal tax breaks for health insurance for higher income workers." Reinforcing the principle of shared responsibility, PPI suggests "requiring proof of insurance for individuals to claim personal tax exemptions." This would be similar to states requiring proof of automobile insurance for residents seeking driver's licenses:

> [W]hen people who could buy coverage decline to do so, the result is higher health care premiums for the rest of us.…Nationally, one in four uninsured families earns more than $50,000 [annually] but relies on expensive emergency room care. By requiring that everyone contribute to the insurance pool, costs will decrease across the board.[11]

A segment of a program lauded in the PPI report is Washington state's "health record bank," which securely stores complete copies of patients' medical records from all sources.[12] It saves the costs of duplicate tests for those who have no medical homes and who arrive at EDs with advanced symptoms of chronic diseases, for example. "[When] adults have medical homes—defined as health care settings that provide patients with

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[10] Katie Donohue and David Kendall, "Health Coverage for All," Progressive Policy Institute, *Policy Report* (Washington, DC: Progressive Policy Institute, October 2007): 1, http://www.ppionline.org/documents/StateHealthCoverage101607.pdf (accessed December 19, 2007).

[11] Ibid., 3.

[12] Ibid, 7.

timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated."[13] Providers do not order tests if they can see the patients' medical records, including previous tests' results, and, from them, diagnose and, ideally, correct the problem.

PPI recommends a "federal-state partnership for universal coverage," and asks Congress to jumpstart such a program by working with state governments to:

- Use FEHB "as a backstop for guaranteeing all workers a choice of coverage;"
- Expand "federal financial assistance to make coverage affordable," in part by reducing the tax break for job-based coverage by one-fourth, which "would generate roughly $50 billion in new federal revenue;"
- Require health coverage for all taxpayers "in order to receive the standard tax deduction for themselves and their children;" and
- Authorize Medicare administrators "to join state efforts to implement pay-for-performance and other innovative approaches to reducing costs and improving quality of care."[14]

Patients having insurance coverage would, over the short term, curb the losses UTMB encounters as a result of uncompensated care. In the long run, though, patients with insurance will be treated by physicians closer to their homes, resulting in fewer medical cases for instruction and training.

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[13] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Care Quality Survey," (New York, NY: The Commonwealth Fund, June 2007), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814& (accessed January 15, 2008), 1.

[14] Donohue, 7.

REGIONAL HOSPITAL DISTRICT

As discussed in chapter 2, the State Legislature has had difficulty swallowing the approximately $120 million annual allocation from the general revenue to pay for the operation of the John Sealy Hospital, even though the state owns it. The reasoning, inarguably, is that taxpayers in other parts of Texas pay for their local safety-net hospitals through hospitals districts; so why should state revenue pay for UTMB, when some 70 percent of its unsponsored patients come from six local counties? The answer could well be that they are right. Those local counties *should* pay for their indigent patients who go to UTMB. In fact, an editorial in the *Galveston County Daily News* argued precisely for that notion:

> We…think the thing to do is to organize local support for the treatment of indigent patients from this area. The most straightforward approach would be to create a hospital district to fund the area's fair share of the cost. Galveston County leaders could take the lead in organizing a hospital district that includes several counties. Or they could form a countywide district and bill the other counties whose residents end up here.[15]

The question is whether the state would be willing to hand over control of the hospital it has owned for 117 years. "In a heartbeat," said Dr. John D. Stobo, President of UTMB from 1997 to 2007. Even though the state earns a sizeable income from federal Disproportionate Share Hospital and Upper Payment Limit payments because of the uncompensated care UTMB provides, the annual allocation for the hospitals is higher in some years and lower in others. "It's essentially a wash," Stobo said. But the headaches the legislators incur because of the UTMB allocation means they likely would readily hand over control of the institution.[16] Of course, the educational and research enterprise would remain under the control of the University of Texas (UT) Board of Regents.

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[15] Heber Taylor, "Have a Care for January 2009," *Galveston County Daily News*, January 27, 2008.

[16] John D. Stobo (Former President of the University of Texas Medical Branch), conversation with Joanna Bremer, in his office in the Marvin Graves Building, January 28, 2008.

County officials would have to propose the hospital district and put it before their voters for approval. But would voters in Galveston, Brazoria, Jefferson, Montgomery, and Fort Bend Counties[17] approve an additional tax on themselves in order to pay for medical care for low-income and indigent residents? The Daily News believes they have few alternatives:

> We could hope that the fist-on-the-table argument works and that the State Legislature suddenly grows a much larger social conscience than it's displayed in years. We could hold our collective breath in anticipation that legislators from around the state will suddenly decide to fully fund the treatment of indigent patients at a state institution. Or we could do nothing and continue to watch the erosion of state funding to the medical branch. In thoughtful moments, we could ponder what that may mean, in the long haul, to such an important institution in Galveston County.[18]

What that would mean, Stobo said, is that the 6 percent annual rate of medical inflation would eat away at the $120 million allocation, causing the hospital to send away more and more patients; also eroding the number of cases for instruction, which affects the university's accreditation, which curtails the educational and research enterprise. And the institution eventually closes.[19]

So, if UTMB and county leaders choose the hospital district route, it's up to them to tell voters the bottom line result: "Pay us now or pay us later." In other words, property owners would pay taxes for a hospital district now or be forced to pay even higher taxes later when the largest employer in the county closes its doors.

PROACTIVE MEASURES CURRENTLY IN PLACE

Before that eventuality, however, UTMB officials have taken on a share of the responsibility in attempting to reform the system from the inside out. As examined in previous chapters, the health care situation in Galveston is not directly under control of

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[17] Harris County would not be included in a proposed hospital district because it already has one.
[18] Taylor.
[19] Stobo, January 28, 2008.

UTMB executives, administrators, physicians, and staff. But the university is addressing the issues from several points of entry, using what resources—internal and external—it is able to muster.

In an attempt to attract more commercially insured patients, in April 2005 the Department of Obstetrics and Gynecology opened the Women's Health Center in Dickinson, in the northern, more affluent section of Galveston County. The 9,980-square-foot facility provides annual gynecologic screenings and general obstetrics, as well as specialists in reproductive infertility, gynecologic cancer, incontinence, chronic pelvic pain, and problems associated with menopause.[20] Another step toward obtaining more private patients, announced the following year, was construction of the UTMB Specialty Care Center at Victory Lakes in the same part of Galveston County. The UT System Board of Regents approved $30.5 million from the Permanent University Fund for construction of the clinic, toward the goal of boosting the university's "competitiveness in key scientific areas." UTMB leaders' goal was to:

> Expand the clinical, surgical, and diagnostic services that UTMB offers on the mainland, providing affordable, high-quality care to the growing population in that area. It also will strengthen educational opportunities for the university's medical, nursing and allied health students, as well as for clinical research.[21]

Unfortunately, the plan was scrapped because, among other things, physicians in private practice in the surrounding communities loudly protested the move. Among them was UTMB alumnus and State Senator Kyle Janek, who contended "the government-sponsored institution will anger private doctors by competing with them, thus making the doctors unlikely to refer patients to UTMB hospitals and clinics." In response to the

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[20] Office of Public Affairs, "New Women's Health Center Opens in Dickinson" (Galveston, TX: University of Texas Medical Branch, April 18, 2005), http://www.utmb.edu/impact/stories/2005/05APRIL18/OBGYNclinic.htm (accessed February 18, 2008).

[21] Office of Public Affairs, "UT System Regents Grant $30.5 Million for UTMB Medical Specialty Center," *Impact* 30, no. 8 (Galveston, TX: University of Texas Medical Branch, August 2006): 11.

criticism, President Stobo said that hospitals in the Texas Medical Center (TMC) in Houston were making similar moves, so the doctors should plan to deal with the competition.[22]

Were UTMB to reinstitute the Victory Lakes center, the first step it must take is working with and marketing to precisely those same physicians. The goal would be to convince them that UTMB specialists would not be in competition with them, but rather would work side by side with them toward improving the health of their patients. Serving the Victory Lakes clinic would be the doctors, currently housed in Galveston, to whom they refer their patients today. The difference is that the clinic would be local, rather than twenty or thirty miles away. Of course, the most important audience for UTMB's marketing is the people who live in that part of the county, many of whom are employed in the aerospace industry situated around the Johnson Space Center in Houston. Precisely because of the new hospitals and clinics sponsored in that locale by the institutions of the TMC, UTMB must convince potential patients that its specialists are better, more qualified, and more highly trained. That is a tall order.

