Texas State Government Effectiveness and Efficiency

Selected Issues and Recommendations

SUBMITTED TO THE 80TH TEXAS LEGISLATURE JANUARY 2007

PREPARED BY LEGISLATIVE BUDGET BOARD STAFF

TEXAS STATE GOVERNMENT EFFECTIVENESS AND EFFICIENCY

SELECTED ISSUES AND RECOMMENDATIONS

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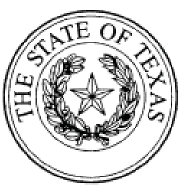

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Honorable Governor of Texas
Honorable Members of the Eightieth Legislature

Ladies and Gentlemen:

The Legislative Budget Board staff report *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations* contains 58 analyses on the effectiveness and efficiency of Texas state government. The report has been prepared in compliance with the provisions of Section 322 of the Texas Government Code.

The evaluation and audit processes established under the provisions of Section 322 are valuable tools to help the Texas Legislature identify and implement changes that improve state agency effectiveness and efficiency. The results of these evaluations and audits, coupled with ongoing reviews of each agency's progress towards the achievement of established performance targets contained in the General Appropriations Act, facilitate the accomplishment of state goals and objectives.

The 58 analyses contained in the *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations* report are organized by functional area. Each analysis is designed to provide the reader with an understanding of the salient findings, concerns, and recommendations (if warranted) related to the issue or program that has been reviewed by Legislative Budget Board staff. When appropriate, the five-year fiscal impact of any recommendation(s) is discussed, and information is provided as to whether the recommendation(s) has been included in the introduced 2008–09 General Appropriations Bill.

The staff of the Legislative Budget Board appreciates the cooperation and assistance state agencies provided during the preparation of this report.

Respectfully submitted,

John O'Brien
Director

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CONSOLIDATE STATE FLEET MANAGEMENT OPERATIONS

Vehicle fleet management operations undertaken by Texas agencies include vehicle acquisition, maintenance and repair activities, fueling operations, management of inventory and use, collection and reporting of cost data, and disposal, or sale, of excess inventory. Ninety-six agencies and institutions of higher education within the state of Texas operate 26,766 vehicles at an average yearly cost of $157.8 million. Excluding institutions of higher education, 37 state agencies expend approximately $120.4 million a year to acquire, maintain, fuel, and report the use and operations of 20,125 state fleet vehicles.

Over the last four biennia, the state steadily improved the management of agency vehicle fleets by consolidating data reporting, instituting standard use criteria, and increasing the centralized operational oversight of disparate programs. Further consolidation would allow Texas to continue to improve the efficiency of vehicle fleet operations by reducing related indirect management costs and coordinating direct maintenance operations statewide. Improving the state's fleet data system would augment the quality and consistency of data available to state legislators and agency executives, while streamlining agency reporting requirements.

FACTS AND FINDINGS

- State agencies expended $15.4 million in indirect fleet management operating costs during fiscal year 2005. Indirect costs include salaries and benefits; insurance; maintenance facilities; equipment and tools; and parts. Labor resources account for 47 percent of total indirect fleet costs. As a result, these resources are unavailable to serve the core functions and constituencies of each agency.
- A random sampling of state vehicle mileage logs recorded during fiscal year 2005 reveals that, on average, state vehicles sit idle for approximately 8.5 workdays per month. Based on this data, state agencies are achieving average fleet usage rates of only 72 percent.
- The current fleet data management system, which 96 state agencies and institutions of higher education access, requires cumbersome and resource intensive data entry and monitoring processes that agencies find both difficult and costly to maintain.

CONCERNS

- Allowing 37 state agencies and 59 institutions of higher education to manage independent fleet operations creates multiple maintenance standards and duplicate drains on limited state resources, negatively affecting core agency functions.
- Texas' fleet data management system, while successful in providing consolidated statewide information for legislative and executive use, demands more time and staff resources than alternative options for capturing the required information.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Government Code §2171 to centralize state fleet management operations into six functional agency hubs of similar vehicle numbers. The six hubs would represent the four largest agency fleets and two consolidated fleets created from health and human services enterprise vehicles and general government agency vehicles.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill to direct the Office of Vehicle Fleet Management, at the Building and Procurement Commission, to implement an improved state fleet data management system.

DISCUSSION

Over the last two decades, Texas improved its management of agency fleet vehicles. The most significant changes occurred during the Seventy-sixth Legislature, Regular Session, 1999. Concerned about the lack of data available on the state vehicle fleet and uncoordinated management, the Legislature required the Office of Vehicle Fleet Management (OVFM) to develop a state vehicle fleet management plan and institute a state fleet data reporting system. This requirement came under the direction of the State Council on Competitive Government (Council). In October 2000, with the assistance of OVFM, and advised by seven large agencies, the Council adopted a plan that defined acceptable vehicle acquisition, maintenance, and disposal processes for state agencies and institutions of higher education to implement. In September 2003, the plan was reissued with Council approved revisions.

The plan contains three principle requirements. The first is that agencies remain within an imposed vehicle fleet size cap, defined and monitored by OVFM. The second requires that vehicles meet a minimum usage threshold defined within the plan; vehicles consistently failing to meet the criteria are identified as excess and disposed of through surplus property operations. The final requirement sets data reporting standards; each agency operating state owned vehicles is responsible for maintaining accurate and updated statistics on those vehicles within the state fleet database, overseen by OVFM.

Texas' efforts in improving statewide fleet management place it in the vanguard nationally. Many states, including California and Oklahoma, are modeling recent fleet efficiency improvements on Texas' plan and requirement standards.

STATE FLEET COMPOSITION

As of January 2006, 96 state agencies and institutions of higher education operated 26,766 state owned and maintained vehicles. One quarter of those vehicles are operated by institutions of higher education, with 37 state agencies maintaining and using 20,125 vehicles. As **Figure 1** shows, the Texas Department of Transportation (TXDOT) maintains the largest state fleet with 9,594 vehicles; this number excludes roughly 7,500 pieces of heavy construction and testing equipment that the state fleet database does not track because of their atypical use. The smallest fleets are operated by the Office of the Secretary of State, the Commission on Fire Protection, and the Juvenile Probation Commission, each having a single vehicle. Three agencies, the Texas Department of Public Safety (DPS), the Texas Department of Criminal Justice (TDCJ), and the Texas Parks and Wildlife Department (TPWD), maintain fleets of between 2,000 and 3,000 vehicles. The average fleet size of the remaining 30 agencies is 120 vehicles.

Passenger vehicles, including 11,828 light duty trucks, 5,562 sedans and sport utility vehicles, and 3,034 vans primarily comprise the state fleet. The primary programmatic uses of state fleet vehicles are maintenance operations (7,728 vehicles), law enforcement activities (5,294 vehicles), materials transportation needs (4,846 vehicles), and staff transportation needs (3,902 vehicles). State agencies currently allow employees to use 1,205 vehicles to commute from home to work due to the specific demands of their position.

Many state fleet vehicles are operated beyond their useful life and past the replacement criteria recommended by the State Vehicle Fleet Management Plan, causing substantial decreases in equipment performance and fuel economy. Although the average age of state vehicles is 6.5 years, individual agency ranges reach from a low of two years, at DPS and the Texas Department of Licensing and Regulation, to a high of 13 years at the Commission on Fire Protection. This range evidences certain disparity in the quality, safety, and efficiency of vehicles operated at each agency. In addition, these disparities increase maintenance and repair costs and cause extreme fluctuations in the administrative burden placed on the user agency.

FIGURE 1
AGENCY FLEET SIZES

AGENCY	NUMBER OF VEHICLES	PERCENTAGE OF TOTAL
Texas Department of Transportation	9,594	47.7%
Texas Department of Public Safety	2,620	13.0
Texas Parks and Wildlife Department	2,184	10.8
Texas Department of Criminal Justice	2,117	10.5
Texas Department of Aging and Disability Services	866	4.3
Department of State Health Services	665	3.3
Texas Commission on Environmental Quality	377	1.9
Texas Youth Commission	336	1.7
Texas Alcoholic Beverage Commission	293	1.5
Railroad Commission of Texas	231	1.2
All Other Agencies	842	4.2
Total	**20,125**	

SOURCE: Office of Vehicle Fleet Management.

FLEET MAINTENANCE AND OPERATING COSTS

The state expends an average of $157.8 million per year on fleet operating and maintenance activities, including: indirect management; vehicle acquisitions; fuel costs; and maintenance and repair work. State agencies, excluding institutions of higher education, spend approximately 76 percent of the total, an average of $120.4 million annually.

New vehicle acquisitions are the largest single yearly fleet expense, $45.6 million in fiscal year 2005 for state agencies alone, as **Figure 2** shows. For fiscal year 2005, capital budget authority to purchase transportation items was provided to only 18 of the 37 state agencies with fleet operations. Capital budget authority remained relatively constant over the last several biennia, meeting the replacement needs of 62 percent of agencies with active vehicle fleets.

FIGURE 2
2005 AGENCY FLEET EXPENSES

EXPENSE CATEGORY	EXPENSE	PERCENTAGE OF TOTAL
Vehicle Purchases	$45,646,123	34.3%
Fuel	41,451,320	31.1%
Repairs	25,670,447	19.3%
Indirect Operations	15,394,739	11.6%
Preventative Maintenance	4,877,097	3.7%
Fleet Data System	116,296	0.1%
Total	**$133,156,022**	

SOURCE: Office of Vehicle Fleet Management.

Fuel costs are the next largest fleet expense for state agencies, totaling $41.4 million in fiscal year 2005. The largest four fleets consume 88 percent of vehicle fuel purchases: TXDOT; DPS; TDCJ; and TPWD. While acquisition expenses held steady for several biennia, fuel costs have recently increased dramatically. From fiscal year 2003 to fiscal year 2004 agency fuel costs increased by nine percent, followed by a 38 percent increase into fiscal year 2005. If fuel trends continue to increase at a rate equal to the average of the most recent biennium, agency fuel costs will surpass $50 million a year during fiscal year 2006.

Agency fleets also face routine preventative maintenance and repair expenses. Repair costs averaged a six percent increase since fiscal year 2003 and totaled $25.7 million in fiscal year 2005. This increase is partially due to the aging of many agency fleets. Preventative maintenance expenditures remained relatively flat over the last several years, declining slightly in fiscal year 2005 to $4.9 million. Declining preventative maintenance efforts can be a significant concern when operating older fleets, leading to more costly repairs. Indirect expenses, which include salaries, facilities maintenance costs, parts inventories, and computer system fees, fluctuated very little, and totaled $15.4 million during fiscal year 2005.

Vehicles that exceed their useful life are disposed of by state agencies through the State Surplus Property Program. Yearly surplus sales revenue is highly dependent on the quality of vehicles the state is releasing into the market and the disposal method. The State Surplus Property Program reported vehicle sales revenue of $3.1 million in fiscal year 2004 and $5.7 million in fiscal year 2005.

INCREASED CONSOLIDATION OF FLEET OPERATIONS

To reduce administrative effort and realize additional improvements, the state should continue to increase efficiencies and minimize costs by further consolidating fleet management and oversight functions. By centralizing fleet management within six hubs created on a functional basis, the state would realize savings through decreased indirect expenses and avoid future costs by streamlining vehicle purchasing, assignment, and maintenance operations.

Consolidating fleet operations would minimize the number of employees serving functions related to vehicle fleet management, while maximizing the impact of their actions. Currently, most employees handle fleet responsibilities in a part-time capacity while also working in activities such as property management, facilities management, support services, information technology, accounting, and budgeting. The range and technical nature of fleet responsibilities, including maintenance, repair, fueling, procurement, and disposal, requires staff to dedicate time to develop skills and knowledge outside of their primary duties. Part-time fleet management removes staff resources from their primary agency duties. Further consolidation of fleet resources would allow the state to concentrate its vehicle knowledgebase and staff resources in a few key locations and free most staff to fulfill their primary agency duties.

The recommended consolidation will remove or ease the responsibilities for vehicle purchasing, maintenance, repairs, and reporting activities from 31 agencies. For example, 431 state employees maintain active access to the fleet data management system to enter and maintain vehicle data. Of that total, 339 employees prepare and enter data for the 31 agencies that would have their operations consolidated into

the six hubs by Recommendation 1. The consolidation would allow state agencies to redirect these 339 employees from fleet data reporting to core agency activities.

Greater consolidation would allow the state to improve the use rates and efficiencies of active vehicles in the fleet. A random sampling of mileage logs shows that an average state vehicle sits idle and available 28 percent of the time, or approximately 8.5 workdays per month. If fewer agencies managed vehicles in larger pools, this excess time could be used to either increase operational efficiency at agencies currently lacking necessary fleet resources or reduce the total size of the fleet, thereby reducing both direct and indirect expenses and generating revenue through surplus sales. Eliminating only half of the estimated current idle time experienced by general government hub agencies could decrease their vehicle replacement needs by over 400 vehicles, reducing related capital appropriation requests by $6.6 million for the biennium.

Finally, consolidation would enable the legislature to address vehicle replacement needs and related fiscal matters at a higher level. Reviewing only six requests for capital fleet appropriations would enhance the legislature's ability to implement a more efficient and consistent fleet resource policy.

Implementing Recommendation 1 would locate the six vehicle management hubs within TXDOT, DPS, TDCJ, TPWD, the Health and Human Services Commission (HHSC), and the Building and Procurement Commission (TBPC). Each hub would manage approximately 2,000 vehicles, as shown in **Figure 3**, except for TXDOT, which would retain authority for its current fleet of almost 10,000 vehicles. TXDOT, DPS, TDCJ, and TPWD would continue to oversee fleet operations for the vehicles they own; HHSC and TBPC would oversee management of consolidated fleets made up of health and human services enterprise vehicles and general government vehicles, respectively. The proposed consolidation frees 31 agencies to redirect staff and financial resources from administrative work tied to fleet management responsibilities and align them with the agencies' core functions.

Lack of centralization is an emerging concern for many states. California is currently reviewing the Texas State Vehicle Fleet Management Plan and related policies to use as a model in expanding centralized control of its own fleet operations. Oklahoma is considering amending state statute to match Texas' internal controls on issues from surplus vehicle disposal to minimum use criteria. South Carolina recently contracted with a consulting firm to provide a full review of state fleet operations. The firm's primary finding revealed "a lack of centralized, coordinated, and consistent management" leading to "pronounced inconsistencies in operating procedures, weaknesses in financial management and accounting practices, duplication of effort, parochial attitudes, and, with few exceptions, a distinct lack of cooperation among agencies." Further consolidation of fleet management activities would ensure these issues do not become a financial drain on Texas agencies.

FLEET DATA MANAGEMENT SYSTEM

Before installing the current fleet data management system in fiscal year 2001, the state did not have a centralized sustainable system that captured, reported, and analyzed statewide fleet costs and use trends. Over the ensuing six years, the state took advantage of the system to increase overall understanding of state fleet operations and improve related management activities. However, while the results met the original expectations, using the current system is exceedingly difficult for both the agencies entering the required data and OVFM, which is responsible for administering and maintaining the system.

A joint advisory group of the largest fleet agencies selected the system. This complex asset management tool can capture intricately detailed information on vehicle assets and is meant to operate fully integrated with agency financial, payroll, maintenance, budgeting, and planning systems. In this respect, the state purchased a system far more advanced than its needs, and, in doing so, paid a premium. To meet the data entry processes and error checks the system requires, agencies must enter data detail in excess of state requirements. This causes a greater burden on staff resources than the requirement originally anticipated. To complicate this problem, system protocols to allow data to be imported into the system from existing agency data systems are error prone and technically cumbersome. Beyond the demanding conditions this creates for agency administrative resources, over the years these issues created inconsistencies in the data; even today, anomalies and errors are not uncommon.

The concept of a uniform statewide database for collecting and merging vehicle fleet data has proven successful; however, the current system is error prone and operationally troublesome. Newer alternative software packages offer the state the opportunity to continue to accrue relevant information regarding a large asset pool while addressing the

FIGURE 3
RESULTING FLEET SIZES AND AGENCY COMPOSITION OF PROPOSED CONSOLIDATION INTO HUBS

HUB	AGENCY		VEHICLES	PERCENT OF TOTAL
1	**TXDOT**	**Texas Department of Transportation**	**9,594**	**47.7%**
2	**DPS**	**Texas Department of Public Safety**	**2,620**	**13.0%**
3	**TPWD**	**Parks and Wildlife Department**	**2,184**	**10.9%**
4	**TDCJ**	**Texas Department of Criminal Justice**	**2,117**	**10.5%**
5	**General Government**		**1,987**	**9.9%**
	TCEQ	Texas Commission on Environmental Quality	377	1.9%
	TYC	Texas Youth Commission	336	1.7%
	TABC	Texas Alcoholic Beverage Commission	293	1.5%
	RRC	Texas Railroad Commission	231	1.1%
	TDA	Department of Agriculture	209	1.0%
	TBPC	Texas Building and Procurement Commission	82	0.4%
	OAG	Office of the Attorney General	75	0.4%
	GLO	General Land Office	73	0.4%
	TDI	Texas Department of Insurance	54	0.3%
	TWDB	Texas Water Development Board	40	0.2%
	AGD	Adjutant General's Department	39	0.2%
	TSD	Texas School for the Deaf	33	0.2%
	TSBVI	Texas School for the Blind and Visually Impaired	27	0.1%
	TAHC	Texas Animal Health Commission	18	0.1%
	TWC	Texas Workforce Commission	17	0.1%
	TSSWCB	State Soil and Water Conservation Board	15	0.1%
	THC	Texas Historical Commission	13	0.1%
	TSPBE	Texas Board of Pharmacy	12	0.1%
	DIR	Department of Information Resources	10	less than 0.1%
	CPA	Comptroller of Public Accounts	9	less than 0.1%
	TSPBE	Texas State Board of Plumbing Examiners	8	less than 0.1%
	TSL	Texas State Library and Archives Commission	6	less than 0.1%
	TEA	Texas Education Agency	3	less than 0.1%
	TLC	Texas Lottery Commission	2	less than 0.1%
	TDLR	Texas Department of Licensing and Regulation	2	less than 0.1%
	SOS	Secretary of State	1	less than 0.1%
	TCFP	Texas Commission on Fire Protection	1	less than 0.1%
	TJPC	Texas Juvenile Probation Commission	1	less than 0.1%
6	**Health and Human Services**		**1,623**	**8.1%**
	DADS	Texas Department of Aging and Disability Services	866	4.3%
	DSHS	Texas Department of State Health Services	665	3.3%
	HHSC	Health and Human Services Commission	57	0.3%
	DARS	Department of Assistive and Rehabilitative Services	27	0.1%
	DFPS	Department of Family and Protective Services	8	less than 0.1%
		Total Vehicles:	**20,125**	

SOURCE: Legislative Budget Board.

specific software programming issues of concern by user agencies. Recommendation 2 would require OVFM to replace the current system with a web-based system that is easier to maintain and use. To be successful as an improvement, the new system requires the following: a web-based user interface; a streamlined process for data entry, through both manual entry and batch entry means; the ability to assume all historical data contained in the current system; and an enhanced reporting construct at both the agency management and legislative oversight levels. Because of the premium paid for the current system to have functionality that was not used during its six-year tenure, the state can expect to reduce overall system maintenance and administrative costs.

To implement Recommendation 2, the following Building and Procurement Commission rider could be included in the 2008–09 General Appropriations Bill:

> **State Fleet Data Management System.** From funds collected through interagency contracts with agencies operating vehicle fleets, and appropriated above in Strategy D.1.2, Fleet Management, the Texas Building and Procurement Commission will implement and maintain a state fleet data management system for agencies to report fleet operating expenses and uses, as required by Chapter 2171.101, Government Code. The system shall be accessible through a web-based interface, provide forms for efficient entry of data required by the State Vehicle Fleet Management Plan, allow agencies to batch load relevant data from internal legacy systems, provide fiscal and managerial reports for both direct asset management and oversight needs, and be flexible enough to accommodate future agency or legislative needs. All funds collected through inter-agency agreements shall be expended solely on the fleet system; funds not expended in the fiscal year received shall be expended in the following fiscal year for the development or maintenance of the system.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations would save $664,000 in General Revenue Funds during the 2008–09 biennium, create opportunities for future savings, and enable state agencies to redirect resources from general administrative tasks to core mission functions. Structuring the system in the manner recommended provides the economic benefits of consolidation while keeping fiscal responsibility and operational efficiency tied to each agency's actions. Agencies would retain access to the vehicles necessary to meet their core functions while increasing their ability to make staffing decisions that best meet their operational needs. At the same time, the state, as a whole, will realize indeterminate direct savings through the increased use of fleet vehicles and decreased maintenance costs.

Recommendation 1 would save $664,000 in General Revenue Funds during the 2008–09 biennium. Agencies overseeing consolidated fleet management operations under Recommendation 1, primarily the Health and Human Services Commission and the Building and Procurement Commission, would recover operational program expenses from a charge-back methodology paid by user agencies. Given state budget structures, fleet management consolidation will create savings within the Texas Building and Procurement Commission's budget; fleet related salaries, currently paid through general revenue appropriations, will be reimbursed through interagency contract payments in the consolidated system. **Figure 4** shows probable yearly savings resulting from Recommendation 1. Savings in fiscal year 2008 could be reduced due to the actual implementation schedule pursued by the consolidated agencies.

Recommendation 2 requires the Office of Vehicle Fleet Management, through the Building and Procurement Commission, to continue to collect yearly fees from user agencies to support new or amended systems as they do with the current system. The new web-based system is not expected to have yearly maintenance expenses in excess of the current system's expenses. Because such savings are dependent upon the actual system selected and the continuing fleet data needs of the state, no estimate is made of potential savings.

FIGURE 4
FIVE-YEAR FISCAL IMPACT OF CONSOLIDATING FLEET MANAGEMENT OPERATIONS

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS
2008	$332,236
2009	$332,236
2010	$332,236
2011	$332,236
2012	$332,236

Source: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill contains rider language to implement Recommendation 2 but does not address Recommendation 1.

INCREASE THE ACCOUNTABILITY AND EFFECTIVENESS OF THE STATE SURPLUS PROPERTY DISPOSAL PROGRAM

The Texas Building and Procurement Commission's State Surplus Property Program netted an estimated $8.2 million in sales in fiscal year 2006. While proceeds from this program increased from the $5.2 million generated in fiscal year 2004, the agency's ability to improve the program is limited by the information system dedicated to tracking surplus property inventory and sales, leading to a lack of data about the program's performance. These limitations impede Texas Building and Procurement Commission's capacity for data-driven program management. Addressing these concerns will result in more timely and cost-effective disposition of surplus property, improving the program's ability to increase sales.

CONCERNS

- Although the Texas Building and Procurement Commission may identify property it believes could be surplus, ultimately such a determination is up to the state agency owning the property. This limited role increases the need for the agency to target its education efforts to agencies that could potentially be retaining unneeded property, impacting the amount of property available for sale.
- Texas Building and Procurement Commission's surplus property information system does not fulfill the needs of program management. As currently structured, the system captures few of the data elements which could gauge the efficiency of the surplus property disposal process by identifying potential backlogs or other inefficiencies. Moreover, the information system itself delays the processing of surplus property by necessitating manual data entry for the logging of property.
- The Texas Building and Procurement Commission cannot readily access performance data for analysis that it needs to manage the state surplus property disposal process effectively. Additionally, TBPC does not regularly evaluate the various aspects of the disposal process under its control for timeliness, cost and profitability.
- By statute, proceeds from the sale of surplus or salvage property are to be deposited to the credit of the General Revenue Fund less the cost of advertising the sale, the cost of selling the surplus or salvage property, and associated fees. However, agencies are currently authorized in the 2006–07 General Appropriations Act, to expend net receipts for the purchase of similar property, equipment, or commodities. Agencies spent an estimated $7 million based on this authority during fiscal year 2006, which could have funded other programs.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Building and Procurement Commission Rider 18 in the 2008–09 General Appropriations Bill entitled, "State and Federal Surplus Property," to require the agency to target select state agencies, based on a risk assessment of the potential surplus property needs of agencies, with information about the state's surplus property program and related benefits.
- **Recommendation 2:** Amend Texas Building and Procurement Commission Rider 18 in the 2008–09 General Appropriations Bill entitled, "State and Federal Surplus Property," to allow the Texas Building and Procurement Commission to use a portion of the receipts collected through surplus property disposal to modify its existing surplus property inventory information system or procure a new system for more effective management of the agency's surplus property inventory and the tracking of surplus property sales.
- **Recommendation 3:** Amend Texas Building and Procurement Commission Rider 18 in the 2008–09 General Appropriations Bill entitled, "State and Federal Surplus Property," to require the Texas Building and Procurement Commission to develop and track performance benchmarks and targets within the state surplus property disposal process.
- **Recommendation 4:** Amend Article IX Section 8.04 in the 2008–09 General Appropriations Bill entitled, "Surplus Property," to appropriate 25 percent of the receipts from the sale of surplus property, equipment, commodities, or salvage pursuant to the provisions of Chapter 2175, Texas Government Code.

DISCUSSION

Administered by the Texas Building and Procurement Commission (TBPC), the State Surplus Property Program (SSPP), sells surplus property to the public while striving to realize the maximum benefit to the state of Texas. Surplus property is personal property exceeding a state agency's needs that will not be required in the foreseeable future. This classification includes new and used property retaining some usefulness for its original intention or some other purpose. Personal property includes items such as furniture, equipment, vehicles, boats and aircrafts, and other assets that are not real property. The TBPC reported net sales proceeds of $5.2 million in fiscal year 2004 and $7.7 million during fiscal year 2005. As of late fiscal year 2006, TBPC reported net sales of $8.2 million. During the 2006–07 biennium, TBPC was appropriated a total $2.9 million for Surplus Property Management of which $950,300 was assigned to the SSPP. TBPC Rider 18 in the 2006–07 General Appropriations Act, prevents the agency from expending an amount greater than sales and appropriations for the SSPP.

In 2000, the Sunset Advisory Commission (SAC) found that "cumbersome and inefficient" statutory requirements prevented the disposal of surplus property through the most effective methods. At the time, the SSPP was statutorily prevented from acquiring, storing, or setting the sales price of state surplus property. Consequently, surplus property warehousing and disposal was largely decentralized, and the SSPP was limited to providing information on the availability of surplus property and organizing public sales. In response to the SAC findings, the Legislature modified the surplus property disposal process during the Seventy-seventh Regular Session, 2001, by granting TBPC greater authority over the sale of surplus property. However, although the Legislature increased TBPC's surplus property disposal responsibilities, not all the phases of surplus property disposal fall within the control of TBPC.

Under the current disposal process:

- State agencies are largely responsible for identifying surplus property within their organization. Although TBPC may identify property it believes could be surplus during the regular course of business, ultimately such a determination is up to the state agency owning the property. Consequently, TBPC's role with respect to surplus property identification is limited to educating agencies and property managers about the SSPP and the benefits of surplus property disposal. This limited role increases the need for TBPC to target its education efforts at agencies which could potentially be retaining unneeded property.
- Once surplus property is identified, the property is advertised on the Comptroller of Public Accounts website for 10 days. During this period, state agencies, political subdivisions, and eligible assistance organizations may seek direct transfer of the surplus property. Entities seeking direct transfer of surplus property coordinate with the state agency in possession of the property. During this phase of property disposal, the SSPP informs eligible entities of the availability of property for direct transfer, certifies assistance organizations as being eligible for direct transfers, and conducts retrospective reviews of direct transfers to assistance organizations.
- After the direct transfer period, the remaining surplus property is eligible for sale to the public. During this phase of the property disposal process, the SSPP is responsible for disposing of property through the most advantageous sales method. Property disposal methods include sealed bids, live auctions, storefront sales, and Internet auctions. Most sales are carried out directly by TBPC or through a contracted auctioneer. However, on a case-by-case basis, TBPC may provide agencies with limited delegated authority to sell atypical items when the agency can prove that it can maximize sales proceeds.

Recommendation 1 augments the amount of surplus property available for sale under the current disposal process by requiring TBPC to target select state agencies, based on a risk assessment of potential surplus property, with information about the SSPP and related benefits. This recommendation would not require TBPC to identify surplus property but to instead engage agencies that may not be maximizing surplus property for disposal.

INFORMATION SYSTEM AND PERFORMANCE DATA LIMITATIONS

TBPC's ability to effectively dispose of state surplus property is hampered by the limited functionality of the information system dedicated to tracking surplus property and a lack of readily accessible performance data.

TBPC's information system dedicated to tracking surplus property does not capture all of the data elements that could be used to gauge the efficiency of the surplus property disposal process such as identifying potential backlogs or

other inefficiencies. Moreover, the information system itself delays the processing of surplus property by necessitating manual data entry of surplus property that TBPC warehouses. Program managers indicated that the manual data entry requirement introduces data entry errors and process delays necessitating after-hours work. The information system also fails to track surplus property TBPC sells on behalf of other agencies through sealed bids and live auctions. TBPC staff identified the need for an enhanced point-of-sale and inventory information system as far back as calendar year 2004.

Recommendation 2 would allow TBPC to use a portion of the receipts collected through surplus property disposal to either modify its existing information system for managing surplus property inventory and tracking sales or procure a new system. The modified or new system should allow automated processing of surplus property by using readily available technology, such as barcodes and scanners.

Performance data essential for the effective management of the stages of the SSPP disposal process within TBPC's control are not readily accessible for analysis. Currently, SSPP data resides in multiple information systems and paper reports. As a consequence, extensive staff resources are expended to compile basic program data. For instance, to determine surplus property sales proceeds by the sales methods, staff had to access paper reports and manually tally sales from sealed bids, live auctions, and online sales. This manual process increases the risk that data entered or compiled by staff may contain errors. Program managers are aware of this risk and indicated that they review reports for errors. However, increasing the level of automation within the process would further reduce the risk of errors.

Moreover, although the information system and data limitations outlined above affect the ability to collect key performance metrics for the SSPP, the program does not regularly evaluate available data for cost and profitability. The program appears to focus on total revenue generation with little regard to other factors that affect the efficiency and cost-effectiveness of the disposal process. A more comprehensive approach to evaluating the program's effectiveness would involve:

- continually assessing the costs associated with warehousing, cataloguing and administering surplus property and related sales;
- determining the percentage of the estimated value of surplus property being recovered through disposal methods;
- assessing the cost-effectiveness of the various sales methods; and
- analyzing the timeliness of the various components of the process.

During its August 1999 review of the SSPP, the Sunset Advisory Commission recommended that TBPC set performance standards for the timely disposal of surplus property to minimize storage and handling cost while maximizing returns. Recommendation 3 would require TBPC to develop and track performance benchmarks and targets within the state surplus property disposal process. These metrics should provide agency management with the necessary data to oversee the various aspects of the disposal process for timeliness, cost, and profitability. After the implementation of these benchmarks and performance targets, TBPC could assess the feasibility of phasing-out more work-intensive activities and less-profitable sales methods and redeploying resources to other areas, such as Internet auctions. Moreover, as TBPC implements Recommendation 2, it should ensure the enhanced information system is used to track program data, such as performance benchmarks and targets required by Recommendation 3.

The following modifications to the Texas Building and Procurement Commission rider in the 2008–09 General Appropriations Bill entitled, "State and Federal Surplus Property," could be made to implement Recommendations 1 to 3:

18. State and Federal Surplus Property.

a. Included in the amounts appropriated above in Strategy D.2.1, Surplus Property Management, are appropriations not to exceed $2,651,237 from receipts collected for the biennium beginning September 1, 200~~5~~7 to be collected pursuant to Chapter 2175, Government Code. Out of funds appropriated above, the Texas Building and Procurement Commission shall procure or develop a surplus property inventory information system to allow for the efficient processing and management of the State Surplus Property Program inventory and the tracking of surplus property sales conducted or managed by the Texas Building and Procurement Commission. The Texas Building

and Procurement Commission may not expend, in a given fiscal year, an amount greater than the amount of receipts collected during the biennium pursuant to Chapter 2175, Government Code and appropriated by Article IX, §8.04 of this Act in that fiscal year.

b. The State Surplus Property Program shall target its education and outreach efforts to select state agencies, based on a risk assessment of potential surplus property needs, to ensure state agencies are actively identifying surplus property eligible for disposition.

c. The State Surplus Property Program shall develop and track performance benchmarks and targets necessary to evaluate program activities for timeliness, cost, and profitability. The Texas Building and Procurement Commission shall provide no later than August 31, 2008, a report to the Legislative Budget Board and the Governor detailing at a minimum:

i. Surplus property sales proceeds by sales method;

ii. Costs associated with warehousing, cataloguing, and administering surplus property and sales activities;

iii. Percent of the estimated value of surplus property being recovered through disposal method; and

iv. Timeliness of surplus property disposal.

STATE SURPLUS PROPERTY SALES

TBPC reports that gross sales proceeds for the SSPP in fiscal year 2005 were $7.7 million, as shown in **Figure 1**. This amount is an increase of 50 percent over the reported fiscal year 2004 gross proceeds of $5.2 million. This rise in gross receipts is due to large increases in live auction, storefront, and Internet auctions sales. During this period, live auctions sales increased by 36 percent ($1.1 million), storefront sales increased by 122 percent ($1.5 million), and Internet auctions sales increased by 133 percent ($387,137).

Conversely, program expenditures declined by 12 percent from $771,123 in fiscal year 2004 to $675,930 in fiscal year 2005, as referenced in **Figure 2**. However, based on TBPC reported sales proceeds from late fiscal year 2006, it appears as if the growth in sales proceeds is leveling off. As of late fiscal year 2006, TBPC reported net sales of $8.2 million, an estimated 6.5 percent increase from fiscal year 2005 sales.

Of the four sales methods employed by TBPC in the disposal of surplus property, the Live Auction method is the most profitable. During fiscal years 2004 through 2005, live auctions accounted for $7.1 million, 62 percent of nets sales proceeds. For every dollar expended by the program in activities related to live auctions during this period, the state netted $97 dollars in sales. Items sold through this venue include vehicles and heavy equipment.

The profitability of TBPC storefront operations increased between fiscal years 2004 and 2005. The state netted $1.01 in sales for every dollar expended in activities related to storefront operations in fiscal year 2004. In fiscal year 2005, this amount increased to $4.10 due to the combined effect of increased storefront sales and declining costs. However, opportunities exist for TBPC to increase the effectiveness of its storefront operations by addressing the information system concerns cited earlier in this report and improving agency inventory controls.

Although program managers indicated that they conduct monthly invoice audits and physical property control audits of high dollar or electronic items, these audits do not cover the remainder of the surplus property controlled by TBPC. TBPC's Office of Internal Audit reported a similar concern when it found that the program had not conducted a physical inventory of storefront surplus property during fiscal year 2004. At the time, TBPC auditors concluded that a physical count of all state surplus property within the program's control was needed to identify discrepancies between recorded and physical inventory, thereby lowering the risk

FIGURE 1
STATE SURPLUS PROPERTY GROSS PROCEEDS, FISCAL YEARS 2004 AND 2005

	2004	2005	PERCENTAGE CHANGE	DOLLAR CHANGE	PERCENTAGE OF TOTAL
Sealed Bid	$630,630	$195,776	(69%)	$(434,854)	6%
Live Auctions	3,053,750	4,154,872	36	1,101,122	56
Online Auctions	291,807	678,944	133	387,137	8
Storefront	1,211,384	2,695,104	122	1,483,720	30
Total	**$5,187,571**	**$7,724,696**	**49%**	**$2,537,125**	**100%**

Source: Texas Building and Procurement Commission.

FIGURE 2
STATE SURPLUS PROPERTY PROGRAM COST, FISCAL YEARS 2004 AND 2005

	2004	2005	PERCENTAGE CHANGE	DOLLAR CHANGE	PERCENTAGE TOTAL
Sealed Bid	$37,883	$31,190	(18%)	$(6,693)	5%
Live Auctions	41,051	33,389	(19)	(7,662)	5
Online Auctions	90,989	83,108	(9)	(7,881)	12
Storefront	601,201	528,243	(12)	(72,958)	78
Total	**$771,123**	**$675,930**	**(12%)**	**$(95,194)**	**100%**

Source: Texas Building and Procurement Commission.

that missing property might go undetected. TBPC managers indicated they conducted an inventory at the conclusion of fiscal year 2006; however, the results of the inventory were not available prior to the completion of fieldwork. As TBPC implements Recommendation 2, it should ensure that the enhanced information system contains a comprehensive inventory of the surplus property managed by TBPC.

Another initiative TBPC could undertake to increase the visibility of surplus property for sale through its storefront is posting additional information online. Currently, TBPC places only basic information (general category description, units, and price) about property available through the storefront. Potential customers may benefit from a detailed description of the individual items for sale with information about the property's condition, in addition to photographs of items for sale at the storefront.

Sales proceeds from Internet auctions totaled $291,807 in fiscal year 2004 and $678,994 in fiscal year 2005. Although these sums accounted for only 8 percent of the total sales proceeds during this period, fiscal year 2005 Internet auctions proceeds increased by 133 percent over the previous year. For every dollar expended by the program in activities related to Internet auctions, the state netted $5.58 dollars in sales. Moreover, customers are overwhelmingly pleased with their SSPP online purchasing experiences as evidenced by the 99.5 percent positive feedback rating attained by the program. However, TBPC appears to have additional opportunity to build upon its success.

Sales through the Internet auction method accounted for 509 individual sales or 4 percent of the over 12,100 individual sales during fiscal years 2004 and 2005. TBPC indicated it could build upon its current Internet auction efforts given additional resources. Without those resources, surplus property that could be sold through the Internet is selling through less profitable means. Currently, a single online sales coordinator is responsible for the majority of the duties associated with Internet auctions.

Increasing TBPC's ability to conduct sales through Internet auctions would increase the efficiency and cost-effectiveness of the SSPP. Sales via online auctions for similar items reportedly result in greater profits than what could be obtained through more traditional disposal methods due to increased competition. Additionally, disposal of surplus property through the Internet appears to shorten overall disposition time. Because of the potential for increased cost-effectiveness through greater competition, shortened sales times, and reduced warehousing cost, other states have reportedly stopped using sealed bids for the disposal of surplus property in lieu of online auctions.

As TBPC implements the benchmarks and performance targets associated with Recommendation 3, it could assess the feasibility of phasing-out more work-intensive activities and less-profitable sales methods and redeploying resources to other areas, such as Internet auctions.

SURPLUS PROPERTY PROCEEDS

By statute, proceeds from the sale of surplus or salvage property are to be deposited to the credit of the General Revenue Fund less the cost of advertising the sale, the cost of selling the surplus or salvage property, and associated fees. The Seventy-eighth Legislature, Regular Session, 2003, adopted this mechanism in part because of a 2003 Comptroller of Public Accounts recommendation that the proceeds from surplus property sales of goods originally purchased with General Revenue Funds be returned to the General Revenue Fund to increase the amount of funds available.

However, agencies are currently authorized under Article IX, Section 8.04 of the 2006–07 General Appropriations Act, to expend these receipts from the appropriation item from which like property, equipment, or commodities would be

purchased, less the cost of advertising the sale, the cost of selling the surplus or salvage property, and associated fees. During fiscal year 2006, state agencies spent an estimated $7 million from the sale of surplus property in All Funds, based on this authority. Modifying Article IX, Section 8.04 in the 2008–09 General Appropriations Bill, as outlined in Recommendation 4, would allow agencies to continue expending 25 percent of the receipts from the sale of surplus property, equipment, commodities, or salvage pursuant to Chapter 2175, Texas Government Code, while providing additional revenue to the state. Thus, agencies will still have an incentive to participate in the SSPP, while providing additional legislative oversight over the remaining funds.