In moves designed to offset costs for unsponsored patients, UTMB officials in recent years took two programs to the State Legislature, with mixed success. One plan, from UTMB's Center for Health Disparities (CHD), is based on a successful program in Muskegon, Michigan. Called Three-Share, it was adopted in Senate Bill 10 for implementation as a pilot, as part of the state's application for a section 1115 waiver, submitted in January. The CHD worked with Galveston chambers of commerce, local businesses, and state and national government officials to implement this minimal health insurance program for the working uninsured. A limited-benefit HMO, it requires an

[22] Marty Schladen, "Stobo to Resign as UTMB President," *Galveston County Daily News* (Galveston, TX: October 5, 2006), http://galvestondailynews.com/story.lasso?ewcd=1013d695dd03adb0& (accessed February 18, 2008).

equal investment in premiums by the employee, the employer, and the state/federal SCHIP program. Three-Share is discussed more fully in chapter 3. The other program, adding a penny to the area's sales tax to create a fund for an indigent HMO, was approved in 2001 by the House but it never left the Senate Finance Committee. Although no one found fault with the plan, it would have meant exceeding the state's 8.5-cents ceiling on sales tax, which the Senate was not willing to do. This program is outlined in chapter 2.

Acting locally, UTMB's Office of Community Health Services (OCHS) helped the Galveston County Health District apply for a grant from the Health Resources and Services Administration (HRSA) in 2000, part of which went to the Galveston Community Health Access Program (GCHAP), as discussed in chapter 1. In 2005, a second HRSA grant to the county and other community resources created a case management program for patients of the Gulf Coast Center for Mental Health/Mental Retardation (MHMR) who had been lost to the center. The Gulf Coast Center cares for patients with chronic mental health problems who are near crisis points in their diseases, their lives or both. The 2005 grant paid for two pairs of mobile case managers, working in their cars, who located these missing patients in their homes, on the streets, sometimes in jail, or wherever they could find them, and got them back under care. Then they followed up with the patients to ensure they were taking their medications, to arrange transportation to doctor's appointments, to make sure they had food, and generally to keep tabs on them. HRSA funding for the second year of the grant was eliminated, due to federal cutbacks. Because UTMB's ED was seeing savings from the program, Dr. Karen Sexton, CEO for University Hospitals and Clinics, supported its second year.[23]

[23] Rebecca T. Walsdorf (Executive Director, Community Health Promotion, UTMB), interview by Joanna Bremer, in her office in Shearn Moody Plaza, November 6, 2007.

The savings were considerable. One group of 445 people went to the ED an average of 5.5 times in one year, for various reasons, and costing an average of $1,500 per visit (without hospitalization). Eliminating only one visit for each of those 445 patients in one year would save the department almost $700,000. Keeping this group of "frequent fliers" healthy, and avoiding the ED entirely, would conservatively save $3.7 million in one year, or about $10 million over three years.[24] As a result, at the end of the grant period, the Gulf Coast Center became a partner of the UTMB hospitals and clinics in the operation of this program. It also earned the Excellence in Community Service Award from the Texas Hospital Association in 2007.[25]

In the meantime, OCHS applied to the Meadows Foundation in Fall 2007 for a grant to add telemedicine to the MHMR program, enabling psychiatrists and therapists at UTMB to treat patients at the 4Cs clinics in Galveston and Texas City, as well as the Gulf Coast Center's clinic in Brazoria County. The foundation granted $375,000 over two years, and invited OCHS to resubmit its application in February 2008, a rare event.[26]

WelCare Initiative

Via a grant to St. Vincent's House Free Clinic in Galveston from the Office of Minority Health, U.S. Department of Health and Human Services, OCHS helped establish the WelCare initiative, which helps individuals understand their personal responsibility for their own well-being, and refers them to the 4Cs clinics as a medical home.[27] The WelCare Initiative primarily addresses three health areas (diabetes, obesity and overweight, and cancer, especially those associated with women) among those who

[24] Diana Smith, "UTMB Behavioral Health Model Takes Care to Vulnerable Patients in the Community," *Texas Hospitals* (November-December 2007): 22-24.

[25] Walsdorf.

[26] Ibid.

[27] Ibid.

are uninsured and live in low-income, predominantly minority neighborhoods. It provides a comprehensive and holistic approach to:

- Understanding health care and promoting community awareness;
- Reducing disease-risk behaviors;
- Facilitating use of appropriate medical care services; and
- Assisting patients in navigating/negotiating the medical services delivery system.[28]

St. Vincent's Free Clinic, an initiative of UTMB medical students since 1969, offers free primary care to men, women and children who might otherwise go without medical care or treatment—the indigent, homeless, under and/or uninsured residents of Galveston. It is administered by a full-time patient coordinator and staffed by volunteer health professionals and medical and physician assistant students from the Schools of Medicine and Allied Health Sciences, under faculty supervision. A major focus of the clinic is the prevention, early detection and control of chronic illnesses such as diabetes, hypertension, high cholesterol, and heart disease, and emphasizes cancer, HIV/AIDS and other sexually transmitted diseases.[29] Despite the student-based nature of its program, St. Vincent's is a medical home for many of these patients, who live nearby or feel more comfortable going there regularly than going to a clinic or hospital. When possible, they are referred to the 4Cs clinics to establish their medical homes, for preventive care and chronic disease management.

Community Health Program

A program piloted for about one year with funding from indigent care dollars in UTMB's Hospitals and Clinics budget is the Community Health Program (CHP). It

[28] The WelCare Initiative, "About the Program" (Galveston, TX: St. Vincent's House, undated), http://www.stvhope.org/WelCare%20Initiative/About%20the%20Program/About%20WC.htm (accessed December 29, 2007).

[29] St. Vincent's House, "Free Clinic: A Place Where Healing Begins," (Galveston, TX: St. Vincent's House, undated), http://www.stvhope.org/free_clinic.htm (accessed December 29, 2007).

proved successful enough that the program is no longer a pilot, and in the second half of fiscal year 2008 will become a part of the Community Health Network, under the Office of Community Health Services, with a $1.5 million allocation from the hospital. The allocation will pay only for infrastructure—employees, office space, and systems that will enable them to do their jobs. For the pilot, some 230 patients from Galveston, Brazoria and Jefferson counties were identified, by case managers reviewing UTMB data files, as frequent visitors to the ED. The patients arrived with such chronic diseases as congestive heart failure and coronary artery disease, chronic obstructive pulmonary disease, diabetes, asthma, high risk hypertension, liver disease, and cellulitis. The CHP goal is to direct these patients away from the ED and into preventive care, to keep their conditions from reaching the crisis stage.[30]

When the program becomes fully functional, it will be limited at first to Galveston County residents, who may be referred to 4Cs or to the Residents Clinic in the Internal Medicine Department in the Primary Care Pavilion at UTMB for their regular care if they do not already have primary care physicians (PCP). But, if one of those physicians detects exacerbation of the chronic disease—coronary artery disease, for example—the patient will be referred directly to a cardiologist, without having to go through the Demand and Access Management Program (DAMP) procedures. For issues not related to the chronic disease that qualifies the patient for CHP, he or she will have to use DAMP.[31]

The care managers will review UTMB data to identify patients who visited the ED at least twice in one year for one of the chronic diseases the program focuses on. After ensuring the patients really are unsponsored, the care managers—nurses—will make home visits, where they will conduct an initial assessment, ask if the individuals

[30] Beverly Dowling (Assistant Vice President for Community Health Networks), telephone interview with Joanna Bremer, January 28, 2008.

[31] Ibid.; the Demand and Access Management Program is explained in chapter 1.

want to be on the program, and educate the patients about their diseases. If they do not already have a PCP, the nurses (who will be assigned about one hundred patients each) will find them one. They also will follow up periodically with home and phone visits, inquiring about patients' health, whether they are staying on the medications, making appointments with doctors as needed, and the like. When CHP participants do see a doctor, they will pay their co-pays (on a sliding scale, based on their income in relation to the Federal Poverty Level) at the intake window, just as all the other patients. If they do not have the money, they can work out paying as they are able. CHP requires no premiums, and provides limited durable medical equipment in the home, such as a scale, glucometer, or blood pressure cuff, so patients can their manage diseases; it does not pay for drugs.[32]

Because the pilot was over a short period, its actual savings to the hospital have not been identified. CHP leaders still want to track outcomes, finances, operations, and health outcomes for chronic disease, the measures for which will be established as the program rolls out. The goal is to move patients from the acute setting to the preventive setting. As CHP ramps up, managers are looking at hiring people in other positions to build the model—social workers, community health workers, and the like.[33]

In another proactive measure designed to assist this population, UTMB helped Galveston County apply for a $350,000 grant, shared by the Gulf Coast Center and the Jesse Tree, to obtain federal benefits for eligible residents who do not know about them or, if they do know about them, do not know how to file for them. The grant provides salaries for resource managers to assist with these applications. According to the Jesse Tree:

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[32] Ibid.
[33] Ibid.