The following modifications to Article IX, Section 8.04 in the 2008–09 General Appropriations Bill entitled, "Surplus Property" could be used to implement Recommendation 4:

> Sec. 8.04. **Surplus Property.** Twenty-five percent of all receipts to any agency of the state government specified in this Act received from the sale of surplus property, equipment, commodities, or salvage (including recycling products) pursuant to the provisions of Chapter 2175, Government Code, are hereby appropriated to the state agency for expenditure during the fiscal year in which the receipts are received. Receipts from such surplus and salvage (including recycled products) sales shall be expended from the appropriation item from which like property, equipment, or commodities would be purchased.

FISCAL IMPACT OF THE RECOMMENDATIONS

The estimated fiscal impact of allowing agencies to spend only 25 percent of the receipts from the sale of surplus property, equipment, commodities, or salvage pursuant to Chapter 2175, Texas Government Code as discussed in Recommendation 4 would result in an estimated revenue gain in fiscal years 2008 and 2009 in General Revenue Funds and General Revenue–Dedicated Funds of $10.3 million and $483,000, respectively. The five-year fiscal impact of Recommendation 4 as shown in **Figure 3** assumes no growth in the sale of surplus property.

Although Recommendations 1 to 3 will result in more timely and cost-effective disposition of surplus property, the impact of these recommendations on increased sales proceeds cannot be estimated at this time.

FIGURE 3
FIVE-YEAR FISCAL IMPACT

FISCAL YEAR	PROBABLE REVENUE GAIN/(LOSS) TO GENERAL REVENUE FUND	PROBABLE REVENUE GAIN/(LOSS) TO GENERAL REVENUE–DEDICATED FUNDS
2008	$5,166,182	$241,725
2009	$5,166,182	$241,725
2010	$5,166,182	$241,725
2011	$5,166,182	$241,725
2012	$5,166,182	$241,725

SOURCE: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill includes modified riders to implement Recommendations 1 to 4.

IMPROVE STATE FACILITY MANAGEMENT AND MAINTENANCE PRACTICES

The Texas Building and Procurement Commission (TBPC) is responsible for managing and maintaining the majority of state owned office and auxiliary space, including warehouses and laboratories, located in Travis County. TBPC provides state tenants facility maintenance services, including: general maintenance; custodial services, grounds keeping, minor construction, recycling services, and deferred maintenance. In fiscal year 2004, TBPC began assuming responsibility for an additional 1.4 million square feet, bringing the total area of space the agency manages to 10.8 million square feet. Total facility management and maintenance expenses increased from $45.4 million during the 2004–05 biennium to $72.7 million during the 2006–07 biennium.

TBPC's building inventory is deteriorating, as evidenced by both mounting deferred maintenance projects and increasing general maintenance expenses. Concurrently, the commission is curtailing basic maintenance activities, such as preventative maintenance and building management programs, which could slow building deterioration and reduce total costs. Improving TBPC's allocation of available facility resources and increasing preventative maintenance activities would reduce long-term maintenance expenses and preserve the state's real property assets.

CONCERNS

- ♦ Building and Procurement Commission facility maintenance programs lack defined standards for evaluating whether the programs are meeting performance expectations. As a result, agency tenants receive varying levels and quality of service.
- ♦ The Building and Procurement Commission has not been proactive in addressing the dramatic cost increases associated with major repairs and replacement of primary building systems in state owned property. Average yearly requests, by the Commission, for agency funds to cover expected critical repairs, compliance projects, and deferred maintenance climbed 49 percent from fiscal year 2000 to fiscal year 2004. Although anticipated expenses for fiscal years 2007 through 2011 total $117.4 million, the agency has made no plans to benefit from Energy Performance Contract financing structures to meet the state's deferred maintenance needs.
- ♦ The Building and Procurement Commission lacks a formal evaluation process to compare the efficiency of state operated facility maintenance programs against private, non-profit, and government provided alternatives. As a result the agency cannot assess the quality and cost effectiveness of its building programs.
- ♦ House Bill 3042, Seventy-eighth Legislature, Regular Session, 2003, transferred management and maintenance responsibility for five properties owned by the Texas Historical Commission, comprising 22,433 gross square feet of space adjacent to the Capitol Complex, to the Building and Procurement Commission. Without restorative and preservative attention similar to the maintenance programs in place at the State Preservation Board, these properties face potential deterioration resulting in a loss of historical value.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code, Section 2165.057, to direct the Building and Procurement Commission to improve building maintenance operations by implementing service level contracts for building maintenance with each tenant agency and creating property specific budgets.
- ♦ **Recommendation 2:** Amend Texas Government Code, Section 2165.052, to direct the Building and Procurement Commission to reinstate a formal preventative maintenance program and use energy savings performance contracting to meet deferred maintenance needs.
- ♦ **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill to direct the State Council on Competitive Government to evaluate the facility maintenance programs of the Building and Procurement Commission against competitive market operations and make recommendations regarding the improvement or possible outsourcing of these programs.
- ♦ **Recommendation 4:** Amend Texas Government Code, Sections 442.0071, 442.0072, 443.007, and 2165.007, to transfer management and maintenance responsibility for Texas Historical Commission facilities

in Travis County from the Building and Procurement Commission to the State Preservation Board.

DISCUSSION

The Texas Building and Procurement Commission (TBPC) is the state's lead property management and maintenance agency. Originally established in 1919 as the State Board of Control, the agency consolidated many general government services including property management. The agency reorganized as the State Purchasing and General Services Commission in 1979, and, was renamed the General Services Commission in 1991. State Auditor reports throughout the 1990s cite numerous deficiencies, operational failures, and insufficient direction at the General Services Commission, causing the Seventy-seventh Legislature to abolish the agency and replace it with the Texas Building and Procurement Commission (TBPC) in 2001.

Although TBPC is the state's lead agency for property management, many other agencies maintain independent property management responsibilities throughout the state. Twenty state agencies and entities, not including institutions of higher education, own 6,350 buildings valued at more than $2.4 billion with a combined area of 56.4 million square feet. **Figure 1** shows that TBPC owns the fourth largest building area, following the Texas Department of Criminal Justice, the Health and Human Services Commission, and the Texas Department of Transportation.

FIGURE 1
STATE PROPERTY/BUILDING OWNERSHIP BY AGENCY (SORTED BY SQUARE FOOTAGE)

AGENCY	SQUARE FEET	VALUE
Texas Department of Criminal Justice	20,554,687	$1,284,775,181
Health and Human Services Commission	11,027,241	315,441,755
Texas Department of Transportation	7,256,183	116,329,113
Texas Building and Procurement Commission	6,826,312	280,138,000
Parks and Wildlife Department	2,235,346	112,068,443
Texas Department of Public Safety	1,895,831	64,752,140
Military Facilities Commission	1,851,229	35,789,430
Texas Youth Commission	1,772,044	110,896,760
Texas Workforce Commission	957,690	23,119,155
Adjutant General's Department	717,274	11,643,487
Other Agencies	1,304,152	65,520,606
Total	**56,397,988**	**$2,420,474,070**

Source: General Land Office.

In addition to its own building inventory, TBPC provides property management and facilities maintenance services to many facilities owned by other state agencies. The passage of state legislation by the Seventy-eighth Legislature, Regular Session, 2003, increased the number of properties managed and maintained by TBPC. Due to this legislation, the agency now provides services to 11 percent of the total building area of property owned by state agencies. The bill transferred management and maintenance services for all state buildings in Travis County to TBPC with the exception of military facilities, residential facilities, and several exempted agency facilities. As a result of this legislation, TBPC assumed property management responsibilities for 28 buildings in Travis County, comprising 1.4 million square feet of space during the 2004–05 biennium.

During fiscal year 2006, TBPC managed 6.2 million gross square feet of office space in 49 buildings and complexes. Of the total gross space, 74 percent, or 4.6 million square feet, was classified as usable representing varied applications including office space, laboratory facilities, warehouse space, conference centers, and historical buildings. TBPC also manages 4.1 million square feet of parking garage facilities and more than 20 additional flat-lot parking locations. While 85.5 percent of space managed and maintained by TBPC is in Travis County, the commission also has responsibility for facilities in other parts of the state, including: Houston, San Antonio, Fort Worth, Waco, El Paso, and Corpus Christi.

TBPC maintains in-house property-management programs providing general maintenance services, custodial and recycling services, grounds maintenance, coordination of minor construction contracts, and deferred maintenance project management. Total maintenance expenditures for the division are estimated at $72.7 million during the 2006–07 biennium, up 60 percent from $45.4 million during the 2004–05 biennium. **Figure 2** shows cost totals by program area for the 2004–05 and 2006–07 biennia. TBPC facility programs employ up to 171 full-time employees a year, at a direct cost of $5.2 million during fiscal year 2006. The programs are complemented by varying degrees of contract labor provided by private vendors. Not including deferred maintenance projects, which are primarily handled

FIGURE 2
TEXAS BUILDING AND PROCUREMENT COMMISSION FACILITY MANAGEMENT AND MAINTENANCE EXPENSES BY PROGRAM AREA

	BIENNIAL EXPENSES	
PROGRAM	**2004–05**	**2006–07***
General Maintenance Programs	$22,653,201	$24,471,197
Custodial Services	$11,737,676	$10,787,676
Deferred Maintenance Projects	$11,008,892	$37,404,751
Total	**$45,399,769**	**$72,663,624**

*Fiscal year 2007 expenses represent budgeted amounts.
Source: Legislative Budget Board.

through private vendors, contract expenses accounted for 57 percent of total maintenance activities during fiscal year 2006.

TBPC manages its inventory of state facilities through a building manager-based organizational structure. The stated role of the building manager is to serve as a liaison between tenant agencies and the commission's facility programs by monitoring the flow of work order requests, supervising building crews and custodial contracts, and developing an institutional knowledge of building conditions and ongoing work. Current assignments require each building manager to oversee between 2 and 12 occupied buildings, ranging in size from 166,000 to more than 1.3 million gross square feet; the average assignment is more than 600,000 square feet of space across six buildings. Each building manager is assigned one or two building maintenance technicians to assist them with minor maintenance and building upkeep work; on average, each technician is assigned to two buildings covering more than 400,000 square feet.

Building managers reassign work involving specific technical skills or coordination to one of several specialty maintenance programs within TBPC's Facility Management Division, including: grounds maintenance, custodial services, minor construction, core maintenance, and systems operations. Either the core maintenance crew or the systems' operations team performs work requiring specific technical certification or training. These teams are jointly staffed by 49 skilled and certified maintenance tradesmen. The operations team is also responsible for active monitoring of building system controls and mechanical issues and provides the first response to any issues that arise from major building systems.

The majority of maintenance work performed is scheduled for completion by the appropriate maintenance program after a request is received from one of the tenant agencies indicating a maintenance issue requiring resolution. Emergency requests are reported to the agency's maintenance call center, but most work order requests are received through a web-based request center and work order management system. TBPC maintenance programs receive an average of 3,683 work requests a month, up to 46,000 a year. Requests are received and logged in a maintenance tracking system and all related costs and operational notes are recorded as the work progresses to completion. The system was introduced in fiscal year 2004 to provide a more accurate accounting of building maintenance costs. During the second half of fiscal year 2006, the list of open work orders included more than 1,500 work orders past their due date, including six requests dating back to fiscal year 2004.

TBPC is also responsible for state facilities needs identification and long-term maintenance and replacement planning. The primary vehicle for this task is the biennial Facilities Master Plan, which TBPC is statutorily responsible for publishing by July 1 of each even-numbered year.

RESOURCE ALLOCATION AND SERVICE LEVEL IMPROVEMENTS

While technology can greatly enhance the efficiency of maintenance processes, facility maintenance activities are inherently labor intensive. Three factors affect an organization's ability to maintain its real property: the total amount of space maintained, the number of technicians employed, and the maintenance standard expected. The larger the area of space, or the higher the quality of service expected, the greater the staff resource needs.

In response to both agency appropriation reductions and commission policy decisions, TBPC reduced staffing levels in facility maintenance programs during recent years. From fiscal year 2003 to fiscal year 2006, TBPC decreased maintenance staff by 19 employees while the total area of managed space increased 27 percent. During this period, the ratio of square feet maintained per maintenance division employee increased 33 percent.

Tenant agencies report a decrease in both the quantity and quality of building maintenance services provided by TBPC over the last several biennia. In interviews conducted for this review, agencies reported a greater quality of service in past years, citing higher levels of dedicated resources assigned to their buildings. Previously dedicated building technicians

provided a single dependable point of contact for building tenants to address inquires and concerns, served as a consistent and invaluable source of institutional building knowledge, and provided more timely and efficient maintenance services than currently offered.

A primary contact point to coordinate multiple maintenance programs for a single property can provide valuable resource controls and coordination; however, in the current implementation of the building manager program such positive opportunities are not consistently realized because each employee's focus is stretched over large areas. Building managers oversee total property space ranging from 166,000 to more than 1.3 million gross square feet, with the number of buildings managed by each ranging from 2 to 12. Facility division directors have been informed by the International Building Owners and Managers Association that current TBPC square footage allocations are high compared to industry standards, but would be workable with adequate back-up support in place. Available support is questionable because building technicians provide coverage of anywhere from 166,000 to 770,000 square feet; no building manager has access to more than two building technicians regardless of the area they manage.

A more debilitating lack of support is evident in the limited authority granted to building managers by TBPC management regarding the direction and approval of maintenance activities undertaken within the buildings they supervise. While senior maintenance program managers at TBPC acknowledged that building managers are the principle liaison between commission programs and tenant agencies, building managers have limited decision-making authority for maintenance work, and instead serve more as record keepers. This lack of authority negates the positive and cost-effective affect these employees could make within the program. Because building managers have no authority over property specific budgets and performance levels, they are unable to efficiently manage system operations or monitor the quality of services provided to tenants.

The lack of consistent and defined communication processes results in persistent confusion concerning the specific duties required of TBPC building maintenance staff. This uncertainty is also expressed by TBPC maintenance program staff, which causes disagreement as to the proper role of tenant agencies in supporting maintenance programs like utility conservation and space reconditioning.

With limited resources and an increasing inventory, efficient resource allocation and detailed planning become imperative to running an effective operation. Recommendation 1 would address this issue by requiring TBPC to increase the planning and coordination of facilities maintenance activities by implementing property specific budgets and service level contracts with each tenant agency. As part of the implementation of legislation by the Seventy-eighth Legislature, Regular Session, 2003, TBPC negotiated annual interagency contracts with affected agencies, both parties agreeing to the maintenance services TBPC would provide during the year. Recommendation 1 extends this idea by requiring TBPC to enact service-level agreements individually with all agencies occupying TBPC maintained state-owned space. The agreements would describe the specific level of services TBPC would provide as part of its statutorily mandated mission and define any activities the tenant agency and its employees are expected to undertake at a direct cost. Providing such definitions in a single document agreed to by both parties would help address the confusion and misunderstandings that are evident in current operations.

The recommendation also requires TBPC to develop individual maintenance budgets for each property. By segmenting the total maintenance division budget by property, the commission would anticipate building needs more precisely and allocate resources more efficiently based on mid- or long-term strategies instead of making reactive decisions based on emergency needs. Property based budgets would aid in the development of service level agreements and provide division and building management a base from which to evaluate the success and efficiency of maintenance program operations. Property specific budgets are intended for planning and evaluation purposes; TBPC should be allowed to redirect appropriated funds between properties as necessitated by actual events throughout the course of the year.

MANAGE INCREASING MAINTENANCE COSTS

As discussed above, improving the management of facilities maintenance activities through increased planning, coordination, and accountability will increase the quality and consistency of service provision; however, the state should also take proactive steps to limit future increases in maintenance project costs. Maintenance costs can be managed and contained in two key ways: preserving and protecting current building assets, and procuring the most efficient equipment possible when building systems reach the end of their useful life. Moving from TBPC's current policy

of responding to maintenance needs in a primarily reactive capacity to a focus on preventative maintenance operations will strengthen building operations and extend the useful life of major equipment systems, thereby reducing replacement and repair costs. Simultaneously, planning for unavoidable equipment system upgrades and replacements using a process centered on improving energy efficiency will allow the state to avoid future cost surges while meeting the capital needs of state operations.

During fiscal year 2003, TBPC eliminated the majority of its formal preventative-maintenance program, leaving only two employees to address filter replacements in air-conditioning systems. A stable and effective preventative maintenance program includes non-destructive testing, periodic inspections, preplanned maintenance activities, and follow-up maintenance to correct identified issues. Formal preventative maintenance programs contain costs by reducing production downtime, increasing the life expectancy of major assets, reducing repair costs, and increasing the efficiency of maintenance resource allocations. TBPC's internal policy decision to discontinue preventative maintenance operations has increased long-term operational maintenance costs and placed state facilities at risk of major system failure. This situation is evidenced by recurring air-conditioning system shutdowns at state-owned buildings in north Austin, resulting in lost employee productivity within the tenant agencies. Tenants within the buildings have incurred direct costs of more than $100,000 because of the system failures, having to send employees home prior to the completion of the workday due to environmental or health concerns.

Ceasing preventative maintenance activities has a direct effect on the long-term costs of state property maintenance, significantly increasing the cost required to meet critical repair, compliance projects, and deferred maintenance needs. These costs are estimated biennially in the State Facilities Master Plan report published by TBPC. In fiscal year 2000, TBPC estimated total major repair and replacement work on building systems at $16.5 million for the 2002–03 biennium and $7.6 million for the 2004–05 biennium. Four years later, the same report estimated total major repairs at $42.0 million for the 2006–07 biennium, and $31.9 million for the 2008–09 biennium. In a more direct comparison, both reports provided estimates for an extended period from fiscal year 2006 through fiscal year 2011. In the 2000 report TBPC estimated total expenses at $59.2 million; four years later the estimate had increased to $92.8 million, a 57 percent increase.

The strategic plan released by the TBPC in August 2006 for fiscal years 2007 through 2011 places the total at $117.4 million This amount is a 98 percent increase over estimates completed in 2000 and more than 11 times the value of deferred maintenance projects overseen by TBPC programs in fiscal year 2006.

TBPC traditionally seeks to fund deferred maintenance projects through appropriations of general obligation bond proceeds and capital authority requests. Reducing their dependence on general obligation bonds by shifting to a system structured around performance based contracting would save the state money and improve the implementation and effectiveness of facility retrofits. Energy Performance Contracting allows agencies to complete energy-saving improvements within their existing budget by financing them with money saved through reduced utility expenditures. The initial funding for such projects is provided through mid-term debt financing, including the Texas Public Finance Authority's Master Lease Purchase Program and the State Energy Conservation Office's LoanSTAR program. Increased use of the LoanSTAR program by state agencies would decrease the amount of funds available to finance local government and higher education projects.

The types of projects available in this financing structure cover most of the major building system repair and replacement needs TBPC faces, including: insulation of building structure and systems; heating, ventilating, or air-conditioning system modifications or replacement; electric system improvements; building shell improvements; and load management projects. Projects have a high level of oversight, and are closely designed and monitored by certified engineers to guarantee the savings necessary to finance the project. Many projects contain clauses that require the contract vendor to pay the difference between the project cost and realized savings if the savings do not accrue as expected; although, such clauses are rarely needed as the state Energy Conservation Office has found that most Energy Performance Contract projects save 12 to 15 percent more than the guarantee.

Many governmental entities have achieved significant savings through successful projects. In December 2004, the Health and Human Services Commission (HHSC) began an Energy Performance Contracting project at the Kerrville State Hospital as part of a larger $53 million facility improvement plan. The project is projected to save $60 million during its 15-year life. The project structure allowed HHSC to replace equipment without requesting or spending additional

appropriations from General Revenue Funds and assisted the agency in meeting state mandates related to cost effective energy and water efficiency measures. HHSC funded the project through funds available through Texas Public Finance Authority's Master Lease Purchase Program and the State Energy Conservation Office's LoanSTAR program.

Recommendation 2 seeks to reinstate a formal preventative maintenance program to protect the state's investment in its real property assets, and reduce long-term maintenance costs, through reduced production downtime, increased asset life expectancy, reduced major repair costs, increased effectiveness of capital planning, and improved safety conditions. The recommendation also seeks to improve the efficiency and cost effectiveness of capital repairs to state facilities by funding such projects through performance based contracts, specifically Energy Performance Contracting.

COMPETITIVE REVIEW OF MAINTENANCE PROGRAMS

In its 2000 Staff Report on the General Services Commission, the Sunset Advisory Commission (SAC) found that TBPC "is unique among state agencies in that most services it provides are commercially available." This is especially true of TBPC facility-maintenance programs as evidenced by the large levels of contracting already taking place within these operations. SAC staff also found that TBPC "lacks an established process to evaluate whether…a private vendor, can provide goods and services at the best value to the State" and that "without competition, the State may act as a monopoly, lacking incentive to reduce costs, improve quality, and increase efficiency." Sunset concluded that TBPC should "establish a regular process for reviewing its operations for outsource potential" to "guarantee that state agencies—as well as Texans—receive best value."

Legislative Budget Board (LBB) staff review found that these same concerns and opportunities are still of issue six years later, and that TBPC has made no progress in establishing regular directed review of maintenance programs for possible outsourcing. Recommendation 3 proposes directing the State Council on Competitive Government (CCG), charged in Chapter 2162, Government Code to review "state services to identify the most cost-effective and efficient provider," to review TBPC facility maintenance programs during the 2008–09 biennium, including: general maintenance; building management; ground maintenance; custodial operations; and core system operations. Any recommendation resulting from the reviews would be implemented under the CCG's authority.

Recommendation 3 could be implemented by including the following rider in the 2008–09 General Appropriations Bill:

> **Directed Competitive Reviews.** From funds appropriated above, State Council on Competitive Government staff shall conduct competitive reviews of all Texas Building and Procurement Commission facility maintenance programs, including, but not limited to: building maintenance; building management; custodial operations; grounds maintenance; minor construction; and core system operations. Recommendations resulting from review will be implemented under the statutory authority of the Council on Competitive Government at the discretion of its members. State Council on Competitive Government staff will provide review finding reports to the Legislative Budget Board and the Governor as completed, but no later than September 1, 2008.

MANAGEMENT AND MAINTENANCE OF HISTORICAL FACILITIES

Texas has assigned management and maintenance responsibility for historical buildings to several agencies over time. The Seventy-fifth Legislature, Regular Session, 1997, directed the State Preservation Board (SPB) to assume, from TBPC, property management functions for the Capitol, Capitol Extension, Capitol grounds, and the 1857 General Land Office Building. SPB provides general maintenance services to these buildings, including: housekeeping, grounds keeping, and facilities maintenance. TBPC, however, retained similar responsibilities for the Governor's Mansion, a historic building located adjacent to the Capitol grounds.

The Seventy-eighth Legislature, Regular Session, 2003, granted TBPC responsibility for several historical facilities owned by the Texas Historical Commission (THC). Legislation passed by the Seventy-eighth Legislature, Regular Session, 2003, transferred facilities management services for most state-owned properties in Travis County to TBPC, including five facilities owned by THC: the Carrington-Covert House; Gethsemane Church; Luther Hall; the Christianson-Leberman House; and the El Rose Apartments.

The SPB was created by the Sixty-eighth Legislature in 1983 to provide historical facility preservation and protection. Since its inception, SPB has provided preservation, maintenance, and restoration services for the Capitol and surrounding buildings, including developing an expertise in the curation of historical artifacts. In doing so, SPB has

pursued aggressive comprehensive preventative maintenance programs, predictive maintenance actions, and capital investments in critical systems and equipment.

Historical state facilities under the management of TBPC are required to compete constantly for the same employee and financial resources that are allocated across all state facilities, without direct access to the skilled preservationist and restoration skill sets available from SPB programs. To preserve and protect the historical property of Texas government, the management and maintenance of historical facilities should be coordinated under SPB authority.

Recommendation 4 proposes transferring property management services for six THC facilities to the State Preservation Board from TBPC, including: the Governor's Mansion, Carrington-Covert House, Gethsemane Church, Luther Hall, Christianson-Leberman House, and the El Rose Apartments. Amendment to Government Code would be required to implement this recommendation. Through this recommendation, SPB would assume responsibility for 34,182 gross square feet within a two-block radius of the State Capitol grounds. During the 2004–05 biennium, TBPC expended more than $300,000 on these historical buildings in their maintenance inventory, just under $5 per square foot. Related maintenance expenses increased significantly in fiscal year 2006 and are estimated to top $550,000 during the current biennium. **Figure 3** provides maintenance cost histories for the buildings under consideration.

Contingent upon passage of related legislation, this recommendation could be implemented by including the following rider in Article IX of the 2008–09 General Appropriations Bill:

> **Contingency Appropriation Transfer for Facility Management and Maintenance Activities.** Contingent upon the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation relating to the transfer of facility management and maintenance responsibilities for Texas Historical Commission buildings from the Texas Building and Procurement Commission to the State Preservation Board, Texas Building and Procurement Commission, General Revenue Funds for Strategy C.2.1, Facilities Operations, shall be decreased by $500,000 in fiscal year 2008 and $200,000 in fiscal year 2009. Capital Budget amounts for Repair or Rehabilitation of Buildings and Facilities shall be reduced by $300,000 in General Revenue Funds in fiscal year 2008. State Preservation Board General Revenue Funds for Strategy A.1.1, Preserve Buildings and Contents, shall be increased by $300,000 in fiscal year 2008 and General Revenue Funds for Strategy A.2.1, Building Maintenance, shall be increased by $200,000 in each year of the biennium. Capital Budget amounts for Repair or Rehabilitation of Buildings and Facilities shall be increased by $300,000 in General Revenue Funds in fiscal year 2008.

FIGURE 3
HISTORICAL BUILDINGS IN THE TEXAS BUILDING AND PROCUREMENT COMMISSION MAINTENANCE INVENTORY: SIZE AND COST

		COST PER FISCAL YEAR		
FACILITY	GROSS SQUARE FEET	2004	2005	2006
Governor's Mansion	11,749	$93,589	$67,231	$184,764
El Rose Apartments	8,737	14,469	33,618	31,231
Christianson-Leberman House	5,120	11,267	17,611	10,371
Carrington-Covert House	3,800	17,596	21,998	15,428
Luther Hall	2,560	12,532	15,779	17,489
Gethsemane Church	2,216	10,353	12,851	19,143
Total	**34,182**	**$159,806**	**$169,088**	**$278,426**
		2004–05 Biennial Cost	**$328,894**	
		Estimated 2006–07 Biennial Cost		**$556,851**

Source: Texas Building and Procurement Commission.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations in this report have no direct impact on General Revenue Fund appropriations during the 2008–09 biennium. The recommendations do provide for increases in the quality or quantity of services provided to state property tenant-agencies at no additional cost to the state.

Recommendation 1 would have no fiscal impact to the 2008–09 General Appropriations Bill. The recommendation is intended to improve the quality and consistency of facility maintenance services received by tenants in state-owned buildings through enhanced governance and management of state facilities. The recommendation can be implemented given current resource levels, improving service levels at no additional cost to the state.

Recommendation 2 would have no direct fiscal impact to the 2008–09 General Appropriations Bill. Implementing the proposed recommendation components would improve state facility operations while positively impacting health and safety considerations and increasing the effective life of capital building equipment. While the immediate impact of utility bill savings from Energy Performance Contracting is canceled by the required debt service payments, the state will see cost avoidance gains from such actions in the long-term. While major building system components average a useful life of 20 to 30 years or more, the financing arrangements required for these contracts expire in 10 to 15 years. The difference allows the state 10 to 20 years, or more, of actual realized utility savings over the life of the equipment, beginning at the end of the debt financing arrangement. Therefore, projects initiated during fiscal year 2008 could generate full utility savings for the state beginning in fiscal year 2018.

Recommendation 3 would have no fiscal impact. The State Council on Competitive Government (CCG) is currently staffed to perform competitive reviews of state services and operations. The size and scope of the recommended reviews would not require additional staffing or resources. Any savings generated from the CCG's review of state facility services would be expected to occur in fiscal year 2010 and beyond.

Under Recommendation 4, appropriations to TBPC for the management and maintenance of Texas Historical Commission buildings would be transferred to the State Preservation Board, as would similarly designated capital appropriations required to implement any necessary capital improvement projects during the course of the biennium. This transfer would result in neither an increase nor a decrease to the total cost of the 2008–09 General Appropriation Bill.

The introduced 2008–09 General Appropriations Bill contains rider language to implement Recommendation 3.

IMPROVE STATE PROCUREMENT PRACTICES TO MAXIMIZE THE STATE'S BUYING POWER

In fiscal year 2005, Texas state government spent over $26.6 billion procuring goods and services. In making these purchases, the state must ensure that it achieves the best value for each dollar spent, that it procures goods and services in an accountable, effective manner, and that vendors are provided fair and open competition. However, the state's current organizational and statutory structures prevent it from fully maximizing the state's buying power.

Consolidating coordination and oversight responsibility for statewide procurement would position the state to be more effective in its procurement practices. In addition, expanding the use of technology to streamline purchasing processes and increasing the availability of spending data would allow the state to leverage its buying power further to reduce the cost of goods and services purchased by the state.

CONCERNS

- ♦ Current state statutes do not sufficiently encourage agencies to use centralized purchasing support services. Less than 3 percent of total spending is directly coordinated by the two state agencies that provide these services.
- ♦ The state's purchasing technology does not easily support the use of pre-negotiated state contracts. State agencies and local governments often buy products and services outside of the statewide contracts, causing quantities of goods purchased from these contracts to appear smaller and reducing discounts and rebates available to the state.
- ♦ Detailed information on statewide purchasing patterns is unavailable. The statewide accounting system does not capture data on the specific commodities agencies buy. As a result, the state is unable identify areas of opportunity to reduce unit costs.

RECOMMENDATIONS

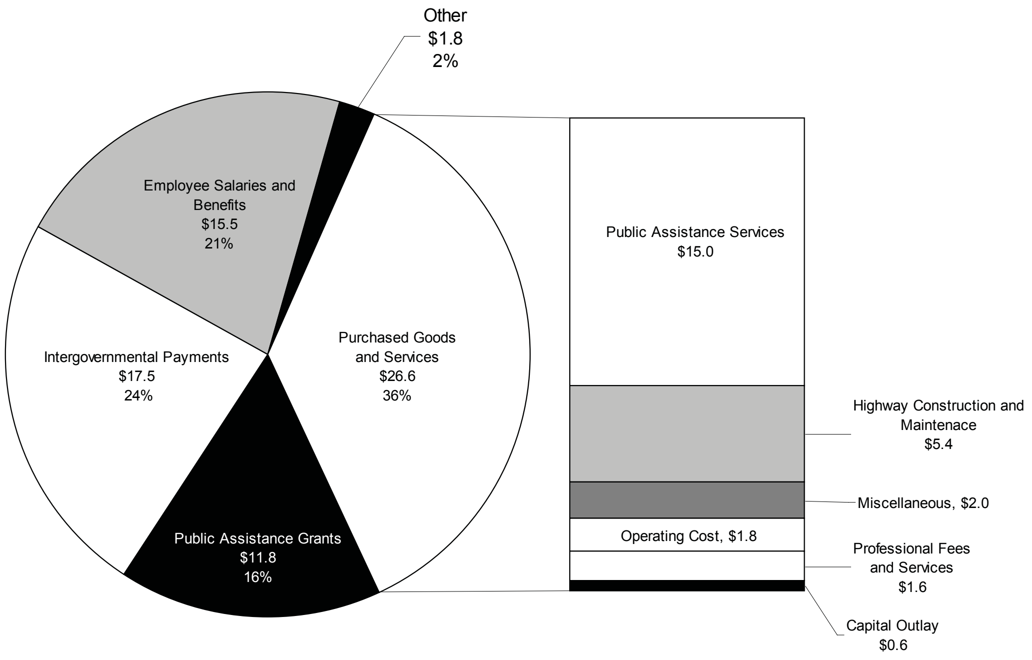
- ♦ **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Building and Procurement Commission and the Department of Information Resources to jointly report on the costs and benefits of consolidating statewide procurement coordination, oversight and management functions.
- ♦ **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Building and Procurement Commission and the Department of Information Resources to jointly report on the following:
  - a. The efficacy of procurement exemptions and delegations in statute and rule, with a focus on enhancing statewide coordination, efficiency and oversight.
  - b. The costs and benefits of reporting detailed purchasing expenditure data in the statewide accounting system, in conjunction with the Comptroller of Public Accounts.
  - c. The costs and benefits of implementing an automated transaction system shared by the Texas Building and Procurement Commission and the Department of Information Resources that will identify goods and services available through pre-negotiated state contracts and enable online transactions.
- ♦ **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Building and Procurement Commission and the Department of Information Resources to implement strategic sourcing initiatives that results in better value for the state for commonly purchased goods and services.

DISCUSSION

State expenditures totaled approximately $73.1 billion during fiscal year 2005. As shown in **Figure 1**, employee salaries and benefits, intergovernmental payments (including $14.6 billion in public education funding to school districts), and public assistance grants including unemployment assistance and temporary assistance to needy families composed the majority (61 percent) of the state expenditures.

FIGURE 1
TOTAL STATE EXPENDITURES BY SPENDING CATEGORY, FISCAL YEAR 2005

(IN BILLIONS) **TOTAL = $73.1 BILLION**



NOTE: Totals may not sum due to rounding.
SOURCES: Legislative Budget Board; Comptroller of Public Accounts.

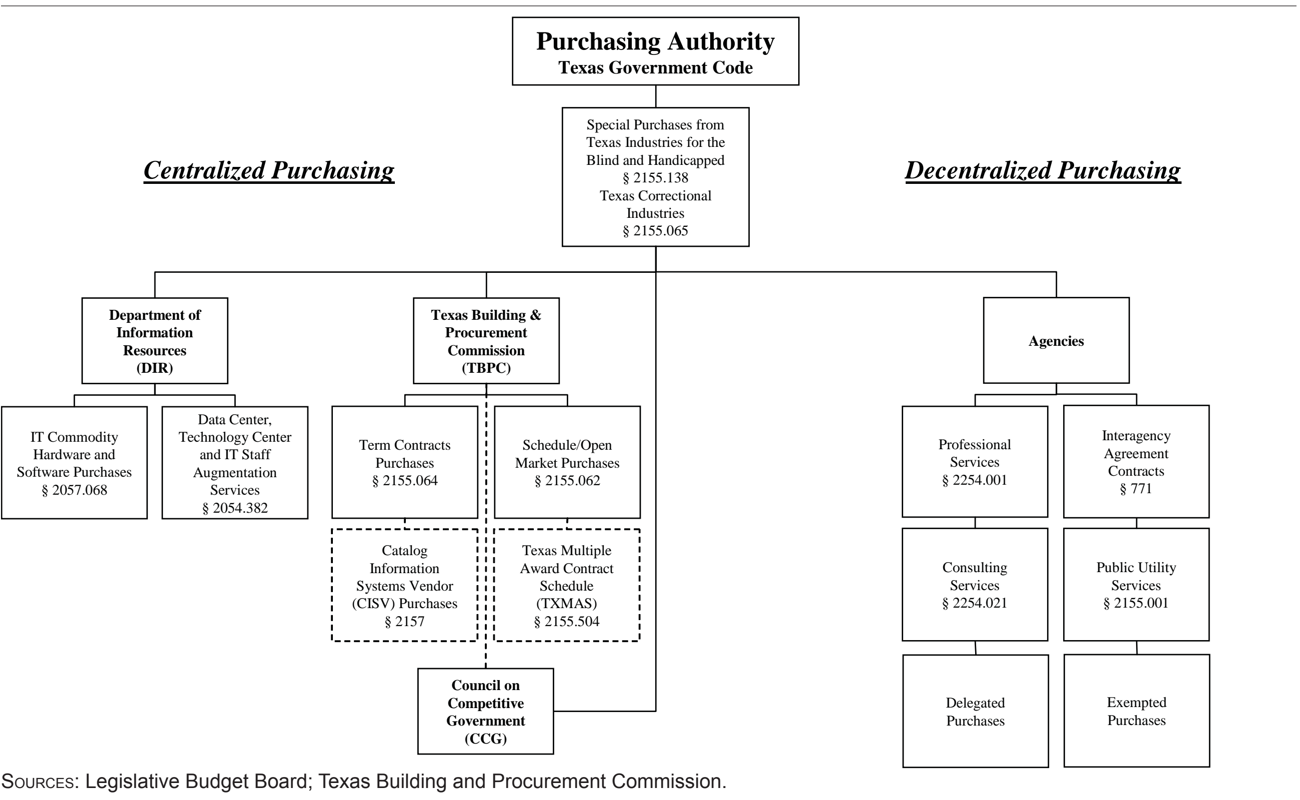
Approximately $26.6 billion, 36 percent of total expenditures, was used to purchase a wide variety of goods and services, including:

- $15 billion for public assistance services such as nursing home services and medical services including prescription drugs;
- $5.4 billion for highway construction and maintenance;
- $2 billion for miscellaneous expenses such as cost of goods sold (e.g., cost of manufacturing by Texas Correctional Industries);
- $1.8 billion for operating costs such as supplies and materials, communications and utilities, and rentals and leases;
- $1.6 billion for professional fees and services such as architectural and engineering services; and
- $600 million for capital outlay including capitalized property purchases and construction.

STATE PURCHASING AUTHORITY

The Texas Government Code, Title 10, contains the majority of statutory requirements relating to the conduct of state procurement. As shown in **Figure 2**, the Texas Building and Procurement Commission (TBPC) and the Department of Information Resources (DIR) are authorized in statute to provide centralized purchasing services to support state agencies and institutions of higher education. TBPC primarily focuses on commodity supplies, materials, services and equipment, while DIR specializes in technology including commodity software and hardware, telecommunications equipment and services and technology-related services. In addition, the State Council on Competitive Government (CCG) also plays a role in statewide purchasing processes. CCG, which is administratively attached to TBPC, develops opportunities for competitive arrangements, such as managed competition, outsourcing, reengineering, and public/private partnerships. Agencies are required to use such competitive arrangements when available. CCG currently has contracts in place for specific services including energy management and document destruction services.

FIGURE 2
PURCHASING AUTHORITY OVERVIEW



SOURCES: Legislative Budget Board; Texas Building and Procurement Commission.

CENTRALIZED PURCHASING

While many types of purchases are either delegated to agencies to carry-out directly or exempted altogether from centralized purchasing authority, there are instances when agencies are required to use centralized purchasing support services. The *State of Texas Procurement Manual*, developed by TBPC, provides guidance to agencies on identifying circumstances when it may be required to use centralized purchasing services. In general, agencies are required to use TBPC or DIR contracting vehicles and other purchasing support services in the following cases:

- When needed commodities or services are available on TBPC term contracts. TBPC establishes term contracts for commodities and services in an effort to consolidate demand and obtain volume pricing from suppliers for agencies and other governmental entities. Contracts are based on estimated quantities, specified by the TBPC, and may be used as needed by agencies.
- When goods needed are available through existing TBPC Schedule Purchase contracts (e.g., fertilizer, bread, pastry, or dairy products for state schools or TDCJ). Schedule purchase contracts are contracts for a definite known quantity of a commodity with a definite delivery schedule, and
- When the anticipated cost of a needed service exceeds $100,000 a TBPC-administered open market solicitation is used for the purchase. An open market purchase is the purchase of a good or service made by soliciting from any available source.