> In 2005, 54,219 people were estimated as eligible to receive food stamps in Galveston County. Only 44 percent of [them] participated in the program. If…just 60 percent of those eligible [applied and used them], an additional $9.7 million would be released into the community…
>
> As of 2004, only 5.03 percent of Galveston County's 64,290 children were enrolled in the CHIP program; however, nearly 17 percent are possibly eligible to enroll. This indicates that 7,694 children may be missing out on a valuable health care option available to them.
>
> The eligibility and enrollment numbers are similar for all social service programs available to low-income Galveston County residents, [such as] Qualified Medicare Beneficiary, Women, Infants and Children Program, HeadStart, Medicaid, and Medicare.…Increasing enrollment [in these programs] will help out Galveston County's economy as well, because the distributed funds will be spent in our local community.[34]

Should the benefits enrollment program prove itself via the trickle-down of increased spending, one hopes the county will receive enough additional income to consider making the positions permanent.

OTHER POSSIBLE SOLUTIONS

The initiatives described above demonstrate that UTMB officials are proactively addressing the needs of the indigent population. Proposed below are two other potential avenues for achieving this end.

Retail Health Clinics

Retail health clinics opening around the country pose a viable solution for the uninsured to address urgent health care needs before they reach the crisis stage—and at reasonable cost. Also called convenient care clinics, they are staffed seven days a week, with extended hours on weekdays, by nurse practitioners (NPs) or physician assistants (PAs) who are licensed to diagnose, treat, and prescribe medications for common ailments. "Care is intended to be quick, inexpensive and convenient: visits and waiting

[34] Gabriella McDonald, "Losing $1,000,000s," *Jesse Tree Journal* 11, no. 1 (2007-2008): 2.

times are short, the charge is usually less than $50, and extended hours are offered, along with ample parking," writes Richard Bohmer in the New England Journal of Medicine.[35] The clinics are located inside pharmacies, such as CVS, or retail establishments with their own pharmacies, such as Wal-Mart, or grocery chains that also have on-site pharmacies, such as HEB. The profit motive for the host location is that these patients will have their prescriptions filled at the pharmacy just a few steps away, or store patrons will go to the clinic for a quick examination, rather than asking the pharmacist for advice about an over-the-counter treatment for their ailments.[36]

Prices for the limited range of services are posted at the entrance to the clinic, so patients know up front how much the visit will cost—usually in the range of $50-$75. Preventive services, such as diabetes or cholesterol screening, vaccinations, and physical exams, start at $19. Payment is expected at the time of service, and co-pays are required for those who carry some of the health insurance plans that are accepted.[37] For the working uninsured, particularly, being able to get treatment for a possible strep throat or mild allergic reaction to a bee sting, for example, with a minimal wait at a retail clinic after work or on the weekend is much preferred to long hours in the ED and a larger out-of-pocket expense.[38]

The American Academy of Family Physicians embraced the retail clinic concept in 2006, issuing a description of "AAFP's Desired Attributes of Retail Health Clinics," which include:

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[35] Richard Bohmer, "The Rise of In-Store Clinics – Threat or Opportunity?" *New England Journal of Medicine* 356, no. 8 (February 22, 2007): 765-768.

[36] William M. Sage, "The Wal-Martization of Health Care," Health Disparities Lecture, UTMB Center to Eliminate Health Disparities, March 9, 2007, www.utmb.edu/cehd/PDF/WilliamSage_RetailClinicLecture.pdf (accessed November 18, 2007).

[37] RediClinic, Frequently Asked Questions, http://www.rediclinic.com/faq.asp (accessed December 30, 2007).

[38] Sage.

- Scope of service: Retail clinics must have a well-defined and limited scope of clinical services;
- Evidence-based medicine: Clinical services and treatment must be evidence-based and quality improvement-oriented;
- Team-based approach: The clinic should have a formal connection with physician practices in the local community, preferably with family physicians, to provide continuity of care. Other health professionals, such as nurse practitioners, should only operate in accordance with state and local regulations, as part of a "team-based" approach to health care as prescribed by the Future of Family Medicine report and under responsible supervision of a practicing, licensed physician;
- Referrals: The clinic must have a referral system to physician practices or to other entities appropriate to the patient's symptoms beyond the clinic's scope of work. The clinic should encourage all patients to have a "medical home";
- Electronic health records (EHRs): The clinic should include an EHR system sufficient to gather and communicate the patient's information with the family physician's office, preferably one that is compatible with the Continuity of Care Record supported by AAFP—and others.[39]

One such clinic (RediClinic, headquartered in Houston) already is situated in northern Galveston County, at an HEB grocery store at Bay Colony Center in League City, less than a block away from UTMB's Women's Health Center, which has several other specialty practices. Because the RediClinics refer patients without medical homes to local providers for follow-up, they appear not to be in competition with the university for patients.[40] In fact, this clinic probably relieves some of the traffic otherwise headed to the Galveston ED.

Why not have UTMB establish retail health clinics of its own, starting, for example, with the Wal-Mart stores in Galveston County and expanding from there? This plan would use NPs and PAs already trained at UTMB to staff the clinics; connect via a secure link to the patients' electronic medical records (EMRs) at UTMB to review

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[39] Drew Sullivan, "Retail Health Clinics Are Rolling Your Way," *Family Practice Management* 13, no. 5 (2006): 65-72, http://www.medscape.com/viewarticle/536090_print (accessed December 30, 2007).

[40] RediClinic.

existing conditions, medications, etc., and to add information about the clinic visit; and, a competitive advantage, be able to connect via telehealth to an emergency physician at the hospital for a patient whose condition warrants urgent intervention. At the same time, the clinician could refer patients who need them to primary care physicians to establish medical homes.

Only one issue would need to be addressed in pursuing this opportunity: Texas law stipulates that one physician at such a chain of clinics may supervise only three NPs, and must be on-site 20 percent of the time the clinic is open.[41] With its ubiquitous telemedicine system, UTMB may be able to circumvent this requirement, but legislation specific to the university would be advisable.

Dr. Glenn G. Hammack, Assistant Vice President and Executive Director of the UTMB Electronic Health Network (EHN), said Wal-Mart inquired about having EHN provide telemedicine services for retail clinics in their stores in communities that do not have potential health partners, or where the providers are unwilling. But, on closer scrutiny, the idea of a Wal-Mart partnership was not such a good idea, he said. Wal-Mart's goal is to increase pharmacy business by renting space to a convenient care provider whose patients would get their prescriptions from its pharmacy. Wal-Mart also is requiring the provider to buy supplies exclusively from the corporation's Sam's Club warehouse outlets. The reality is that it would be much less expensive to stock such a clinic with supplies UTMB purchases in large quantities than to buy them from Sam's Club, which, in addition to charging more, carries supplies only from a limited choice of vendors.[42]

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[41] Web Golinkin, "Health Care When You Want It," *Wall Street Journal*, August 2, 2007.

[42] Glenn G. Hammack (Assistant Vice President and Executive Director of the UTMB Electronic Health Network), telephone interview with Joanna Bremer, January 3, 2008.

In his New England Journal of Medicine article, Bohmer noted that one criticism of convenient care clinics from the perspective of doctors and their practice institutions is that they take away quick-and-easy patients from primary care practices, leaving the sicker populations for the physicians to deal with. This is particularly a problem if the PCP uses the simple cases to subsidize the cost of more complex ones. Others view the retail operations as a way to increase access to medical care for the uninsured, leaving the doctors more time to spend with their patients.[43] Advantages of UTMB having its own retail clinics include taking the pressure off the ED, and alleviating some uncompensated care costs; furthermore, if the NPs or PAs in the retail clinics were to act as preceptors, medical, nurse practitioner, and physician assistant students would have additional opportunities for exposure to patients. One issue discussed in the Quality Enhancement Plan in the application to the Southern Association of Colleges and Schools is the concern that UTMB clinics do not have a large enough "capacity to provide large numbers of students with enough experience to have a sustained, substantial effect."[44] Clinics such as these would add to the current capacity, and increase learning opportunities for the students.

Other problems critics have with retail clinics are that PAs and NPs following strict treatment protocols, as outlined by their companies, may miss diagnoses or other health issues, or that patients whose episodic ailments are addressed there do not have the continuity of care they would with medical homes.[45] These present opportunities for UTMB, as well. Having linked EMRs, the supervising physicians would be able to review the records and identify patterns that might lead to more serious conditions. At the

[43] Bohmer, 767.

[44] David L. Callender, "Synergy: Quality Enhancement Plan" (draft), University of Texas Medical Branch application for accreditation by the Southern Association of Colleges. January 4, 2008.

[45] Bohmer.

same time, if the clinic establishes a medical home at UTMB for the patient at the time of the first visit, the continuity of care would be managed through the retail clinic in concert with the campus- or community-based clinic via the medical record.

However, rather than establishing convenient care clinics inside retail establishments, Hammack said the EHN may establish its own small telehealth clinics in strip centers, for example, in communities whose medical services are limited. The telemedicine clinic in the Brazoria County Health Department and the clinics in Texas Department of Criminal Justice facilities are models for the program. A primary care physician in the EHN center is able to see patients in several different clinics in a short period of time because he or she can be talking to a patient in one location while patients in other locations are being moved into and out of the exam rooms. The clinics occupy a small footprint: a waiting area, an office/check-in desk, and an exam room. They are staffed by an outpatient service associate (OSA) and a paramedic. The OSA checks in the patients, accepts their payments, obtains their records, and alerts the paramedic to the patients' presence. The paramedic escorts the patient to the exam room, equipped with a secure electronic and video link to the EHN at UTMB, where a primary care physician sits at a console with computer screens containing the patients' medical records, recent test results, a telephone link, and a video monitor of the patient. The medic, at the doctor's instruction, manages and moves the patient to provide a clear view of the presenting ailment and related symptoms. At the conclusion of the exam and long-distance visit, the physician prints out prescriptions and patient instructions to a computer printer in the exam room. Telemedicine clinics with a behavioral health component have a third person, a licensed mental health professional who accompanies the patient, and a

second exam room, with an identical secure electronic set-up, on the other end of which is a UTMB psychiatrist or psychologist.[46]

Having a PCP staff the EHN clinics exclusively saves money and time over having someone from the ED or a faculty member assigned to telehealth calls, Hammack said. Experience has shown that non-distracted providers (those who do not simultaneously face several tasks) work best for providing telemedicine services, as opposed to providers whose attentions are distributed among teaching, research, and face-to-face clinical duties. For the most part, patients have a pretty good idea of what their ailments are—or at least know when they are serious enough to go to the ED. So, when they go to a convenient care clinic, the idea is to get in and out quickly. Experiencing a long wait will just turn off, and turn away, patients. The learning experience comes for the students, who can staff the telemedicine clinics and experience patient care first-hand.[47]

What about the possibility of having students not only obtain clinical experience in this setting but also learn about the cultural needs of indigent patients?

Center for Excellence in Indigent Care

With its 117-year history as the health care provider for medically indigent patients from not only the State of Texas but also foreign shores, beginning in the days when Galveston was a port of entry to the United States, UTMB has particular expertise, knowledge, and insight into the needs and culture of sick children, women, and men who cannot pay for their medical care. From that perspective, it makes sense to undertake either or both of two parallel alternatives: 1) create a virtual Center for Excellence in Indigent Health Care or 2) establish a new indigent care specialty or elective or 3) both.

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[46] Hammack.
[47] Ibid.

The university already has the Center to Eliminate Health Disparities, whose mission is: "To improve access to care by supporting research into the basic causes of health inequities in society, developing new models for understanding and eliminating health disparities, and promoting policy change to effectuate health reform."[48] As originally envisioned by Dr. Harold Y. Vanderpool, Professor in the History of Medicine in the Institute for the Medical Humanities (IMH), the proposed Center for Excellence in Indigent Health Care (center) would be somewhat different.[49] It would not have a research and policy-oriented program, but rather would focus on modeling medical education and patient care for low-income individuals, using an interdisciplinary faculty from all four schools: Allied Health Sciences, Biomedical Sciences, Medicine, and Nursing.

- From allied health, for example, occupational therapy (OT) faculty conduct training at (among others) Our Daily Bread, which traditionally serves a clientele of indigent, often jobless, sometimes homeless individuals in Galveston. The OT students help clients with "communication, health promotion, self-esteem, and skills for living and leisure…[and, in the process] understand what it is like to be old and alone, or homeless, or worried about the violence in your neighborhood or in your home."[50]
- In the IMH, several faculty members have focused for many years on health policy, law, and access to care, specifically as they relate to racial and ethnic minorities and the un- and underinsured, who comprise the medically indigent population.[51]

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[48] Center to Eliminate Health Disparities, "Center Mission Statement" (Galveston, TX: University of Texas Medical Branch, undated), http://www.utmb.edu/cehd/ (accessed December 30, 2007).

[49] Harold Y. Vanderpool, thesis meeting with Joanna Bremer, April 11, 2007; reiterated in an e-mail message to Garland Anderson, Dean of the UTMB School of Medicine (copied to Bremer), April 18, 2007.

[50] Faith Lagay, "Occupational Therapy Students Learn Through Community Service," *UTMB Quarterly* 1, no. 2 (Fall 1999): 30-31, http://www.utmb.edu/utmbmagazine/archive/Quarterly/Fall99.pdf (accessed December 30, 2007).

[51] Institute for the Medical Humanities, "IMH Faculty," University of Texas Medical Branch, http://www.utmb.edu/imh/faculty.asp (accessed December 28, 2007).

- The School of Medicine has (among others) the Regional Maternal and Child Health Program (RMCHP), sponsored by the Department of Obstetrics and Gynecology, an outreach program serving women and children in more than twenty-five counties in south, southeast, and deep east Texas. Using county-based facilities, along with the university's telehealth capabilities for patients with complex needs, teams of obstetrics and gynecology nurses and residents travel to the regional clinics to treat primarily Medicaid and unsponsored patients. This program was initiated in the 1970s by Dr. William McGanity, department chair, and Dr. Alvin LeBlanc, then Director of Resident Education for the department. Dr. Garland Anderson, Dean of Medicine, headed the ob/gyn department for nearly fifteen years, and oversaw the growth of the RMCHP. He and the faculty have thorough personal experience with the needs and culture of this population of women and children.[52]
- The School of Nursing has a number of faculty members who specialize in many aspects of nursing and care issues related to diversity and indigent care: in serving patients, in community and public health nursing, and in educating and training new nurses from a variety of racial and ethnic backgrounds.[53]

The faculty for the center would come from among these areas for the didactic education. The clinical and practical piece, however, would be an expansion of the Teen Health Center, which has operated free clinics at several schools in the county through UTMB since 1986, with funding from the Robert Wood Johnson Foundation matched by contributions from the Harris and Eliza Kempner Fund, the Moody Foundation, and others. The clinics offer free medical treatment to any child who lives in a school residence zone from age zero to age twenty-one at Ball High School and Central and

[52] Alvin L. LeBlanc, M.D. (UTMB Associate Dean Emeritus for Graduate Medical Education), interview with Joanna Bremer in his office in the Jennie Sealy Hospital, November 27, 2007.

[53] School of Nursing, "School of Nursing – Faculty Directory," Galveston, TX: University of Texas Medical Branch, http://www.son.utmb.edu/general_info/faculty.asp (accessed December 28, 2007).

Weis Middle Schools in Galveston. The age range is limited to each city's school-age students in La Marque at La Marque High School and in Texas City at Blocker Middle School.[54] The key difference is that the new clinics proposed here would serve children and adults at the elementary schools, which are within walking distance of nearly every resident in Galveston. In other words, transportation would not be an issue. Galveston Independent School District (GISD) has nine elementary school buildings; although not all of them are being used as schools, the district still occupies and maintains them for other purposes. People who live beyond walking distance from the western-most elementary school, Oppe (on 81st Street), tend to be more affluent and likely would not use this program.