Under these circumstances, TBPC will coordinate the competitive process as a non-delegated purchase. Purchases of IT commodity software, hardware and IT-related services are coordinated by DIR unless approval is obtained from the executive director of DIR or in certain cases (e.g., technology center services) prior approval is obtained from the Legislative Budget Board (LBB). In addition, agencies may be required to use contracts established by the Council on Competitive Government.

Agencies may also purchase goods and services directly from vendors listed in the Texas Multiple Award Schedule (TXMAS) and the Catalog Information Systems Vendor (CISV) catalog maintained by TBPC. The TXMAS program is an adaptation of the Federal General Services

Administration's (GSA) catalog to the procurement needs of the state. Purchases made from TXMAS catalog vendors do not require delegated authority from the TBPC for agencies to make purchases over $25,000 for commodities and over $100,000 for services. The TXMAS catalog is similar to the GSA catalog and TXMAS prices must be identical to those on the GSA schedule. The CISV program allows for automated information systems type products and services to be purchased directly from approved vendors subject to DIR approval.

As shown is **Figure 3**, approximately $912 million out of a total of $26.6 billion (or 3 percent) of goods and services purchased by state agencies was coordinated by TBPC or DIR during fiscal year 2005.

TBPC coordinated purchases of approximately $663 million in fiscal year 2005 for state agencies including institutions of higher education through term contracts, open market orders and TXMAS. The Texas Department of Transportation (TXDOT) and the Texas Department of Criminal Justice (TDCJ) comprised $516 million (77 percent) of this spending. A majority of this expenditure is comprised of purchases for road materials and food supplies. Local governments also utilized TBPC contracts, spending $118.6 million in fiscal year 2005 primarily through term contract and TXMAS purchases. In total, TBPC coordinated $782 million in purchases in fiscal year 2005 for state and local government.

DIR coordinated almost $249 million in state agency and higher education purchases for IT commodities including computer hardware and software through its Go-Direct program, which provides a contract vehicle between vendors and governmental entities. Local governments comprise a significant proportion of spending through this program. During fiscal year 2005, local government entities, including cities, counties, and school districts, spent almost $460 million, 69 percent of total program purchases, through the Go-Direct program. In total, DIR coordinated $668 million in purchases during fiscal year 2005 for state and local government. The share of spending by DIR will increase in future years due to new rules established by House Bill 1516, Seventy-ninth Legislature, 2005, Regular Session, requiring certain agencies to purchase all commodity software and hardware, technical services and data center services through DIR.

DECENTRALIZED PURCHASING

The Texas Government Code provides agencies significant flexibility to purchase most goods and services independent of the centralized purchasing support services provided by the TBPC and DIR. For example, agencies may purchase goods and services directly from the Texas Industries for the Blind and Handicapped (TIBH), and the Texas Correctional Industries (TCI) operated by the Texas Department of Criminal Justice. The purpose of TIBH is to encourage and assist disabled persons to achieve maximum personal

FIGURE 3
CENTRALIZED PURCHASING VOLUME FOR STATE AGENCIES, FISCAL YEAR 2005

(IN MILLIONS) **TOTAL = $26.6 BILLION**

Agency Purchasing Volume $25,700.0 97%
Centralized Purchasing Volume $911.7 3%
TxMAS $11.6
Commodity Hardware and Software $208.7
DIR Data Center Service Contracts $40.0
TBPC Term Contract Purchases $267.5
TBPC Open Market Purchases $383.9

NOTE: Totals may not sum due to rounding.
Totals do not include telecommunications and TxOnline purchasing volumes.
SOURCES: Legislative Budget Board; Department of Information Resources; Texas Building and Procurement Commisssion.

independence by engaging in useful and productive activities. Purchases from TIBH are also exempted from competitive bidding requirements. While statute provides certain reporting requirements for procuring most professional and consulting services, agencies are able to purchase these services without significant involvement from central purchasing functions.

In addition, agencies are delegated responsibility for certain purchases as indicated in **Figure 2**. A delegated purchase is a procurement for which the authority to manage the competitive process is delegated to an agency by TBPC through rule or statute. Major categories of purchases subject to delegated authority include:

- Any purchase under $15,000: Agencies are delegated the authority to purchase goods and services if the purchase does not exceed $15,000.
- Commodity purchases under $25,000: A commodity purchase is a procurement of supplies, materials, or equipment and does not include the purchase of real property or services.
- Purchases of services under $100,000: A service is defined as the furnishing of skilled or unskilled labor or professional work.
- Direct publications: Direct publications are publications only available from a single source. Any publication that could be purchased using a competitive process is not considered a direct publication.
- Perishable purchases: Perishables are goods that are subject to spoilage within a relatively short period.
- Distributor purchases: A distributor purchase is the purchase of repair parts for a unit of major equipment that is needed immediately or for maintenance contracts for laboratory/medical equipment.
- Fuel and lubricants: Fuel, oil, and grease purchases include gasoline, diesel fuel, kerosene, aviation fuels, transmission fluids, motor oil and other lubricants, liquefied petroleum gas, and compressed natural gas.
- Printing and copying services: Printing is defined as word processing or graphic reproduction of paper documents using a printing press.
- Proprietary purchases: A proprietary product or service has a distinctive characteristic that is not shared by competing products or services.
- Internal Repair Purchases: An internal repair is a repair to state-owned equipment that cannot be reasonably defined prior to the actual repair and the extent of which can not be determined until the equipment is disassembled.
- Purchases for Research Purposes: TBPC may delegate to institutions of higher education upon written request the authority to purchase supplies, materials, services or equipment for research projects from state funds appropriated for that purpose.
- Emergency Purchases: Emergencies occur as the result of unforeseeable circumstances and may require an immediate response to avert an actual or potential public threat.
- Agency-Specific Delegations: Certain purchases by specified agencies including the General Land Office, the Railroad Commission of Texas, the Texas Commission on Environmental Quality, the Employee Retirement System of Texas, and the Statewide Emergency Service Personnel Retirement Fund are delegated directly to the agencies to administer as necessary.

Purchases of certain commodities and services, or purchases made by certain agencies, may also be statutorily exempt from the purchasing authority of TBPC, exempt from competitive bidding, or may be required by statute to be procured through a specific purchasing method. As shown in **Figure 4**, the exemptions apply to a wide array of purchases.

ORGANIZATIONAL STRUCTURE OF STATEWIDE PROCUREMENT

The current organizational structure of statewide procurement impedes the state's ability to consolidate purchases and maximize the state's buying power. It also results in duplicative administrative and overhead functions. Texas maintains two state agencies with primary responsibility for coordinating and overseeing statewide purchasing. As shown in **Figure 5**, TBPC and DIR provide similar centralized purchasing support services to state agencies including institutions of higher education, and local governments. While they generally focus on different types of goods and services there are occasions when there is overlap. In addition, both TBPC and DIR share significant operational similarities including:

- Both agencies administer contracts with vendors for goods and services at pre-negotiated prices. DIR administers the Go-Direct program to facilitate this

FIGURE 4
STATUTORY EXEMPTIONS SUMMARY

- Construction projects of:
  - The Texas Department of Transportation
  - The Texas Department of Criminal Justice
  - a public authority
  - a local government
- Certain purchases of healthcare services by Health and Human Services Commission
- Legislative agency purchases
- Texas Lottery Commission purchases
- Treatment or education services purchased by Texas Youth Commission
- Certain purchases of state owned hospitals
- Items required by statute to be purchased from a particular source
- Auxiliary enterprises not within TBPC's authority
- Office space for certain agencies
- Legal services including obtaining outside legal counsel services
- Library material purchases of an institution of higher education
- Organized activities relating to instructional departments of universities
- Purchases from the Texas Department of Criminal Justice
- Purchases made with gifts or grants not within TBPC's authority
- Repairs and renovations to buildings excluded by TBPC
- Repairs and renovations to buildings at various agencies including:
  - Texas Department of Transportation
  - Institutions of Higher Education
  - Certain buildings at the Department of Agriculture
  - Texas Parks and Wildlife Department
  - Certain buildings at the Texas Commission on Environmental Quality
  - Texas Department of Housing and Community Affairs or the Texas State Affordable Housing Corporation
  - Veterans' Land Board
- Residential space of the Department of Aging and Disability Services and the Texas Youth Commission
- Services of an employee of a state agency
- Certain vehicle maintenance and repair services
- Medical equipment purchased by an institution of higher education
- IT commodity purchases if DIR grants approval
- Data center service purchases if DIR grants approval
- Technology center service purchases if the LBB grants prior approval

Sources: Legislative Budget Board; Department of Information Resources; Texas Building and Procurement Commission.

FIGURE 5
DUPLICATIVE CENTRALIZED PURCHASING SUPPORT SERVICES

ACTIVITY	TBPC	DIR
Contract Administration	X	X
Customer Service and Quality Assurance	X	X
Customer Outreach	X	X
HUB Coordination and Promotion	X	X
Open Market/Request for Proposal Contracting	X	X
State Contract Management Team Participation (CAT)	X	X
Internal Procurement	X	X
Purchasing Training and Certification	X	
Vendor Performance Tracking System Maintenance	X	
Procurement Audits	X	
Statewide Travel Contract Management	X	
Electronic State Business Daily Maintenance	X	

Source: Legislative Budget Board.

process while TBPC sets-up term and schedule contracts used by agencies and local governments.

- Both agencies provide customer support and quality assurance services and outreach efforts to encourage local government participation.
- Historically Underutilized Business (HUB) coordination and promotion are integral to both operations, although TBPC's role in this area is broader with responsibility for conducting periodic disparity studies to benchmark HUB participation goals for state contracts.
- TBPC and DIR both manage extensive bidding, evaluation, and award activities for statewide contracting. Through the open market order process TBPC solicits and evaluates bids from potential vendors for commodities while DIR manages extensive request for proposal initiatives for complex services such as data center services.

TBPC's purchasing program also manages additional activities that are not provided by DIR such as coordination of training and certification for state purchasers, maintaining the vendor performance tracking system, conducting procurement audits, managing the state travel program and maintaining the Electronic State Business Daily website.

As shown in **Figure 6**, TBPC and DIR are responsible for coordinating similar levels of total spending. During fiscal year 2005, $782 million and $668 million in total spending were coordinated by TBPC and DIR, respectively. While total spending levels (including state and local government) are comparable, the composition of this spending is different. For example, local government represents 69 percent of DIR total contract spending but only 15 percent of contract spending at TBPC.

The similarities in centralized purchasing support services provided by TBPC and DIR result in significant duplication of effort in competing strategies including customer outreach and contract management. In addition, this organization results in decreased efficiency in the use of resources due to additional overhead and other support costs and decreased effectiveness in implementing a cohesive approach to statewide procurement.

FUNDING STATEWIDE PURCHASING ACTIVITIES

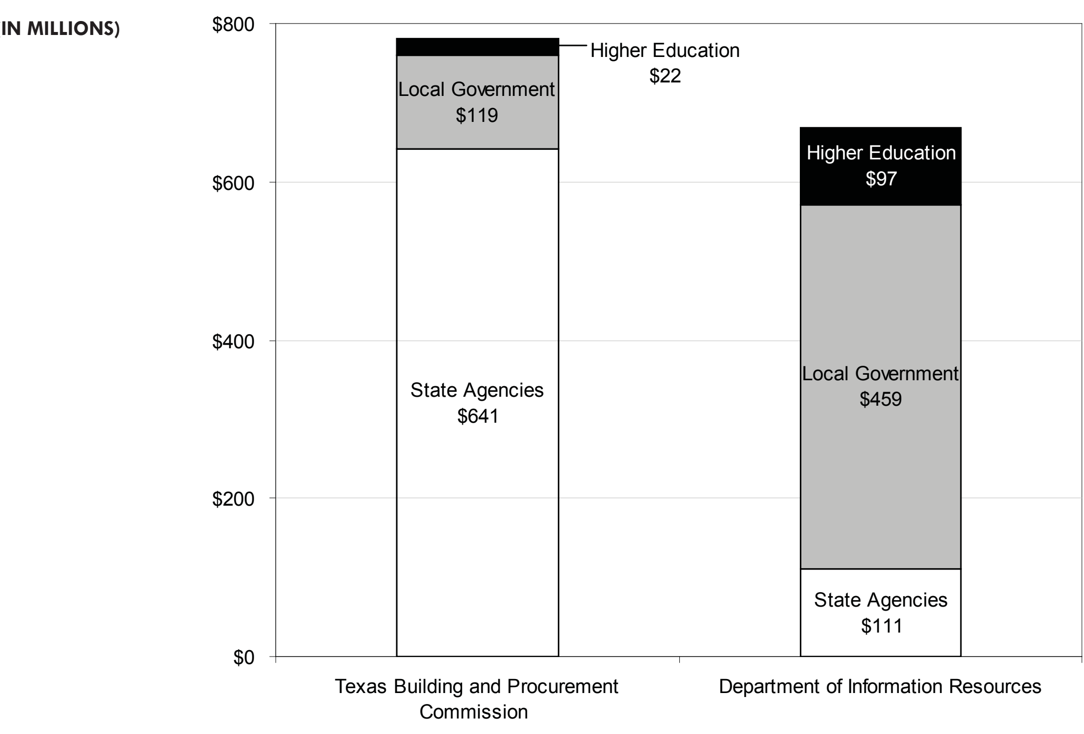
As shown in **Figure 7**, DIR's purchasing program budget of $3.9 million funded through Other Funds, compares to TBPC's purchasing program budget of $3.2 million, of which 73 percent is funded with General Revenue Funds

As shown in **Figure 8**, DIR currently funds their purchasing function on a cost recovery basis, through appropriated receipts and interagency contract revenues. However, TBPC expends $2.3 million in General Revenue Funds to support its purchasing function budget of $3.2 million.

Applying a cost recovery methodology to all statewide purchasing could save General Revenue Funds and encourage the state's consolidated purchasing function to maximize its efficiency. LBB staff estimate that with annual spending of approximately $782 million associated with TBPC's current contracts, an additional $2.3 million annually in administrative fees could be collected to off-set the costs that are currently funded with General Revenue Funds and General Revenue–Dedicated Funds at TBPC. This would require an administrative fee of approximately 0.25 percent. DIR has authority to include up to 2 percent in administrative fees. Currently, it averages a 0.75 percent administrative fee on its contract pricing. On certain goods and services the

FIGURE 6
CONTRACT SPENDING, FISCAL YEAR 2005

(IN MILLIONS)



NOTE: Totals may not sum due to rounding.
Totals do not include telecommunications and TxOnline purchasing volumes.
SOURCES: Legislative Budget Board; Department of Information Resources; Texas Building and Procurement Commission.

FIGURE 7
TEXAS BUILDING AND PROCUREMENT COMMISSION AND DEPARTMENT OF INFORMATION RESOURCES PURCHASING FUNCTION, FISCAL YEAR 2006

PURCHASING FUNCTION	TEXAS BUILDING AND PROCUREMENT COMMISSION	DEPARTMENT OF INFORMATION RESOURCES
Total Agency Full-Time Equivalents	577.9	222.5
Total Agency Budget	$171.6 million	$79.3 million
Purchasing Function FTEs	64.8	33.1
Purchasing Function Budget	$3.2 million *Personnel Cost: $2.9 million*	$3.9 million *Personnel Cost: $2.1 million*
Total Value of Purchases per Purchasing Function FTE	$11.2 million	$20.2 million
Average Purchasing Function FTE Cost	$43,000	$62,500
Purchasing Program Budget Method of Finance	General Revenue Funds/ General Revenue–Dedicated Funds – 73% Other – 27%	General Revenue Funds/ General Revenue–Dedicated Funds – 0% Other – 100%

NOTES: Budget information based on Estimated Fiscal Year 2006 Operating Budget.
Totals may not sum due to rounding.
SOURCE: Legislative Budget Board.

FIGURE 8
EXPENDITURES FROM PURCHASING RELATED STRATEGIES, FISCAL YEAR 2006 (IN THOUSANDS)

		FINANCE METHOD					
NUMBER	STRATEGY	GENERAL REVENUE FUNDS	GENERAL REVENUE–DEDICATED FUNDS	APPROPRIATED RECEIPTS	INTERAGENCY CONTRACT	TOTAL	FTES
Texas Building and Procurement Commission Fiscal Year 2006 Operating Budget							
1.1.1	Provide Competitive Procurement System	$1,624	-	$395	-	$2,018	41.5
1.1.2	Ensure State Purchasers are Qualified	$147	-	$117	$108	$371	6
1.1.3	Effective Promotion of HUB Business Opportunities	$405	-	239	-	$644	14
1.1.4	Minimize Statewide Travel Costs	$167	-	-	-	$167	3.3
	Texas Building and Procurement Commission Total	**$2,342**	**-**	**$751**	**$108**	**$3,200**	**64.8**
	MOF Breakdown	73%	-	23%	3%		
Department of Information Resources Fiscal Year 2006 Operating Budget							
2.1.1	Assist Government Entities in Contract Administration	-	-	$2,939	$969	$3,908	33.1
	Department of Information Resources Total	**-**	**-**	**$2,939**	**$969**	**$3,908**	**33.1**
	MOF Breakdown	-	-	75.20%	24.80%		
	Combined Total	**$2,342**	**-**	**$3,690**	**$1,077**	**$7,108**	**97.9**

NOTES: Budget information based on Estimated Fiscal Year 2006 Operating Budget.
Totals may not sum due to rounding.
SOURCE: Legislative Budget Board.

administrative fee may be as high as 2 percent while on others it may be 0 percent depending on the price competitiveness of the market for a particular good or service.

Recommendation 1 would include a rider in the 2008–09 General Appropriations Bill that requires the Texas Building and Procurement Commission and the Department of Information Resources to jointly report on the costs and benefits of consolidating statewide procurement, oversight and management functions and assess the feasibility of using a cost-recovery methodology to fund statewide procurement. The following rider could be included in Article IX of the 2008–09 General Appropriations Bill to require this analysis:

> **Statewide Procurement Consolidation.** Out of funds appropriated elsewhere in this Act, the Texas Building and Procurement Commission and the Department of Information Resources shall jointly prepare:
>
> - A costs-benefit analysis of consolidating statewide procurement coordination, oversight and management functions;
> - An assessment of the extent to which statewide procurement activities could be funded through a cost-recovery methodology similar to that used by the Department of Information Resources.
>
> Findings, recommendations, and proposed action plans resulting from this analysis should be provided to the Governor and Legislative Budget Board by September 1, 2008.

STATUTORY FRAMEWORK FOR PROCUREMENT

Texas Government Code, Title 10 contains the majority of provisions relating to state procurement policies. Title 10, Sections 2054 and 2152 designate DIR and TBPC, respectively, as the primary purchasing support service agencies for the state. Section 2054 relating to DIR's purchasing authority provides limited leeway for additional options for agencies to purchase IT-related goods and services independently. In contrast, the sections that relate to TPBC's authority establish a loose framework including exemptions and delegations whereby the majority of agency purchasing is not subject to coordination or oversight from TBPC.

Agencies may use authority delegated to them by TBPC to manage the competitive process. Agencies may also use statutory exemptions whereby specific purchases are not subject to the purchasing authority of TBPC, are exempted from competitive bidding, or required by statute to be procured through specific purchasing methods.