The clinics would rotate among the schools, one weekday evening (5-9 p.m.) at each school, every other week. The tenth day would be a Saturday clinic that also would rotate among the schools, or alternate between two or three centrally located venues. Because the schools already have nurses' offices, the exams would be conducted there. Should demand be large enough, classrooms could be converted into one or more exam rooms, as needed, using movable hard-walls currently used in convention and conference facilities to divide meeting rooms. Rather than permanent construction, these walls would be relatively inexpensive to install and would provide privacy, as required by HIPAA. As with the EHN clinics, an OSA would check in the patients. Rather than being managed by a paramedic, however, a medical, physician assistant or nurse practitioner student would escort the patients to the exam room where he or she would learn as the physician at the other end of the telehealth connection conducts the examination with the student's help. Another possibility, if demand warrants, is that one physician could see patients at two or three schools in the same evening. Although GISD facilities already are wired for

[54] "Experts: Prevention Key to Stopping HIV," *Galveston County Daily News*, June 10, 2006, http://blog.utmb.edu/newsroom/?p=348 (accessed January 5, 2007).

electronic educational programs, their electronic firewalls may cause some special issues when it comes to providing secure connections for EMRs and telemedicine links. If the demand—and savings—is large enough, that may be overcome.

Security and safety of the children in the building would be an issue for some. The clinics would need to be scheduled only after school hours, and the buildings would need to be secured when the clinics close.

If the program attracts an adequate number of patients, the clinics could become medical homes, rather than limited service clinics. Because the hours would be limited and the rotation would remain the same, rather than an existing EHN physician, a faculty member from Family Medicine or Internal Medicine could be assigned to each building, ensuring continuity of care. With telemedicine, specialty clinics even could be set up for patient encounters on a periodic basis, depending upon need, similar to the RMCHP.

Elective in Indigent Care

The idea here is that UTMB students would learn about the needs and culture of their prospective patients during the didactic teaching, and then put their lessons into practice in the school-based clinics. Even if the center is not established, this plan could be enacted as an elective or, should the interest be widespread enough, developed into a full-scale specialty program.

An advantage for GISD would be increased attendance. Some youngsters miss classes due to minor illnesses that could be addressed in these clinics. Instead, they must wait in the ED or miss school until they are better—without medical intervention. In other cases, parents require older children to stay home and take care of sick younger brothers and sisters so that parents can work, or because parents are ill and plan to spend hours waiting for treatment in the ED. If an evening or weekend clinic is available, this would not be necessary.

Developing a center of excellence through which the clinics would be managed would require an investment of time and resources, which might become available with an endowment from a benefactor with an interest in supporting indigent care, for example, the Robert Wood Johnson Foundation or Houston Endowment.[55] The funds also might become available if: 1) the program proves to save the hospitals and clinics money in the ED, and the university elects to support the program (as it did with the behavioral medicine care manager program) because patients are getting preventive medicine, or their chronic conditions are managed and do not reach the expensive, crisis, stage; or 2) the state can be convinced of the same thing, and chooses to support the program through budget allocations. This also would require convincing the Texas Department of State Health Services and local state legislators that the program is worthwhile, so they would propose it to the Legislature. Should it prove viable, the program could be implemented in communities throughout the state, and UTMB could obtain reimbursement by providing physician services via telemedicine.

CONCLUSION

Short of creating a multi-county hospital district, none of these other plans alone is enough to solve all the problems associated with UTMB's historic mission of caring for the indigent and educating the medical health professionals the state and the nation require. National health care may or may not become a reality in the next decade. But the state is moving toward possible programs that, within the next few years, are likely to provide some kind of health insurance for the indigent, uninsured, and unsponsored. A state version of the Public Policy Institute program discussed above makes the most sense. The plan would make available the affordable, FEHP insurance options currently

[55] Harold Y. Vanderpool, meeting with John D. Stobo and Joanna Bremer, in Stobo's office in the Marvin Graves Building, December 10, 2007.

open only to federal employees, and would be accompanied by a supplement from Medicaid to make the policies affordable for small companies and their workers. Some 60 percent of the uninsured population in Texas have jobs (in other words, 3.3 million), but their employers do not offer health insurance, or the premiums are too high for them to afford. Under this plan, they could afford them.

That would leave 40 percent of the currently uninsured (2.2 million) without insurance. Their problem could be addressed in one of two ways. Either 1) current federal programs (Medicaid, DSH, SCHIP, for example) could be combined and the money be used to pay the premiums for the FEHP option that is the best one for them; or 2) continue to have the uninsured population come to UTMB through one of the clinic systems proposed above, or through St. Vincent's, 4Cs, or the Residents Clinic on the university campus. This option still would provide patients for teaching purposes.

On the other hand, having UTMB clinics at least in the six surrounding counties whose residents comprise the majority of its patients would provide the visibility and the market reach to encourage them to retain UTMB as their health provider of choice, were they to become insured.

In any case, the historic tradition discussed in this thesis prescribes that UTMB establish itself as the provider of choice for these patients—in addition to potential patients throughout the state. This would be done through marketing to local physicians and patients, expanding specialty services to those areas via telemedicine, and creating a visible presence and reputation as having physicians and staff who truly care about them. Because, once the currently unsponsored patients have some kind of health care coverage that reimburses physicians and hospitals fairly for their services, these same physicians and hospitals who currently refer them will stop sending these patients to Galveston. In

that case, the number of individuals available for teaching students and training residents will dwindle, jeopardizing the future of the institution.

Of course, the obvious solution is a hospital district. Nevertheless, whether it is collaborating with community organizations to establish medical homes at UTMB for patients who have none; identifying federal resources for benefits they are entitled to, and cementing UTMB's reputation as a beneficent, caring, healing resource; creating retail clinics in convenient locations for the workers who do not have time or cannot afford to see a doctor in the middle of the workday; or establishing new telehealth and specialty clinics in their neighborhoods, this medical school cannot afford to limit its efforts to reimbursing costs for uncompensated care. UTMB must aggressively market and promote its caring, healing services, its reputation for excellence, and its historic mission as the hospital that serves everyone in the state. Otherwise, it will not be caring for the indigent that causes problems; it will be that everyone else is caring for them instead.

Bibliography

Academy Health. "Implementation Work Continues in Massachusetts." *Stateside.* July/August 2007. http://newsmanager.commpartners.com/proofs/proofs/?id+ahstsd20070731&articlenumber=3.pdf (accessed August 19, 2007).

Alker, Joan C. "Premium Assistance Programs: Do They Work for Low-Income Families?" Georgetown University Health Policy Institute, Center for Children and Families, March 15, 2007, http://edworkforce.house.gov/testimony/031507JoanAlkertestimony.pdf (accessed January 26, 2008).

Anchondo, Jose Jorge. "Medically Indigent Costs Affecting Local Governments: Background and Issues, Intergovernmental Report No. VIII-1." Austin: TX, Texas Advisory Commission on Intergovernmental Relations, June 1980 (second printing, October 1983).

Beal, A. C., M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis. "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Care Quality Survey." New York: NY, Commonwealth Fund, June 2007. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814& (accessed January 15, 2008).

Bohmer, Richard. "The Rise of In-Store Clinics—Threat or Opportunity?" *New England Journal of Medicine* 356, no. 8 (February 22, 2007): 765-768.

Breier, Barbara. "Galveston County 3-Share Plan Proposal" (draft). Galveston, TX: University of Texas Medical Branch, April 27, 2005.

———. Interview with Joanna Bremer in Breier's office in the UTMB Administration Building, April 29, 2005.

Brown, Curtiss (Director, Community Services, Galveston County, Texas). E-mail message to Joanna Bremer, July 6, 2007.

———. Interview by Joanna Bremer in Brown's office in Shearn Moody Plaza Building, Galveston, TX, July 9, 2007.

Bureau of Labor Statistics. "Consumer Price Index: December 2007." United States Department of Labor. January 16, 2008, http://www.bls.gov/news.release/pdf/cpi.pdf (accessed February 1, 2008).

Burns, Chester R., *Saving Lives, Training Caregivers, Making Discoveries: A Centennial History of the University of Texas Medical Branch at Galveston.* Austin, TX: Texas State Historical Association, 2003.

Busansky, Phyllis. "Prescription for Change: UTMB Health Policy Forum: The Hillsborough Plan for Indigent Care: How We Mobilized the Community to Provide Primary Care Clinics for the Indigent." Health Disparities Lecture. University of Texas Medical Branch, Center to Eliminate Health Disparities, June 27, 2007, http://www.utmb.edu/healthpolicy/busansky.htm (accessed September 13, 2007). Videotape obtained from the Office of University Advancement.

Butler, Patrick (Compliance Auditor, Galveston County Health District). E-mail message to Joanna Bremer, August 24, 2007.

Callender, David L. "Synergy: Quality Enhancement Plan" (draft). Galveston, TX: University of Texas Medical Branch application for accreditation by the Southern Association of Colleges. January 4, 2008.