Texas Government Code, Section 2155.132 (c) provides authority for TBPC to monitor the purchasing practices of state agencies that are making delegated purchases to ensure the certification levels of the agency's purchasing personnel and the quality of purchasing practices continue to warrant the amount of delegated authority provided to the agency. In addition, TBPC may revoke for cause all or part of the purchasing authority delegated to a state agency. Statutory exemptions on the other hand require a statutory amendment to change. In addition, these purchases are exempt from TBPC authority to provide coordination or oversight. As shown in **Figure 3**, purchasing delegations and exemptions cover approximately 97 percent of the state's spending. As a result, the state is limited from expanding opportunities to coordinate purchasing, be more strategic in its purchasing practices and obtain better value from vendors.

State agency procurement processes are based on existing statutes and rules developed to meet the acquisition needs of agencies and to reflect fair and open business practices with vendors. As a result, state agencies developed parallel systems and processes to meet their purchasing needs, leading to inefficiency in agency purchasing practices including duplication and redundancy in purchasing processes and systems. Currently, each state agency maintains a procurement operation, including staff to administer purchasing policies and information systems to aid the process. For example, the Texas Department of Criminal Justice (TDCJ) manages a function of over 92 FTEs to meet their purchasing needs. Their information system, known as "Adpix," provides significant levels of automation in procurement and inventory control. The system also interfaces directly to TDCJ's financial management system. In fiscal year 2005, TDCJ purchased more than $300 million worth of goods and services independent of TBPC and DIR using almost 40,000 purchase orders. The Texas Commission on Environmental Quality (TCEQ) maintains a staff of over 21 FTEs and uses a system known as "Buyspeed" to automate the purchasing process. In fiscal year 2005, TCEQ purchased goods and services valued at more than $85 million without any direct involvement of TBPC and DIR.

Most state agencies do not leverage available technology effectively to automate and streamline procurement processes. State agencies use disparate automated purchasing systems with widely varying levels of functionality in managing the purchasing process. Due to the decentralized nature of state

purchasing processes, each agency independently acquires or develops in-house purchasing systems to automate their procurement processes. In some cases, the level of automation and integration with other systems such as financial or accounting systems is high however, in most cases the process is both paper and labor intensive with multiple handoffs and transfers between staff and systems.

PURCHASING DATA

Detailed information on statewide purchasing patterns is unavailable. The state's financial accounting system, the Uniform Statewide Accounting System (USAS), does not capture purchasing codes used by Texas state agencies to categorize purchases of goods and services. Agencies use the National Institute of Governmental Purchasing (NIGP) commodity and services coding structure. The NIGP code is comprised of an extensive library of descriptive codes assembled and organized into a structure to identify and describe a wide variety of goods and services. The code is useful for tracking purchasing activity, budgeting and managing reporting, tracking and controlling inventory, and classifying suppliers by the types of products they provide. However, many of the advantages of using the code are limited in Texas because this data is not collected in a centralized system where it can be linked directly to expenditures. While purchasers are required to code purchase orders with this data, it is not captured in USAS. As a result, statewide data on purchasing patterns is not available to assist decision-makers in adopting more strategic approaches to purchasing.

PURCHASING TECHNOLOGY

The technology used by TBPC for purchasing is dated and lacks basic automation functionality. TBPC experiences challenges in deploying effective automated purchasing systems. The Impala System, used by TBPC to process term contract purchases, is dated in its functionality, making it cumbersome for state agencies and local governments to purchase goods and services from pre-negotiated contracts. This results in significant spending to occur outside of state contracts whereby agencies and local government use state contracts to find vendors and pricing but do not buy from the contract, opting instead to purchase direct from the vendor due the relative ease of this process. This behavior sidelines TBPC's contracts and causes the state's volumes to appear smaller, reducing discounts and rebates available to the state. In addition, the lack of system interfaces for TBPC's open market order system requires significant manual data entry to transfer information submitted by state agencies in hardcopy format, resulting in significant backlogs in processing open market orders. In some cases, large agencies such as TXDOT and TDCJ have provided agency staff to TBPC on a temporary basis to help clear backlogs due to a concern that urgent needs would otherwise go unmet.

DIR administers semi-automated Go-Direct contracts with vendors. While agencies can view these catalogs online, they cannot, in most cases, execute purchase orders online. DIR is currently considering an online purchasing portal that will facilitate purchasing online by automating the ordering process and providing a direct link to vendors.

Recommendation 2 would include a rider in the 2008–09 General Appropriations Bill that requires TBPC and DIR to jointly develop recommendations for statutory changes needed to improve the state's coordination, efficiency and oversight of purchasing, approaches and system changes to capture detailed commodity codes in the statewide accounting system, and options to automate and streamline the state's purchasing transactions. The following rider could be added to Article IX in the 2008–09 General Appropriations Bill to require this activity:

> **Statewide Procurement Reporting.** Out of funds appropriated elsewhere in this Act, the Texas Building and Procurement Commission and the Department of Information Resources shall jointly conduct the following analyses and report to the Governor and the Legislative Budget Board on the results of these analyses by September 1, 2008.
>
> (a) An evaluation of all procurement exemptions and delegations in statute and rule, with a focus on enhancing statewide coordination, efficiency and oversight.
>
> (b) A costs-benefit analysis of reporting detailed purchasing expenditure data in the statewide accounting system, in conjunction with the Comptroller of Public Accounts.
>
> (c) A costs-benefit analysis of implementing an automated transaction system shared by the Texas Building and Procurement Commission and the Department of Information Resources that will identify goods and services available through pre-negotiated state contracts and enable online transactions.

Findings, recommendations and proposed action plans for implementation resulting from these analyses should be included in the report.

STRATEGIC SOURCING

The state has not taken advantage of strategic sourcing practices to reduce prices and obtain better value for the goods and services it purchases. Detailed information on statewide purchasing patterns that would aid strategic sourcing is unavailable because the statewide accounting system does not capture data on the specific items or commodities agencies buy.

Strategic sourcing is the collaborative and structured process of critically analyzing an organization's spending and using this information to make business decisions about acquiring commodities and services more effectively and efficiently. According to the federal Office of Management and Budget, this process helps agencies optimize performance, minimize price, increase achievement of socio-economic acquisition goals, evaluate total life-cycle management costs, improve vendor access to business opportunities, and increase the value of each dollar spent.

In March 2005, a strategic sourcing business case analysis was conducted for TBPC by an external vendor group. The business case analyzed state spending patterns using a proprietary methodology for extracting fiscal year 2004 expenditure data from Uniform Statewide Accounting System and estimated potential cost savings resulting from a proposed comprehensive strategic sourcing initiative in Texas.

The analysis found that in fiscal year 2004, Texas purchased $7.6 billion worth of goods and services that strategic sourcing practices could address. The analysis further identified 32 specific categories of purchases totaling $1.5 billion in spending where strategic sourcing could result in significant cost savings.

The analysis proposed a four phase approach to strategic sourcing in Texas. Each phase consisted of 7 to 10 categories of goods and services. The initial phase consists of "core" spending categories, such as information technology, office equipment and supplies, janitorial supplies, and postage, while the subsequent phases address categories with increasing purchasing complexity. According to the analysis, the estimated savings ranged from $97.7 to $161.9 million annually, 7 to 11 percent of annual spending. In addition, the business case estimated further savings by including additional agency-specific categories at the Texas Department of Transportation, Health and Human Service Commission, and Texas Department of Criminal Justice. Seven additional categories were identified totaling $619.8 million in spending with estimated savings ranging from $39.8 to $66.0 million annually, 6 to 11 percent of these agencies spending. Total estimated savings identified in the analysis range from $137.5 million to $227.9 million annually in All Funds ($275 million to $455.8 million biennially).

Legislative Budget Board (LBB) staff performed an analysis on the validity of the savings estimated in the March 2005 strategic sourcing business case analysis conducted for TBPC. While the LBB analysis found that the potential for savings would be reduced significantly from the projections provided in the analysis, savings were still possible through a strategic sourcing initiative. As shown in **Figure 9**, the LBB analysis found that the business case did not consider certain factors that could reduce the savings realized by the state.

As shown in **Figure 10**, based on an agency-level method of finance analysis, the state could realize estimated savings, including $14.8 million in General Revenue Funds and General Revenue–Dedicated Funds, by implementing strategic sourcing during the 2008–09 biennium. The methodology for estimating the method of finance for these savings is based on applying the 2006–07 General Appropriations Act method of finance for each agency included in the business case.

Recommendation 3 would include a rider in the 2008–09 General Appropriations Bill that requires the Texas Building and Procurement Commission and the Department of Information Resources to implement strategic sourcing initiatives that result in better value for the state for commonly purchased goods and services. The following rider could be added to Article IX in the 2008–09 General Appropriations Bill to require this activity:

> **Strategic Sourcing.** Out of funds appropriated elsewhere in this Act, the Texas Building and Procurement Commission and the Department of Information Resources shall implement strategic sourcing initiatives that result in better value for the state for commonly purchased goods and services. A quarterly report on the progress of implementing strategic sourcing initiatives shall be submitted to the Governor and Legislative Budget Board by December 1, 2007. A report, in a format prescribed by the Legislative Budget Board, of the savings resulting from strategic sourcing should be submitted to the Governor

FIGURE 9
FACTORS IMPACTING SAVINGS—2005 STRATEGIC SOURCING BUSINESS CASE

FACTORS	IMPACT ON BUSINESS CASE ESTIMATE OF SAVINGS
Higher Education MOF and Operations	Due to the manner in which institutions of higher education are funded in Texas, savings associated with these institutions were removed from the LBB analysis. The business case estimated savings at these institutions at $14.8 million annually ($29.5 million biennially).
House Bill 1516 (Seventy-ninth Regular)	This bill centralized the procurement of information technology hardware, software, and contracting at the DIR. These goods and services account for 25 percent of the business case's savings estimate. Therefore the estimated savings could be reduced by the same percentage.
Implementation Timeframe	The business case assumed a 14-month implementation schedule for the first four phases. Combining this assumption with the state's budget cycle and experience with implementing statewide initiatives, results in full implementation realistically requiring 24 months. As a result, it is anticipated that no savings could be realized until fiscal year 2009 for a total reduction in estimated savings of 50 percent.
Decentralized Procurement Practices	The state's coordination of procurement for most goods and services is decentralized. While TBPC and DIR are the centralized purchasing agents of the state, Title 10 Government Code provides numerous delegations and exemptions that limit the state's ability to coordinate statewide purchasing. Under the current statutory structures, the estimated savings from strategic sourcing could be reduced by an estimated 50 percent due to lack of statutory authority to require agency participation.
Contractor Fees	Assuming the use of contractor assistance and using the fee estimate outlined in the business case analysis ($11.7 million against estimated savings of $97.1million annually for the first four phases), it is assumed that contractor fees could reduce estimated savings realized by 10 percent.

Source: Legislative Budget Board.

FIGURE 10
AGENCY-LEVEL METHOD OF FINANCE ANALYSIS—2005 STRATEGIC SOURCING BUSINESS CASE (IN MILLIONS)

	GENERAL REVENUE FUNDS	GENERAL REVENUE–DEDICATED FUNDS	FEDERAL FUNDS	OTHER
LBB Estimate of Phased Savings		**$28**		
MOF Percentage	31%	9%	30%	29%
Dollar Breakdown	$8.8	$2.5	$8.5	$8.2
LBB Estimate of Agency-Specific Savings		**$17.9**		
MOF Percentage	19%	0.12%	36%	44%
Dollar Breakdown	$3.5	$0.02	$6.5	$8.0
LBB Estimate of Total Savings = $45.9 All Funds	**$14.8**		**$15.0**	**$16.1**

Note: Totals may not sum due to rounding.
Source: Legislative Budget Board.

and Legislative Budget Board on the October 1, 2008 and quarterly thereafter.

FISCAL IMPACT OF THE RECOMMENDATIONS

The total 2008–09 biennial General Revenue Funds and General Revenue–Dedicated Funds fiscal impact of all recommendations is $14.8 million. Recommendation 1 and 2 do not have any significant fiscal impact. Recommendation 3 would save $12.2 million in General Revenue Funds, $2.5 million in General Revenue–Dedicated Funds, $15 million in Federal Funds, and $16.1 million in Other Funds in the 2008–09 biennium. **Figure 11** shows the total fiscal impact of Recommendation 3.

The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendation 3.

FIGURE 11
FIVE-YEAR FISCAL IMPACT TABLE

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED FUNDS	PROBABLE SAVINGS/(COST) TO FEDERAL FUNDS	PROBABLE SAVINGS/(COST) TO OTHER FUNDS
2008	$0	$0	$0	$0
2009	$12,241,926	$2,523,723	$14,968,410	$16,148,708
2010	$12,241,926	$2,523,723	$14,968,410	$16,148,708
2011	$12,241,926	$2,523,723	$14,968,410	$16,148,708
2012	$12,241,926	$2,523,723	$14,968,410	$16,148,708

SOURCE: Legislative Budget Board.

REDUCE RISKS ASSOCIATED WITH STATE CONTRACT MANAGEMENT

Texas state agencies and institutions of higher education managed approximately 21,000 contracts during fiscal year 2005, valued at $41.6 billion. This figure does not account for additional contracts that agencies routinely enter into valued at less than $14,000. Numerous reports by the State Auditor's Office over the last several biennia show that Texas agencies do not have adequate centralized contract management oversight in place to assure consistency and mitigate the risks inherent to contracting. To improve contract oversight, the state should increase the level of review and approval for which agencies entering into high risk contracts are subject. Removing statewide determination of risk from the agency and standardizing its application would also insulate the state from vendor negligence and performance failure.

CONCERNS

- ♦ The current centralized oversight of state contracting activities focuses on preparation of the solicitation document and vendor selection. Agencies do not receive expert oversight or guidance for the higher-risk stages of contract negotiation and performance monitoring.
- ♦ Existing contract oversight entities do not have the authority or ability to force changes to high-risk contracts or, in cases of extreme risk, to halt the execution of a contract or terminate an existing contract.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Chapter 2262, Texas Government Code to create a state Office of Contract Management within the Texas Building and Procurement Commission to review and approve state contracts over $10 million, or those meeting other high-risk criteria established by the office, at each of the three stages of the contract management process.
- ♦ **Recommendation 2:** Amend Chapter 2262, Texas Government Code to enable the state Office of Contract Management to recommend the cancellation of a high risk contract, at any stage in the contract management process, with the approval of the Legislative Budget Board and the Governor.

DISCUSSION

Contract management refers to the complete set of activities, beginning with the preliminary planning stages, necessary to guide a contracting project to completion. There are three principal stages in the contract management process: (1) solicitation and procurement; (2) contract negotiation and execution; and (3) contract administration and monitoring. To successfully mitigate risks, contain costs, and ensure high quality contract engagements, all three stages must be skillfully managed; a sole focus on any one stage will not prevent problems from risks or predatory practices from occurring in subsequent stages.

There are many additional processes within each of the stages that further complicate contract management. The state *Contract Management Guide*, published by the Texas Building and Procurement Commission (TBPC), identifies five principal activities necessary for effective contract management: (1) planning; (2) procurement; (3) contract formation; (4) rate or price establishment; and (5) contract oversight. The solicitation stage begins with preliminary project planning and needs identification and proceeds through the posting of a solicitation document and selection of a qualified vendor. The next stage involves the creation and negotiation of a satisfactory contract and approval by all parties, resulting in final execution. The final stage begins with either the transfer of services to the new vendor or the initiation of a project implementation plan and continues through the completion or cancellation of the contract. During the final stage, performance monitoring, deliverable approval, and invoice auditing are crucial activities to ensure the state is receiving the services outlined in the contract for the agreed cost. The complexity of these processes and the required expertise to manage the diverse issues involved require a strong oversight presence to maintain consistency and prevent problems. Many agencies assign contract management responsibility to program staff or project managers who, while subject matter or service provision experts, lack the expertise needed to successfully manage the contracting process.

Texas depends on private vendors to serve state agencies in activities ranging from custodial services to the implementation of statewide information technology systems. Through numerous provisions in the Texas Government Code, state

agencies and institutions of higher education are required to report the use of professional service, construction, or consulting contracts over $14,000 and major information systems contracts valued at $100,000 or more to the Legislative Budget Board within 10 days of entering into the agreement. Agencies are also required to report any other contract, not included in the above categories, exceeding $50,000. During fiscal year 2005, 128 state agencies and institutions of higher education reported 20,886 active contracts with a total value of $41.6 billion, a 10 percent increase over fiscal year 2004 total value.

As shown in **Figure 1**, 10 agencies and institutions of higher education collectively represent 91 percent of the state's total contract value, $37.8 billion. Agencies and institutions awarded an average of 107 contracts each, and the 10 largest contracts, based on dollar value, represent 32.5 percent of total state contracting value. In fiscal year 2005, 50 agencies reported no eligible contracts.

While TBPC and the Department of Information Resources (DIR) conduct required reviews of procurement solicitation documents for commodities and technology issues respectively, only the state Contract Advisory Team (CAT) provides centralized oversight of contract management activities in Texas. CAT is composed of five member agencies and two technical assistance members: the Office of the Attorney General; the Texas Comptroller of Public Accounts; DIR; TBPC; the Governor's Office; the Legislative Budget Board; and the State Auditor's Office. Members are required by statute to provide staff to review the solicitation of major contracts by state agencies and provide recommendations regarding the development of the contract management guide.

CAT members review contract solicitations with an estimated value of $1 million or more before the submitting agency posts the solicitation for response or bid. The solicitation documents are reviewed for compliance with required contractual language, mitigation of identified risks, and definition of acceptable performance standards. Although staff members provide recommendations for revisions, additions, and corrections to the solicitation documents, CAT has no statutory authority to require the submitting agency to address identified concerns. Agencies are also assisted in preparing solicitation documents by the state's Contract Management Guide. The guide is prepared and revised by CAT members and is published by TBPC.

There are numerous other statutory contracting review requirements, but they are neither centralized within a single agency for consistency nor apply equally to all types of contract engagements managed by state agencies. One example is the review and approval of all consulting contract solicitations by the Governor's Office required by Chapter 2254, Texas Government Code.

FIGURE 1
VALUE OF CONTRACTS BY AGENCY, FISCAL YEAR 2005

AGENCY	VALUE OF REPORTED CONTRACTS	PERCENTAGE OF TOTAL
Texas Department of Transportation	$17,097,035,462	41.1%
Health and Human Services Commission	7,333,092,192	17.6
Teacher Retirement System	4,168,582,683	10.0
Department of Aging and Disability Services	3,749,428,487	9.0
University of Texas MD Anderson Cancer Center	1,532,982,040	3.7
Department of Family and Protective Services	891,556,653	2.1
Department of State Health Services	875,186,147	2.1
Texas Lottery Commission	869,863,332	2.1
Employees Retirement System	670,551,905	1.6
Texas Department of Criminal Justice	643,620,458	1.6
Other Agencies and Institutions	3,785,352,049	9.1
Total	**$41,617,251,408**	**100.0%**

Source: Legislative Budget Board.

CENTRALIZED REVIEW AND APPROVAL OF AGENCY CONTRACTS

All three stages of the contract management process must be managed with diligence to result in success; however, the highest risk activities are in the contract negotiation and performance monitoring stages. Analysis of historical audit findings of contractual use by the State of Florida show that 56 percent of contract management failings occurred during the final stage in the process, with 45 percent of findings relating to problems with performance monitoring alone. It is in these two crucial stages that Texas requires improved oversight to avoid risks related to contracting opportunities. Potential risks include direct financial loss, failure to obtain desired services, payment for defective deliverables, fraud, and loss of funding.

Recommendation 1 proposes creating a state Office of Contract Management (SOCM) within the Texas Building and Procurement Commission (TBPC). The office would be staffed by certified contract management and legal personnel with the ability to provide a variety of guidance and oversight services to agency contract managers. SOCM contract managers would be assigned to individual agency contracts exceeding $10 million, or meeting alternative high risk criteria, to help guide agency staff through the contract management process by providing expert counsel on creating solicitation documents, negotiating final contracts, and monitoring vendor performance. SOCM management would allocate available staff resources to the highest risk agency contracting operations in progress at any given time and would maintain the authority to waive full review of a contract meeting the $10 million criteria if staff determined that the contract was not a high risk to the state.