Center to Eliminate Health Disparities. "Center Mission Statement." Galveston, TX: University of Texas Medical Branch, undated. http://www.utmb.edu/cehd/ (accessed December 30, 2007).

City-Data.com. "Galveston County, TX.", http://www.city-data.com/county/Galveston_County-TX.html (accessed January 7, 2008).

Collins, Sara R., Cathy Schoen, Karen Davis, Anne K. Gauthier, and Stephen C. Schoenbaum. "A Roadmap to Health Insurance for All: Principles for Reform." New York, NY: The Commonwealth Fund, October 2007. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=553840&#doc553840 (accessed December 24, 2007).

Commission on a High Performance Health System. "A High Performance Health System for the United States: An Ambitious Agenda for the Next President." New York, NY: The Commonwealth Fund, November15, 2007. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=584834&# doc58434 (accessed December 24, 2007).

Communities Joined in Action. "Hillsborough County Health Care Plan." http://www.cjaonline.net/Communities/FL_Hillsbourough.htm (accessed September 8, 2007).

Community-Campus Partnerships for Health. "2004 Community-Campus Partnerships for Health Award Recipient." Seattle, WA: University of Washington. http://depts.washington.edu/ccph/awards2004GCHAP.html (accessed May 30, 2005).

Connaughton, David M. (Chief Financial Officer, UTMB Hospitals and Clinics). E-mail message to Joanna Bremer, January 27, 2008.

Donohue, Katie, and David Kendall. "Health Coverage for All, Policy Report." *Policy Report.* Washington, DC: Progressive Policy Institute, October 2007, http://www.ppionline.org/documents/StateHealthCoverage101607.pdf (accessed December 19, 2007).

Dowling, Beverly (Assistant Vice President for Community Health Networks). Telephone interview with Joanna Bremer, January 28, 2008.

Faour, Pat. "$800,000 Grant Announced for Indigent Clinic Plan." *Galveston (TX) Daily News.* April 17, 1970.

Farabee, Helen J., Gordon Arnold, Chet Brooks, Jesse Oliver, John Traeger, Don Les, Les Brown, Ron Mullen, Lester J. Cranek, Cy Rone, Tom Bacus, B. D. Griffin, Jim Tyson, Mary Haynes, Beto Salinas, et al. "Task Force on Indigent Health Care: Final Report." State of Texas. December 1984, www.lrl.state.tx.us/scanned/interim/68/in2.pdf (accessed June 12, 2007).

Felland, Laurie E., Debra A. Draper, and Allison Liebhaber. "Massachusetts Health Reform: Employers, Lower-Wage Workers and Universal Coverage." Washington, DC: Center for Studying Health System Change. *Issue Brief* no. 113 (July 2007), http://www.hschange.org/CONTENT/939/ (accessed September 9, 2007).

Florida Medicaid. "Florida Reform Implementation Plan." November 29, 2005. http://ahca.myflorida.com/Medicaid/medicaid_reform/implementationplan/implementationplan_11-29-05.pdf (accessed August 19, 2007), 35-37.

———. "Introducing the Enhanced Benefits Account Program." Tallahassee, FL: State of Florida. August 2007. http://ahca.myflorida.com/Medicaid/Enhanced_Benefits/enhanced_benefits_brochure-english-08-07.pdf (accessed August 19, 2007).

———. "Low Income Pool (LIP)." Tallahassee, FL: State of Florida. Undated. http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml (accessed August 19, 2007).

Galewitz, Phil. "Local Governments Find Ways to Assist with Care for Uninsured." *Palm Beach Post*, July 31, 2005, http://kff.org/about/upload/fellow-7_31-pkg.pdf (accessed September 8, 2007).

Galveston County Health Access Program. "A Health Partnership with the Community." February 2004. http://www.galvestonchap.org/Publications/presentations.asp (accessed July 2, 2005).

———. "Our History—G CHAP." 2001. http://www.som.utmb.edu/e-NEWS/2001/e-NEWS-July01.htm (accessed May 28, 2007).

Galveston County Daily News. "Cancellation of Hospital Lease Ordered by Board: University Regents Are Given Exclusive Control by City." March 7, 1941.

———. "Experts: Prevention Key to Stopping HIV." June 10, 2006, http://blog.utmb.edu/newsroom/?p=348 (accessed January 5, 2007).

———. "Funds for University." May 2, 1899.

———. "Hospital Board Asks City to Abrogate Lease: City Commission to Receive Letter at Meeting Tomorrow." January 15, 1941.

———. "New Clinic Slated, Opens Monday." July 15, 1972.

———. "Statement to Be Made Later on Hospital Change: Conference Held by Local Officials with University Head." January 31, 1941.

———. "Twenty-Sixth Legislature: The House." May 2, 1899.

Glenn, Jason E. (Assistant Professor of History, Institute for the Medical Humanities). E-mail message to Joanna Bremer. February 16, 2008.

Golinkin, Web. "Health Care When You Want It." *Wall Street Journal*, August 2, 2007.

Government Innovators Network. "Hillsborough County Health Care Plan, 1995 Winner." http://www.innovations.harvard.edu/awards.html?id=3688 (accessed September 13, 2007).

Gray, Patricia. HB 2456, 77th Regular Session of the Texas Legislature, 2001, http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=77R&Bill=HB2456 (accessed September 16, 2007).

Greene, Jessica. "State Approaches to Consumer Direction in Medicaid." *Issue Brief* 113 (July 2007). http://www.chcs.org/usr_doc/State_Approaches_to_Consumer_Direction.pdf (accessed September 9, 2007).

Guckian, James C. (Executive Associate for Health Policy and Planning at UT System in 1988-1999). e-mail message to Joanna Bremer, November 27, 2007.

Hammack, Glenn G. (Assistant Vice President and Executive Director of the UTMB Electronic Health Network). Telephone interview with Joanna Bremer. January 3, 2008.

Handbook of Texas Online. http://www.tsha.utexas.edu/handbook/online/articles/GG/hcg2.html (accessed December 29, 2007).

Herz, Lillian E. "Texas Senators Are Impressed with Size of Medical and Opportunities Offered." *Galveston County Daily News.* March 14, 1947.

Himmelstein, David U., Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. "Illness and Injury as Contributors to Bankruptcy." *Health Affairs* Web Supplement 5 (February 2, 2005): W5-63-W5-73.

Institute for the Medical Humanities. IMH Faculty. Galveston, TX: University of Texas Medical Branch. http://www.utmb.edu/imh/faculty.asp (accessed December 28, 2007).

Institute of Medicine. "Health Literacy: A Prescription to End Confusion." *Report Brief* (April 2004). http://www.iom.edu/Object.File/Master/19/726/health%20literacy%20final.pdf (accessed September 9, 2007).

Jesse Tree, The. "A Community Response to Disparity." Health Disparities Panel presentation at the University of Texas Medical Branch, May 5, 2005.

———. "Orientation and Overview." http://www.jessetree.net/The %20Jesse %20Tree %20Overview %20and %20OrientationVersion %203 %20October2006.pdf (accessed May 25, 2007).

Keller, Brooks. "Indigent Care Pay May Cost $460,000." *Galveston County Daily News.* May 28, 1968.

Kempthorne, Dirk. "Modernize Medicaid: Prevention, Wellness, Responsibility, Value-Based Reform, Concept Summary." Boise, ID: State of Idaho. November 15. 2005, http://dfm.idaho.gov/cdfy2007/OtherDocuments/Modernize-Medicaid-Report.pdf (accessed March 31, 2006).

Lagay, Faith. "Occupational Therapy Students Learn Through Community Service." *UTMB Quarterly* 1, no. 2 (Fall 1999): 30-31. http://www.utmb.edu/utmbmagazine/archive/Quarterly/Fall99.pdf (accessed December 30, 2007).

Lando, MaryAnn. "Innovative Programs Provide Access to Care." *HealthCare Executive* 19, no. 1 (January/February 2004): 16-22.

Lane, Neal, and John D. Stobo. "Code Red: The Critical Condition of Health Care in Texas [The Summary]." Task Force for Access to Health Care in Texas. April 17, 2006, www.coderedtexas.org (accessed April 25, 2007).

———. "Medicaid and the State Children's Health Insurance Program in Texas." *Code Red.* Task Force for Access to Health Care in Texas. April 17, 2006, http://www.coderedtexas.org/files/Report_Chapter04.pdf (accessed September 9, 2007), 68.

LeBlanc, Alvin L. (UTMB Associate Dean Emeritus for Graduate Medical Education). Interview with Joanna Bremer in his office in the Jennie Sealy Hospital. November 27, 2007.

Legislative Budget Board. "Fiscal Note, 77th Regular Session." Austin, TX: State of Texas. April 18, 2001. http://www.capitol.state.tx.us/tlodocs/77R/fiscalnotes/html/HB02456.htm (accessed September 16, 2007).

Long, Stuart. "Approval Seen for Emergency Medical Appropriation." *Galveston County Daily News.* April 6, 1947.

McComb, David G. *Galveston: A History.* Austin: University of Texas Press, 1986.

McDonald, Gabriella. "Losing $1,000,000s." *Jesse Tree Journal* 11, no. 1 (2007-2008): 2.

McNally, Oscar F., Pat Neff, M. T. Lively, George W. McKnight. "Report of Special Committee Appointed to Visit the University of Texas and Medical Branch." Journal of the House of Texas of the Twenty-Seventh Legislature 1901. February 26, 1901, http://www.lrl.state.tx.us/scanned/interim/27/27_0+univTX&UTMB.pdf (accessed June 12, 2007).

National Conference of State Legislatures. "Idaho State Plan Amendment." http://www.ncsl.org/programs/health/idmedicaid.htm (accessed July 21, 2007).

Navigant Consulting. "UTMB—Overall/Institutional Support, Confidential Draft, Executive Summary." UTMB computer printout, Office of the President. May 17, 2007.

Nesbitt, Robert. *50th Anniversary, Report 1922-1972*. Sealy and Smith Foundation for the John Sealy Hospital. Galveston, TX.: 1972.

NetIndustries, LLC. “Health Maintenance Organization.”. http://www.faqs.org/health/topics/71/Health-Maintenance-Organization.html (accessed November 18, 2007).

Nichols, Robert B. *A Bridge to a Better World*. Galveston, TX: Sealy & Smith Foundation by the Office of External Affairs, University of Texas Medical Branch, 1989.

Office of Community Health Services. “County Contract Status—Effective January 2007.” Galveston, TX: University of Texas Medical Branch. http://www.utmb.edu/osainfo/CountyInfo/CountyContracts.htm (accessed July 3, 2007).

Office of Finance, Decision Support. “The University of Texas Medical Branch Unsponsored Care Revenues and Expenses for Fiscal Year August 2006 (in millions).” Galveston, TX: UTMB Finance Department and Office of Community Health Services.

Office of Public Affairs. “HHS Approves Medicaid Waiver to Create New Indiana Health Plan for Uninsured Hoosiers.” U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. December 14, 2007, http://www.hhs.gov/news/press/2007pres/12/pr20071214a.html (accessed January 26, 2008).

Office of Public Affairs. “New Women’s Health Center Opens in Dickinson.” Galveston, TX: University of Texas Medical Branch, April 18, 2005, http://www.utmb.edu/impact/stories/2005/05APRIL18/OBGYNclinic.htm (accessed February 18, 2008).

———. “UT System Regents Grant $30.5 Million for UTMB Medical Specialty Center,” *Impact* 30, no. 8 (Galveston, TX: University of Texas Medical Branch, August 2006): 11.

Office of the Dean, School of Medicine. “Major Grants and Awards.” *SOM eNews* online newsletter, July 2001, http://www.som.utmb.edu/e-NEWS/2001/e-NEWS-July01.htm (accessed May 28, 2007).

Office of the Texas Comptroller. “The Uninsured: A Hidden Burden on Texas Employers and Communities.” April 2005, http://www.window.state.tx.us/specialrpt/uninsured05/ (accessed January 31, 2008).

Pederson, E. J. (UTMB Executive Vice President for Business Affairs, 1985-2005). Interview with Joanna Bremer, in his office in the Bank of America Building. November 28, 2007.

Penzell, Dennis. “Hillsborough County Florida (Tampa), Partners for a Prosperous Athens.” http://www.prosperousathens.org/initiatives/health/images/Hillsborough%20County%20Florida%207-13.pdf (accessed September 8, 2007).

Powell Goldstein. “Memorandum Regarding ‘Proposed Rule Regarding Cost Limit for Public Providers and Defining Public Status’.” Washington, DC: National Association of Public Hospitals and Health Systems, January 19, 2007, http://www.naph.org/Content/ContontGroups/Policy_Priorities/Medicaid_and_SCHIP/Summary_of_Proposed_Rule_1-19-07.pdf (accessed November 23, 2007).

Raimer, Ben G. (Vice-President and Chief Executive Officer, Community Health Services). Interview by Joanna Bremer in his office in the UTMB Administration Building, October 15, 2007.

RediClinic. “Frequently Asked Questions.” http://www.rediclinic.com/faq.asp (accessed December 30, 2007).

Robert Wood Johnson Foundation. “Coverage Profile: Massachusetts, Overview of Medicaid and SCHIP Coverage.” December 2006. http://statecoverage.net/profiles/massachusetts.htm (accessed August 26, 2007).

Sage, William M. “The Wal-Martization of Health Care.” Health Disparities Lecture. University of Texas Medical Branch, Center to Eliminate Health Disparities. March 9, 2007. www.utmb.edu/cehd/PDF/WilliamSage_RetailClinicLecture.pdf (accessed November 18, 2007).

St. Vincent’s House. “Free Clinic: A Place Where Healing Begins.” Galveston, TX: St. Vincent’s House, undated. http://www.stvhope.org/free_clinic.htm (accessed December 29, 2007).

Schladen, Marty. “Stobo to Resign as UTMB President.” *Galveston County Daily News.* October 5, 2006. http://galvestondailynews.com/story.lasso?ewcd=1013d695dd03adb0& (accessed February 18, 2008).

———. “UTMB Changes Are Due by August.” *Galveston County Daily News*, June 5, 2006.

———. “UTMB Reorganization Prompts Fears of Layoffs.” *Galveston County Daily News.* May 26, 2006.

School of Nursing. Faculty Directory. University of Texas Medical Branch. http://www.son.utmb.edu/general_info/faculty.asp (accessed December 28, 2007).

Sellers Feinberg. "A Vision for Texas Health Care Reform." Austin, TX: Texas Health and Human Services Commission. May 8, 2007. http://www.hhs.state.tx.us/medicaid/HealthCareReform.pdf (accessed September 13, 2007).

Seward, Zachary M. "Doctor Shortage Hurts a Coverage-for-All Plan." *Wall Street Journal*, July 25, 2007.

Shirk, Cynthia, and Jennifer Ryan. "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum. *Issue Brief* 812 (July 17, 2006). http://nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf (accessed September 3, 2007).

Sisters of Charity of the Incarnate Word, San Antonio. "Our History." http://www.incarnatewordsisters.org/ourhistory.htm (accessed January 12, 2008).

Sisters of Charity of the Incarnate Word. "Legacy." http://www.sistersofcharity.org/legacy.htm (accessed January 12, 2008).

Smith, Diana. "UTMB Behavioral Health Model Takes Care to Vulnerable Patients in the Community" *Texas Hospitals* (November-December 2007): 22-24.

Smith, Laura (Assistant Vice President for Legal Affairs). Telephone conversation with Bill Ratliff, related in an e-mail message to Joanna Bremer, November 20, 2007.

State Coverage Initiatives. "Matrix Glossary: Medicaid, SCHIP, and Federal Authority." http://www.statecoverage.net/matrix/saivers.htm (accessed September 8, 2007).

Stobo, John D. (Former President of the University of Texas Medical Branch). Conversation with Joanna Bremer, in his office in the Marvin Graves Building, January 28, 2008.

———. E-mail message to Joanna Bremer. February 7, 2008.

———. "From Very Good to Great: Setting an Ambitious Course for the Future." Galveston, TX: University of Texas Medical Branch, 2006. http://www.utmb.edu/townmeeting/March2006.htm (accessed May 30, 2007).

———. "A Message from President John D. Stobo: The Demand and Access Management Program." Galveston: University of Texas Medical Branch, 1998. http://www.UTMB.edu/president/damphome.htm (accessed May 1, 2005).

———. "Town Meeting." Galveston: University of Texas Medical Branch, May 7, 2007, Webcast: http://www.utmb.edu/townmeeting/#webcast (accessed May 13, 2007).

Sullivan, Drew. “Retail Health Clinics Are Rolling Your Way. *Family Practice Management* 13, no. 5 (2006): 65-72.

Taylor, Heber. “Have a Care for January 2009.” *Galveston County Daily News*, January 27, 2008.