Agencies would also be required to receive SOCM approval to proceed at three points within the contract management process: (1) before the public release of solicitation documents; (2) before executing a final contract; and (3) before making payments equal to half of the contract value. At each of these stages assigned SOCM staff would review specific documentation to confirm that potential risks have been identified and mitigated. Assigned staff would also be available to agency project personnel throughout the contract management process to answer questions and provide assistance on any issues that arise. SOCM would not be required to review contracts executed by institutions of higher education. SOCM management would be required to tailor program work plans and staff assignments, using available resources to address the greatest risks to the state at any given time.

The following contingency rider could be included in the 2008–09 General Appropriations Bill to fund SOCM reviews and activities at TBPC:

> **Contingency Appropriation for Contract Management Activities.** Contingent upon the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation relating to the creation of a state Office of Contract Management, the Texas Building and Procurement Commission is appropriated $600,000 in fiscal year 2008 and $1.0 million in fiscal year 2009 in General Revenue Funds. Appropriated funds may be expended only for the statutorily authorized contract management activities of the state Office of Contract Management and no part may be transferred to other strategies within the Texas Building and Procurement Commission.

With the creation of SOCM it would no longer be necessary for the state Contract Advisory Team to review all agency solicitations over $1 million. That responsibility would be removed, allowing CAT members to focus on reviewing contract findings and recommendations made by the state auditor and providing recommendations to TBPC regarding the development of the contract management guide and associated training. Because TBPC already serves as a permanent member, no changes to CAT membership would be required to allow participation in the group by SOCM staff.

CANCELLATION OF HIGH-RISK CONTRACTS

A defined review process encompassing the entire contract management process with required approval at each stage will improve the state's contracting position, but it will not completely eliminate the inherent risks involved in contracting with private vendors. To address risk issues, and contract performance issues that develop during a contracting engagement, the state Office of Contract Management (SOCM) should have the authority to recommend cancellation of a contracting project when the state's best interests are no longer served. Only the contracting agency can cancel a contract, typically for vendor non-performance or lack of appropriated funding.

Recommendation 2 proposes providing SOCM the authority to recommend cancellation of a contract, at any stage of the contract management process, with the approval of the

Legislative Budget Board and the Governor. This authority would allow SOCM staff to identify: a proposed solicitation that is not in the state's best interest to proceed; a negotiated contract that, if executed, places the state at unacceptable risk; or, an executed contract that should be canceled for performance failure or payment irregularities. This authority would provide consistent oversight of such issues across all agency operations and protect state services and finances by removing conflicts of interest between project management and contract management goals.

FISCAL IMPACT

As shown in **Figure 2**, these recommendations would result in a net cost of $1.6 million in General Revenue Funds during the 2008–09 biennium.

FIGURE 2
FIVE-YEAR FISCAL IMPACT OF CREATING A STATE OFFICE OF CONTRACT MANAGEMENT

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS	PROBABLE ADDITION/ (REDUCTION) OF FULL-TIME EQUIVALENTS
2008	($600,000)	7
2009	($1,000,000)	12
2010	($1,000,000)	12
2011	($1,000,000)	12
2012	($1,000,000)	12

Source: Legislative Budget Board.

Recommendation 1 would result in costs of $1.6 million to General Revenue Funds during the 2008–09 biennium due to the creation of the state Office of Contract Management. The costs are required for the addition of seven full-time equivalent positions (FTEs) in fiscal year 2008, as initial implementation staffing for the office, and 12 FTEs in each subsequent year, to provide full staffing for the office. Base level program costs are estimated at $1.0 million per year, but are reduced to $600,000 during the first year to allow for a phased implementation of the program.

Recommendation 2 has no fiscal impact during the 2008–09 biennium; however, the related authority could result in savings from the cancellation of poor performance contracts or from stopping agencies from making unwarranted payments to vendors. Allowing state Office of Contract Management personnel to recommend stopping a solicitation, or contract execution, identified as high risk could also result in significant cost avoidance, reducing project costs and contract payments.

The introduced 2008–09 General Appropriations Bill does not address either of the recommendations.

ENHANCE THE MANAGEMENT AND OVERSIGHT OF STATE DEBT

Debt financing in Texas plays an important role in providing funds for the capital needs of the state. The state currently receives a category AA-rating, the second highest bond rating, from all three rating agencies, which are Fitch, Moody's, and Standard & Poor's. According to Moody's, Texas has the tenth largest amount of gross tax supported debt in the nation. The state had $21.4 billion in debt outstanding at the end of fiscal year 2005.

Texas has a decentralized debt management structure. In fiscal year 2005, there were 39 bond transactions involving 14 different state issuers. While this decentralized structure provides issuers with autonomy, it also presents some challenges to effective debt management at the state level. The Texas Bond Review Board, charged with bond oversight for the state, does not have the authority or does not receive certain bond issuance information early enough in the bonding process to fulfill its role most effectively. Enhancing the state's oversight could help more effectively monitor the cost of debt issuance and position the state to improve its bond rating.

CONCERNS

- The state does not comprehensively review the effect of new debt authorizations and appropriations of debt service on the state's future debt capacity.
- The state's decentralized debt management structure hinders state agencies from systematically sharing information, which results in agencies not having the information they need to manage the debt process effectively.
- The Texas Legislature's finance committees consider approval of new debt by government function. This process makes it difficult to assess the overall impact of new debt authority on future debt service capacity.
- Capital planning is not formally integrated with the legislative debt authorizing process and the Legislature does not have a list of prioritized projects to use as a starting point for deliberations.
- The Texas Bond Review Board staff reviews issuance costs when the state debt application is submitted for review and approval near the end of the issuance process, making it difficult to review professional fees that are negotiated and agreed upon earlier in the issuance process.
- Texas Government Code §1201.027 allows each state issuer of debt to select financing consultants, which results in each issuer having its own Request for Proposal arrangement. However, the Texas Bond Review Board does not receive request for proposal information from issuers.
- The Texas Bond Review Board is not required to approve interest rate swap agreements, which are complex financial tools, for the Veteran's Land Board and the Texas Department of Housing and Community Affairs, two of the three issuers who use swaps.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Government Code, Chapter 1231 to require the Texas Bond Review Board to submit an annual Debt Affordability Study to provide information on the state's future debt capacity.
- **Recommendation 2:** Amend Texas Government Code, Chapter 1231 to create a Debt Management Committee that provides direction on the annual update to the Debt Affordability Study and any other strategic debt initiatives to provide a mechanism for better communication in a decentralized debt management structure.
- **Recommendation 3:** Consider establishing standing subcommittees within the House Committee on Appropriations and Senate Committee on Finance, where all requests for debt financing of bond-funded capital projects must be presented, to provide comprehensive debt information to the two committees.
- **Recommendation 4:** Amend Texas Government Code, Chapter 1231 to require the Texas Bond Review Board, with input from the Debt Management Committee, to integrate capital planning with the level of additional debt service capacity from the Debt Affordability Study. This integration could include a list of prioritized capital projects.

- **Recommendation 5:** Amend Texas Government Code §1201.027 and §1231.081 to require that issuers submit information on cost of issuance fees for services to the Texas Bond Review Board for approval when planned by the issuer.
- **Recommendation 6:** Amend Texas Government Code §1201.027 and §1231.081 to require state debt issuers to submit Requests for Proposals to the Bond Review Board with costs of issuance information prior to selection of service providers including but not limited to bond counsel, financial advisor, and underwriter and upon selection, submit final documents and state the basis for selection.
- **Recommendation 7:** Amend Texas Government Code, Chapter 1231 to require Bond Review Board approval of all interest rate swap agreements prior to an issuer entering into an agreement. Amend Texas Natural Resources Code §161.074, 162.052, and 164.010 as well as Texas Government Code §2306.351 to require Texas Bond Review Board approval of swap agreements prior to the Veteran's Land Board and the Texas Department of Housing and Community Affairs entering into such agreements.

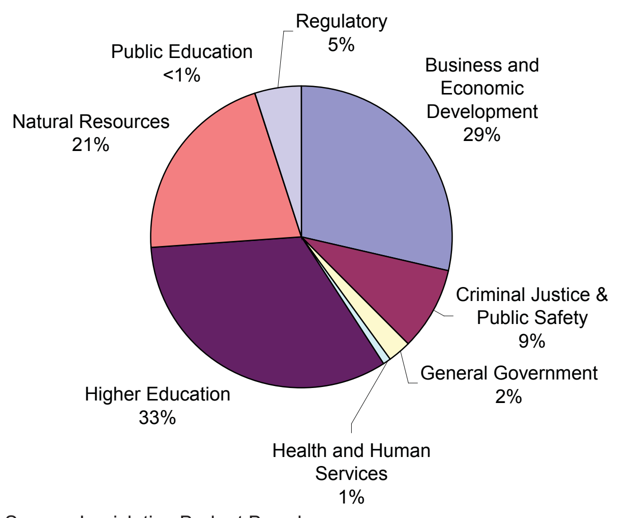
DISCUSSION

Texas uses long-term debt finance for a variety of projects and program areas. At the end of fiscal year 2005, the state had $21.4 billion in debt outstanding. Of this amount, 33 percent is for higher education, 29 percent is for business and economic development, and 21 percent is for natural resources. The remaining debt is allocated among criminal justice, general government, health and human services, public education, and regulatory projects. **Figure 1** shows debt outstanding by government function.

The state's total debt outstanding increased 105 percent over the last decade, increasing from $10.4 billion in fiscal year 1995 to the current $21.4 billion. Self-supporting debt outstanding at the end of fiscal year 2005 total $18.3 billion and not self-supporting debt outstanding totaled $3.1 billion.

In addition to total debt outstanding, an important component of Texas' use of debt financing is bond ratings. Bond ratings measure the amount of risk to investors and play a major role in determining interest rates charged to state debt issuers. The recommendations in this report focus on improving the state's debt management and oversight, but

FIGURE 1
DEBT OUTSTANDING BY GOVERNMENT FUNCTION
FISCAL YEAR 2005



Source: Legislative Budget Board.

some of them may also assist in protecting and perhaps improving the state's bond rating.

Texas currently receives a category AA-rating from all three bond rating agencies, which is considered a high bond rating. Fitch, Moody's, and Standard & Poor's are the bond rating agencies. Bond rating scales are based on letter categories, ranging from A to D, with A being the highest. Within letters, ratings range from one (lowest) to three (highest) letters, and can include numbers or positive and negative signs to further illustrate a state's standing. For example, from Standard & Poor's, a state can receive "AA" rating that includes AA+, AA, or AA-. Many states receive AA-ratings. From Fitch, 52 percent of the 50 states receive a AA-rating. From Moody's, 74 percent of the 50 states receive a AA-rating. From Standard & Poor's, 68 percent of states receive a AA-rating. **Figure 2** provides information on comparative bond ratings.

Until 1987, Texas received a AAA-rating on its bonds. Though a AA-rating is high, the state's cost of issuance is higher with this rating than it would be with a AAA-rating. At current interest rates, for every $100 million of new debt issued, the state will spend approximately $309,000 more over the 20-year life of the bonds (or $15,000 per year).

DEBT AFFORDABILITY STUDY

Debt affordability is an integrated approach that helps analyze and manage state debt by factoring in historical debt use, financial and economic resources of the state, and long-term goals for capital needs. The Debt Affordability Study

FIGURE 2
NUMBER OF STATES WITHIN EACH RATING CATEGORY FOR GENERAL OBLIGATION BONDS

RATING	FITCH	MOODY'S	STANDARD & POOR'S
Highest			
AAA/Aaa/AAA	9	7	10
High			
AA+/Aa1/AA+	5	12	5
AA/Aa2/AA	16	12	20
AA-/Aa3/AA-	5	13	9
Upper medium			
A+/A1/A+	0	0	1
A/A2/A	2	2	1
A-/A3/A-		0	0
Unrated	13	4	4

SOURCES: Fitch; Moody's; Standard & Poor's.

(DAS), to be published in February 2007 as a joint project between the Legislative Budget Board, the Texas Bond Review Board (BRB) and the Texas Public Finance Authority (TPFA) presents the state's current debt burden with an overview of the state's historical and current debt, including five key ratios (listed below) that illustrate the state's debt levels. One key component of debt affordability is determining the state's additional debt capacity, which is measured in terms of annual debt service capacity. The practice of using a DAS has become much more common, with at least 13 states using this kind of debt management tool.

In developing a mechanism for the state to determine debt affordability, or the amount of debt the state can accommodate, the debt capacity model (DCM) calculates five key ratios that provide a big-picture view on Texas' debt and can be used as guidelines or decision-making tools for future debt authorization and debt service appropriations. Only not self-supporting debt is reflected in the ratios because as tax-supported debt it ties up General Revenue Funds. Information on the ratios below covers a five-year period from fiscal years 2005 to 2009. The five key ratios include:

Ratio 1: Debt Service as a Percentage of Unrestricted Revenues. This ratio helps determine additional annual debt service capacity for not self-supporting debt, based on existing debt and guideline ratios. For the purposes of this study, guideline ratios used include a 2 percent target ratio and a 3 percent maximum (or cap). By having target and limit ratios, a range of additional debt capacity is available that allows flexibility in new debt authorizations and subsequent debt service appropriations. If these guideline ratios are adopted, under the 2 percent target ratio the state will have an additional $171.4 million in General Revenue Funds available for debt service in fiscal year 2008. This amount translates to $2 billion in new bond authorizations. Under the 3 percent cap ratio, for fiscal year 2008 up to $493.2 million in additional debt service will be available, which translates to $5.7 billion in new bond authorizations.

Ratio 2: Not self-supporting Debt to Personal Income. This ratio is used by credit (or bond) rating agencies, and is calculated by dividing total not self-supporting debt by total personal income. At current and projected debt and personal income levels, over a five-year period this ratio ranges from a high of 0.4 percent in fiscal year 2005 to a low of 0.3 percent in fiscal year 2009.

Ratio 3: Not self-supporting debt per capita. This ratio is used by credit rating agencies, and is calculated by dividing total not self-supporting debt by population. At current and projected debt and population levels, over a five-year period this ratio ranges from a high of $132.18 in fiscal year 2005 to a low of $102.27 in fiscal year 2009.

Ratio 4: Rate of Debt Retirement. This ratio highlights the state's progress on retiring debt in a timely fashion. The current rate of retirement for not self-supporting debt is a 78.7 percent principal payout in a 10-year period, which is a high rate of retirement. A 50 percent principal payout at 10 years is considered the average ratio by the credit agencies.

Ratio 5: Not self-supporting Debt Service as a Percentage of Budgeted General Revenue. This ratio shows how much of budgeted (or expended for complete fiscal years) General Revenues Funds are dedicated to long-term financing, which is a reflection of the state's financial flexibility. Texas has had a not self-supporting debt service commitment of less than 1.6 percent of General Revenue Funds. The 2006–07 biennial appropriations for annual debt service maintain this low ratio at 1.4 percent for fiscal years 2006 and 2007.

Recommendation 1 would assign responsibility for the Debt Affordability Study to the Texas Bond Review Board (BRB) with input from the Texas Public Finance Authority (TPFA) and the Legislative Budget Board (LBB), and contingent upon its creation, the Debt Management Committee as described in Recommendation 2. It would also require the Texas Bond Review Board to update the Debt Affordability Study annually and submit to the Governor, Speaker of the House, Lt. Governor, Comptroller of Public Accounts and members of each finance committee by December 1 prior to each regular legislative session. It would require the BRB to establish a target and limit for analysis of debt service as a

percentage of unrestricted revenues (Ratio 1) prior to legislative sessions, which the Texas Legislature would approve and perhaps adjust. Finally, Recommendation 1 would require monitoring how year-to-year changes and new authorizations affect the other four ratios included in the debt capacity model. The Debt Affordability Study is a separate report published by the LBB in February 2007, which provides information on the state's current debt position and the key debt ratios. Implementing Recommendation 1 would require additional resources for the BRB and a rider that could implement this recommendation can be found at the end of the Discussion section.

DEBT MANAGEMENT COMMITTEE

The state's debt management structure includes the following agencies and their respective functions:

- Texas Bond Review Board (BRB) approves state debt issuance; monitors costs of issuance; compiles the statewide capital expenditure plan; administers the Private Activity Bond Allocation program; and collects, maintains, and analyzes data regarding the local government debt.
- Texas Public Finance Authority (TPFA) issues debt on behalf of 18 state agencies and three universities to provide financing for the construction or acquisition of facilities, maintains a master lease purchase program, and is the primary issuer of debt payable from General Revenue.
- Texas Higher Education Coordinating Board (THECB) assists institutions with the efficient use of university construction funds and the orderly development of physical plants to accommodate projected college student enrollments and develops the Higher Education Fund (HEF) funding formula.
- Office of the Attorney General (OAG) issues an opinion on the legal issuance of the bonds and approves the bond issues before delivery.
- Comptroller of Public Accounts (CPA), Treasury Division prepares the annual Tax Revenue Anticipation Note, serves as the primary contact with credit rating agencies, provides Securities and Exchange Commission disclosure requirements, and registers the bond.

The BRB oversees and approves bond issuance. Although the agency has the authority to do so, it does not issue debt. In addition to having an oversight agency, Texas' debt structure has a consolidated program in its issuance and monitoring of debt that is funded with General Revenue Funds. The TPFA is the primary issuer of debt funded by General Revenue Funds and issues on behalf of 21 state agencies under a variety of programs, including three commercial paper programs.

For any given bond issue, debt management responsibilities and functions are dispersed among at least five different agencies, including the issuer. These activities include:

- Approval to issue debt;
- Debt monitoring;
- Credit rating agency contacts;
- Debt policy;
- Disclosure requirements;
- Costs of issuance monitoring;
- RFP monitoring;
- Capital project approval;
- Capital planning;
- Tax-supported debt issuance; and
- Debt administration (debt service payments and arbitrage calculations).

The state's decentralized debt system offers a great deal of autonomy to state issuers who have the flexibility to issue debt as needed. A review of three comparable states' (California, Florida, and Oklahoma) debt-related agencies and committee arrangements indicates there is much variation in debt management agency and committee arrangements among states. California and Florida were selected as peer states based on population and debt burdens. In these states the key debt management functions such as treasury services, debt administration and bond monitoring and oversight, are centralized. Oklahoma was selected as a peer state based on its decentralized debt structure.

As a state with a decentralized debt management structure, Texas has additional challenges in ensuring effective communication and timely decision-making. For example, the CPA serves as the main contact for the bond rating agencies, which may exclude or delay some information received by the issuer or BRB concerning bond ratings. Another example of the effects of decentralization is multiple issuers may increase the costs of issuance or not be able to

negotiate the best rates possible due to smaller issuances or other factors. To maximize state resources and ensure the lowest cost financing for taxpayers, some adjustments to the current system could be made.

Recommendation 2 would amend Texas Government Code, Chapter 1231 to create a Debt Management Committee that will allow for better integration of the state's debt management. The committee would provide a mechanism for agency leadership and staff with relevant expertise to share information, raise issues, and problem-solve debt matters or concerns as they occur and in a manner that is not feasible under the existing structure. The coordination of this committee would be the responsibility of the BRB. The committee would provide policy guidance for the annual updates to the Debt Affordability Study by establishing parameters and providing recommendations for the BRB's approval. The committee would also be able to work on debt-related ad hoc projects. The Debt Management Committee would consist of representatives from the state entities shown in **Figure 3**.