———. “Help Spread the Good News.” *Galveston County Daily News.* July 11, 2007.

Texas Health and Human Services Commission (HHSC). “HHSC Council Subcommittee on Medicaid Reform and Hospital Financing.” October 30, 2007. http://www.hhsc.state.tx.us/about_hhsc/council/103007_PresentationPacket.pdf (accessed January 26, 2008).

———. “Medicaid Reform Strategies for Texas: Benchmark Plans (Tailored Benefits).” February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/BenchmarkPlans_TailoredBenefits.pdf (accessed August 21, 2007).

———. “Medicaid Reform Strategies for Texas: CHIP Premium Assistance.” February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/CHIPPremiumAssistance.pdf (accessed August 21, 2007).

———. “Medicaid Reform Strategies for Texas: Enhanced Benefit Accounts.” February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/EnhancedBenefitAccounts.pdf (accessed August 24, 2007).

———. “Medicaid Reform Strategies for Texas: Health Opportunity Pool Trust Fund.” February 2007. http://www.hhs.state.tx.us/medicaid/HOP.shtml (accessed August 24, 2007).

———. “Medicaid Reform Strategies for Texas: Low-Income Pools.” February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/LowIncomePools.pdf (accessed August 24, 2007) 1-2.

———. “Medicaid Reform Strategies for Texas: Medicaid Opt-Out.” February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/MedicaidOptOut.pdf (accessed August 21, 2007).

———. “Medicaid Reform Strategies for Texas: Pay for Performance.” February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/PayforPerformance.pdf (accessed August 21, 2007).

———. “Medicaid Reform Strategies for Texas: Premiums and Cost Sharing.” February 2007.

http://www.hhs.state.tx.us/medicaid/ResearchPapers/PremiumsandCostSharing.pdf (accessed August 21, 2007).

———. "Medicaid Reform Strategies for Texas: Three-Share/Multi-Share Programs." February 2007. http://www.hhs.state.tx.us/medicaid/ResearchPapers/ThreeShare_MultiSharePrograms.pdf (accessed August 21, 2007).

———. "Next Steps and Timelines." http://www.hhs.state.tx.us/medicaid/Timelines.shtml (accessed August 24, 2007).

———. "Senate Bill 10 Sets Stage for Health Care Reform." http://www.hhs.state.tx.us/medicaid/SB10Highlights.shtml (accessed August 24, 2007).

———. "Texas Health Care Reform Goals." June 2007. http://www.hhs.state.tx.us/medicaid/ReformGoals.shtml (accessed August 24, 2007).

Texas Senate. Senate Bill No. 10. Austin, TX: State of Texas. http://capitol.state.tx.us/tlodocs/80R/billtext/pdf/SB00010F.pdf (accessed July 21, 2007).

Theis, David. "Big House Health Care: Why and How UTMB Treats the Incarcerated." *UTMB Magazine* 9, no. 1 (Fall 2007): 6-11.

Thompson, Vernon E. Interview by Chester E. Burns, April 1986 (Part 4). Galveston, TX: UTMB Centennial Oral History Collection, Moody Medical Library. http://ar.utmb.edu/areas/informresources/collections/blocker/oralhistorychild.asp (accessed November 11, 2007).

United States Census Bureau. "Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements." http://www.census.gov/prod/2007/pubs/p60-233.pdf (accessed December 19, 2007).

United States Department of Health and Human Services. "2004 Federal Poverty Guidelines." http://aspe.hhs.gov/poverty/04poverty.shtml (accessed 7/02/2005).

The University of Texas Medical Branch at Galveston, A Seventy-Five Year History by the Faculty and Staff. Austin, TX: University of Texas Press, 1967.

Vanderpool, Harold Y. (Professor in the History of Medicine in the Institute for the Medical Humanities). Thesis meeting with Joanna Bremer. April 11, 2007. Reiterated in an e-mail message to Garland Anderson, Dean of the UTMB School of Medicine (copied to Bremer). April 18, 2007.

Varian, Bill. “Indigent Care’s Reserves Healthy: But Hillsborough’s Health Care Fund Is Wary of Hard Times and Growing Enrollment.” *St. Petersburg Times*, September 2, 2007.

Walsdorf, Rebecca T. (Executive Director, Community Health Promotion, UTMB). Interview by Joanna Bremer, in her office in Shearn Moody Plaza. November 6, 2007.

Warner, David C., Lauren R. Jahnke, and Kristie Kimbell. “Medicaid and the State Children’s Health Insurance Program in Texas: History, Current Arrangements, and Options.” *Code Red*, Appendix B (April 2005): B-8, B-18–B-19.

WelCare Initiative, The. “About the Program.” Galveston, TX: St. Vincent’s House. Undated. http://www.stvhope.org/WelCare%20Initiative/About%20the%20Program/About%20WC.htm (accessed December 29, 2007).

Wikipedia, the Free Encyclopedia. “Health Maintenance Organization.” http://en.wikipedia.org/wiki/HMO (accessed November 18, 2007).

Williamson, Samuel H. “Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1790-2006.” *MeasuringWorth.Com.* 2007, http://www.measuringworth.com/uscompare/ (accessed January 13, 2008).

Wolf, Richard. “What Does a Health Crisis Look Like? See Houston.” *USA Today.* June 18, 2007.

Vita

Joanna Bremer, nee Joanna Forman, was born April 24, 1947, in Roanoke, VA, to Ruth V. and John C. Forman, and grew up in Michigan, Ohio, California, and Utah. In Salt Lake City, Utah, Jo got her first newspaper job, in the research library of the *Salt Lake City Tribune*, where she subsequently was promoted to a reporting position in what was then the Women's Department. She married Robert M. Charles and later moved to Michigan, where she worked at the *News-Herald Newspapers* as the women's editor covering communities south of Detroit. In 1972, she was hired as a copy editor at the *Detroit Free Press*, where she held a number of editing positions over the course of 17 years. In volunteering for the newspaper's annual marathon, Jo met her husband, James A. Bremer, who was a marathon runner and another volunteer for the race. They married in 1987. As a result of the newspaper pursuing a joint operating agreement with the *Detroit News*, the *Free Press* cut a number positions in 1989, among them Jo's. Consequently, she opened a public relations and writing/editing business. Among the positions she accepted after the paper was as a lecturer in journalism at Eastern Michigan University, where she taught two classes for each of two semesters. At that time, she and her husband purchased a house in Galveston, which they rented to University of Texas Medical Branch postdocs and residents until they moved to the island in 1995. She kept her business going until 1999, when she began working at the university in the Office of University Advancement. Jo accepted the position as the first administrative manager of the new Center for Interdisciplinary Research in Women's Health from 2002 to 2006, and became a science writer/editor in the development office of Research Services' Office of

Sponsored Programs in 2006, the position she currently holds. Meanwhile, in 2003 she enrolled in the master's program in the Institute for the Medical Humanities, from which she expects to graduate in May 2006.

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Summary of Thesis

Today, 24.1 percent of Texas inhabitants have no health insurance, by choice or happenstance; medical inflation is approximately 6 percent annually; and federal support for indigent health care is eroding in the face of a war in the Middle East. With the 2008 race for the presidency of the United States in full swing, however, candidates increasingly are focusing on providing some kind of health care coverage for the 15.6 percent of U.S. citizens who live—and die—without it. Thus, with this national focus, one can see that the crisis of finding ways to pay for treating unsponsored patients is not unique to Texas nor to UTMB.

Nor is this issue new to the contemporary era. Even before Texas voters in 1881 selected Galveston as the location for the Medical Department of the University of Texas, the island city was the home of the Texas Medical College and Hospital, founded with the notion that serving paupers was part of its mission. When the medical department opened ten years later, that mission transferred to the new institution, known today as the University of Texas Medical Branch at Galveston (UTMB). Ever since, it has been

considered the charity care provider for the state, as the home of the John Sealy Hospital, the only full-service hospital owned by the State of Texas. The state, however, viewed care of paupers (including maintaining their health) as a local prerogative, and delegated that responsibility to the counties without providing an enforcement mechanism, nor requiring any financial allocation toward that end.

This paper will review the history of UTMB vis a vis its mission of providing health care for indigents and uninsured; examine the role of the State Legislature in helping or hindering UTMB in caring for patients who cannot pay for their treatment; discuss measures enacted by other states that are models for pilot programs the state hopes will recover or reduce uncompensated health care costs; and propose some solutions currently being undertaken or that UTMB may consider to address the problems.

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This thesis was typed by Joanna Bremer