FIGURE 3
STATE ENTITIES COMPRISING THE DEBT MANAGEMENT COMMITTEE

Texas Bond Review Board	Legislative Budget Board
Texas Public Finance Authority	Lt. Governor's Office
Texas Higher Education Coordinating Board	Speaker of the House
Office of the Attorney General	Senate Finance Committee
Comptroller of Public Accounts	House Appropriations Committee
Office of the Governor	

Source: Legislative Budget Board.

In addition to this list, the executive director of the BRB would select one state issuer to serve on the committee as needed. Implementing Recommendation 2 would require additional resources for the BRB and a rider that could implement this recommendation can be found at the end of the Discussion section.

DEBT OVERSIGHT BY LEGISLATIVE APPROPRIATIONS AND FINANCE COMMITTEES

Debt authorization and debt service appropriations are reviewed by the House Appropriations Committee (HAC) and the Senate Finance Committee (SFC). Each committee makes appropriations and authorizations recommendations to the full chambers. To address budgeting for different governmental function areas, each of these committees uses subcommittees or workgroups. SFC typically creates workgroups that cover one to three articles in the General Appropriations Bill, but these are not standing committees. To address tuition revenue bond funding, SFC created a subcommittee on capital funding for higher education during the Seventy-ninth Legislature, Third Called Session, 2006. HAC has six standing subcommittees: criminal justice, education, general government, government efficiency and operations, health and human services, and regulatory.

Although legislators receive some information that provides totals for debt authorization and debt service, debt financing and its impacts are not considered comprehensively. New debt authorizations and debt service appropriations are addressed by functional area, which makes it difficult to approve debt with an overall perspective and to compare debt priorities. With the state's limited financial resources, it is important for legislators to be able to consider overall priorities when considering proposed capital projects and to compare projects of one governmental function to another.

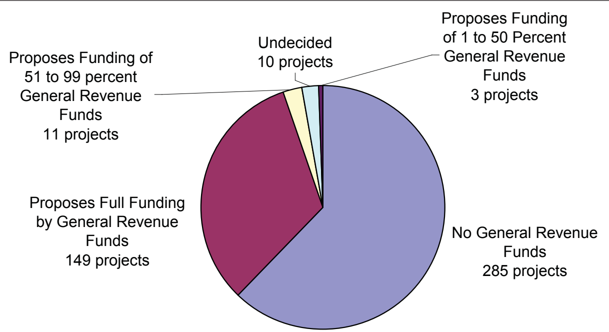
Recommendation 3 proposes establishing standing sub-committees within HAC and SFC where all proposals for debt-financed capital projects would be presented to provide comprehensive debt information to the two committees.

INTEGRATION OF CAPITAL PLANNING

The 2008–09 Capital Expenditure Plan (CEP) is produced by the BRB and it reports information on planned capital expenditures for fiscal years 2007 to 2011, which included submissions from 69 state entities on 901 capital projects. Planned or proposed expenditures total $6.5 billion for the 2008–09 biennium. Of these projects, 458 propose using debt financing, which would cost $810.3 million in debt service for the 2008–09 biennium. Of the debt-financed projects, 285 propose no General Revenue Funds as part of the financing and 149 projects would require full funding by General Revenue Funds. **Figure 4** provides details on the percentage of General Revenue Funds desired for the proposed debt-financed projects.

An important step in the debt financing process involves legislators evaluating the state's debt capacity and considering the effect of new debt funded projects on capacity. Traditionally Texas has not had a formalized process to consider the affect of new debt on debt capacity. When the pool of proposed projects is small, policymakers have enough familiarity with the agencies and specific projects to use experience and existing knowledge to compare projects and make decisions for debt authorization and debt service

FIGURE 4
PERCENTAGE OF GENERAL REVENUE FUNDS DESIRED FOR PROPOSED DEBT-FINANCED CAPITAL PROJECTS FOR FISCAL YEARS 2008 AND 2009



Source: Legislative Budget Board.

appropriation. However, the current volume of proposed projects makes it difficult to evaluate the relative values or merits of one project against another, especially across governmental functions. A ranking process for all proposed projects is a tool that may be helpful to legislators. This kind of ranking process for capital projects would include criteria with an assigned point value for each criterion and a possible maximum score.

In Utah, higher education institutions rank their projects separately from other state agencies, with evaluation by the system's board of regents. Next, higher education and other state agencies submit their project proposals to one agency, which evaluates all projects. Projects are evaluated based on five criteria and are presented to the legislature for consideration. Based on these evaluations, presentations, and financial resources, the legislature selects projects to approve. Another aspect of Utah's process is the separation of capital improvement projects (deferred maintenance) from capital development (new facilities or extensive remodeling) in its evaluation process.

During the Seventy-ninth Legislature, Third Called Session, 2006, the Senate Finance Subcommittee on Capital Funding for Higher Education directed the Texas Higher Education Coordinating Board (THECB) to develop a process to rank proposed projects for tuition revenue bond (TRB) authorization. Universities and university systems internally ranked projects and submitted information the to THECB.

THECB developed a ranking process that included nine criteria to rank 155 project proposals. According to THECB documents, the evaluation process for tuition revenue bonds included these criteria: extraordinary circumstances, Closing the Gaps (the THECB's statewide plan for higher education), planned projects, matching funds, critical and deferred maintenance, cost, efficiency, space need, and space utilization. A maximum score of 100 was possible from the nine criteria. **Figure 5** provides descriptions and point values for these categories.

FIGURE 5
CRITERIA FOR RANKING PROPOSED PROJECTS FOR TUITION REVENUE BOND AUTHORIZATION

CRITERIA	DESCRIPTION	POINT VALUE
Extraordinary Circumstances	Could include hurricane damage, exceptional outside funding, recently constructed schools in high growth regions, accreditation requirements	10
Closing the Gaps (a) Project Specifics (b) Indices	(a) Likelihood of project to help institution meet goals in Closing the Gaps (b) Progress toward Closing the Gap goals and improvement on Accountability System measures	(a) 10 (b) 15
Planned Project	Project rank in an institution's Master Campus Plan	10
Matching/Leveraged Funds	Percentage of non-TRB funding identified	10
Critical and Deferred Maintenance	Percentage of project's cost that addresses identified deferred or critical maintenance items	10
Cost	Estimated project costs per square foot compared to RS Means, a national cost gauge used by the construction industry	10
Efficiency	Compares a building's projected total space with its usable space	5
Space Need	Institution's need for space determined by the Coordinating Board's space model	10
Space Utilization	Compares an institution's use of its classroom and lab space to Coordinating Board guidelines	10

Source: Texas Higher Education Coordinating Board.

The ranking of tuition revenue bond projects completed by the THECB served as a starting point for legislators authorizing the debt, but it was not the only factor used in the tuition revenue bond authorization completed by House Bill 153. In expanding the use of capital project prioritization, the state would have many options. Higher education could be ranked with or separate from other governmental functions. New building projects could be considered with or separate from repair and renovation projects.

Recommendation 4 would amend Texas Government Code, Chapter 1231 requiring the Bond Review Board to integrate capital planning, which could include a prioritized list of capital projects, to the level of additional debt service capacity from the Debt Affordability Study. If Recommendation 2 is implemented, the capital project ranking process could be a duty of the Debt Management Committee. Implementing Recommendation 4, would require additional resources for the BRB and a rider that could implement this recommendation can be found at the end of the Discussion section.

Capital project rankings using criteria are intended to help policymakers as they make debt authorizations, but the ranking is only part of the process. Other factors or legislative goals may impact final debt authorizations, but developing a process and criteria for ranking proposed capital projects could be a useful tool for policymakers when considering a large number of projects.

COSTS OF ISSUANCE OVERSIGHT

Cost of issuance is an important consideration when using debt financing. By using proper oversight and resource maximizing strategies, the state's issuers can ensure efficient use of taxpayer money by achieving low cost financing. There are several key elements in the bond issue process that comprise the total cost of issuance:

Underwriter: Acts as a dealer who purchases a new issue of municipal securities from the issue for resale to investors. The underwriter may be selected through a competitive bid process or a negotiated sale. The underwriter represents the single largest cost of issuance. In fiscal year 2005, the underwriting costs accounted for 61 percent of total average issuance costs.

Bond Counsel: Retained by the issuer to provide legal advice for the bond issue on areas such as issuer's authorization for proposed securities, legal requirements for issue, and tax-exemption status of the interest on the securities. Bond counsel prepares documentation related to these legal opinions. In fiscal year 2005, bond counsel accounted for 10 percent of the total average cost of issuance.

Financial Advisor: Advises the issuer on matters related to the issue, including structure, timing, marketing, pricing, terms, and bond ratings. The advisor may also provide advice on cash flow and investment matters, which are areas unrelated to the new bond issue. In fiscal year 2005, financial advising accounted for 8 percent of the total average cost of issuance.

Rating Agencies: Rating agencies provide publicly available rating of credit worthiness on the issued bonds, measuring the likelihood of repayment on the municipal securities. In fiscal year 2005, rating agencies accounted for 6 percent of the total average cost of issuance.

Paying Agent/Registrar: The paying agent is responsible for transmitting payments of principal and interest from the issuer to the security holders. The registrar is the entity responsible for maintaining records on behalf of the issuer for the purpose of noting the owners of registered bonds. In fiscal year 2005, paying agent/registrar accounted for 3 percent of the total average cost of issuance.

Printer: The printer produces the official statement, notice of sale, and any bonds required to be transferred between the issuer and purchasers of the bonds. In fiscal year 2005, printing accounted for less than 1 percent of the total average cost of issuance.

During fiscal year 2005, the average cost per bond issue was $893,230, or $9.29 per $1,000 issued. From fiscal years 1998 to 2005, the average cost per bond issue increased 16 percent. **Figure 6** shows the average cost per bond issue during these years. The higher cost per issue for fiscal year 2002 is attributable to the Turnpike Authority Bonds issued by the Texas Department of Transportation, which was an unusually large issue at $2.2 billion.

As described in Texas Government Code §1231.081, the BRB requires issuers to submit a state bond issue application for approval, which includes cost of issuance information. All issuers must submit applications unless the issue is exempt from BRB approval. The BRB will not approve an application for bond issuance until the issue has approval from the issuer's governing board and the THECB (for institutions of higher education). As a result, the BRB bond issue application is submitted at the end of the issuer's financing process. In most cases, the issuer has already agreed on issuance costs with

FIGURE 6
AVERAGE COST PER BOND ISSUE, FISCAL YEARS 1998 TO 2005*

Fiscal Year	Average Cost Per Bond Issue
1998	$768,459
1999	$745,849
2000	$528,365
2001	$612,913
2002	$1,284,410
2003	$895,090
2004	$745,562
2005	$893,230

*Excludes conduits.
Sources: Legislative Budget Board; Texas Bond Review Board.

service providers. By not having an opportunity for review early on in the debt process, the BRB staff is not able to oversee debt issuance costs effectively.

The state of Oklahoma has a similar structure to Texas for debt oversight. The BRB's equivalent is Oklahoma's Council of Bond Oversight. In Oklahoma, the state debt applicant is required to submit a Statement of Approval of Professional Fees to the Council. Since the State Bond Advisor, who heads the Council, is responsible for approving or disapproving fees for costs of issuance, the fee statement is usually submitted earlier in the process but can be submitted at any time. This arrangement allows for costs of issuance fees to be approved separate from the state debt application process.

The BRB must approve all bond issuances and the application submitted by the issuer includes cost of issuance information. While the executive director of the BRB does not have the authority to approve costs of issuance as a separate step, the early submission of the fees would allow staff to review fees in a timely manner and provide effective costs of issuance supervision. In a few instances the agency has approved bond issues even when there were concerns about the cost of issuance. The current submission of this information occurs near the end of the process and the agency does not wish to delay an issuance application which is otherwise satisfactory.

Recommendation 5 would amend Texas Government Code §1201.027 and §1231.081 to require that issuers submit information on cost of issuance fees for service to the BRB for approval when contemplated or planned by the issuer. This process change would allow the agency to provide feedback on cost of issuance information and inform the issuer early on in the process if cost of issuance appears high and if it could be a factor affecting the complete application at the end of the approval process.

REQUEST FOR PROPOSAL OVERSIGHT

In determining the parameters of what services will be needed for bond issues, an issuer puts forth a Request for Proposal (RFP). In fiscal year 2005, 39 bond transactions took place that involved selected bond service providers whose terms of service vary from issuer to issuer. The eventual total cost of issuance is summarized by the service needs outlined in RFPs. These RFPs are for positions that have a multi-year contract to provide needed bond expertise services, such as the bond counsel or financial advisor roles mentioned under the Cost of Issuance section.

The BRB does not review RFPs. Due to the connection to cost of issuance, it is important for the agency to have the opportunity to review and comment on RFPs prior to the issuer using a RFP in the solicitation of service providers.

Government Code §1201.027 allows state issuers the exclusive authority to select their financing consultants, but requiring submission on RFP information before and after service provider selection would provide the BRB with a more comprehensive knowledge of the state issuer's practices and a better understanding of the statewide perspective regarding debt issuance costs.

Oklahoma has a comparable debt management structure and uses a process that Texas could replicate. Oklahoma uses the following three-step process to review and comment on issuer's RFPs:

1) Issuers submit RFPs for review and comment by the oversight agency (issuers must submit RFP's seven days prior to use of RFP's).
2) Issuers are also required to submit within seven days copies of final Requests for Proposals bids received.
3) Issuers prepare a written statement indicating the basis for selection and make available to the Council.

Recommendation 6 would amend Texas Government Code §1201.027 and §1231.081 to require state debt issuers to submit to BRB all RFPs with costs of issuance information for all service providers (1) seven days prior to use of RFPs; (2) submit the final bids received for bond counsel, financial advisor, and underwriter and other service providers, and (3) submit final documents with the basis for selection within seven days. Amending this process would give the agency a better understanding of the ongoing needs of state issuers and information on a process that has a key connection to the cost of issuance for each bond issue. These changes would also allow BRB the opportunity to provide feedback as the issuers goes through the bidding and selection process.

USE OF SWAP AGREEMENTS

Interest-rate swaps, commonly called swaps, are a financing tool used to reduce interest expense and hedge against interest rate, tax, basis, and other risks. Swaps can provide issuers with greater financial flexibility and do not constitute additional debt.

Though any state issuer is eligible to enter into swap agreements, only three agencies currently have them in place: the Veteran's Land Board (VLB), the Texas Department of Housing and Community Affairs (TDHCA), and the University of Texas System. At the end of fiscal year 2005, VLB had 40 swap agreements on 43 bond issues. The TDHCA has swap agreements on three bond issues and the University of Texas System has swap agreements on two bond issues.

Swaps can provide financial benefits to the state in the form of cost savings, but these benefits come with risks. Risks associated with swap agreements can be mitigated by strategies employed by the issuer. Texas Government Code §1371.056 authorizes state issuers to enter into credit agreements. Swaps entered into under this statutory authority require BRB approval of the bond transaction prior to entering into the agreement, which was altered by statutory change in 1999. However, the VLB and the TDHCA have additional broad authority to enter into swaps under the Texas Natural Resources Code §161.074, 162.052, and 164.010 and Texas Government Code §2306.351. The Veteran's Land Board first received permission to use swaps in 1994 and removed itself from BRB oversight through statutory change in 2001. The broad authority given to the VLB does not require approval from the BRB prior to entering into swap agreements.

Despite having limited separate statutory authority in Texas Government Code §2305.351 for swap agreements, TDHCA has always obtained BRB approval prior to swap agreement implementation. The VLB uses forward swaps, which require the issuer to enter into a swap agreement prior to issuance of the associated bonds. Consequently, when the BRB staff reviews the bond transaction, the swap agreement is already in place. Though the agency does not have concerns about the quality of the swap programs these agencies have in place, swaps are complex financial tools that carry some risks to the issuer. Other states surveyed, including California and Oklahoma, require the bond oversight agency to approve swap agreements prior to the issuer finalizing agreements.

Recommendation 7 would amend Texas Government Code, Chapter 1231 to require BRB to approve all interest rate swap agreements before an issuer enters into an agreement. It would also amend Texas Natural Resources Code §161.074, 162.052, and 164.010 as well as Texas Government Code §2306.351 to require the Bond Review Board to approve swap agreements prior to the VLB and the TDHCA entering into such agreements. If BRB staff approves swap agreements prior to the issuer entering into the agreement, the process will ensure appropriate oversight. Though swap agreements are not considered a state debt obligation, they have an important relationship with the bond issues that BRB staff approves and ultimately affect the cost of issuance because swaps can save or cost the issuer money.

CONTINGENCY RIDER

To implement Recommendations 1, 2, and 4, which would require additional resources for the BRB, the following Texas Bond Review Board contingency rider could be included in the 2008–09 General Appropriations Bill:

> **Contingency Appropriation for Resources to Enhance State Debt Management.**
> Contingent on the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation relating to expanding the responsibilities of the Texas Bond Review Board to include the Debt Affordability Study, debt management committee coordination, and capital planning integration and project prioritization, in addition to the amounts above, the Texas Bond Review Board is appropriated an amount not to exceed $66,459 for fiscal year 2008 and $66,459 in General Revenue Funds for fiscal year 2009.

FISCAL IMPACT OF THE RECOMMENDATIONS

The net fiscal impact as a result of these recommendations is a cost of $132,919 in General Revenue Funds for the 2008–09 biennium.

Recommendations 1, 2, and 4, would require additional resources for BRB at a cost of $132,919 in General Revenue Funds for the 2008–09 biennium. Recommendation 3 has no significant fiscal impact. Recommendations 5, 6, and 7 may provide long-term savings to the state due to improved oversight of cost of issuance and related items, but these savings cannot be estimated. **Figure 7** shows this fiscal impact.

FIGURE 7
FIVE-YEAR FISCAL IMPACT

FISCAL YEAR	PROBABLE SAVINGS/(COST) GENERAL REVENUE FUNDS
2008	($66,459)
2009	($66,459)
2010	($66,459)
2011	($66,459)
2012	($66,459)

SOURCE: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill does not address Recommendations 1 to 7.

ESTABLISH A CENTRALIZED THIRD-PARTY DEBT COLLECTION CONTRACT

Texas state agencies currently designate outstanding debt as collectible or uncollectible according to rules proscribed by the Office of the Attorney General. Upon referral from state agencies, the Bankruptcy and Collections Division of the Office of the Attorney General pursues debts deemed collectible. However, state agencies with a third-party debt collection contract may pursue delinquent debts that would otherwise be designated as uncollectible. Only two state agencies and 17 institutions of higher education have such debt collection contracts. In fiscal year 2004, the Office of the Attorney General reported an aggregate $1.8 billion in uncollectible debt for the state.

The state could realize additional revenue by establishing a centralized contract with a third-party debt collection vendor to collect certain debts currently deemed uncollectible. According to the Office of the Attorney General, reported uncollectible debts include any debt below an agency-specific dollar threshold or beyond an agency-specific time threshold. By pursuing these debts through a debt collection vendor, the state could have a revenue gain of $2.8 million in All Funds in the 2008–09 biennium.

FACTS AND FINDINGS

- ♦ Most institutions of higher education have third-party collection contracts approved by the Office of the Attorney General to assist them in collecting delinquent accounts.
- ♦ The Texas Comptroller of Public Accounts has independent authority to pursue uncollectible tax debt through a debt collection vendor, and the Texas Commission on Environmental Quality is the only state agency that has a third-party collection contract approved by the Office of the Attorney General.

CONCERNS

- ♦ The state of Texas is losing potential revenue by not expanding the use of third-party debt collection.
- ♦ State agencies do not pursue debts classified as uncollectible. If a third-party vendor were to collect those debts, under current law, agencies would be able to expend these funds, despite having made no additional effort to recover them.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code Chapters 2107 and 2254 to require the Office of the Attorney General's Bankruptcy and Collections Division to pursue debts currently considered uncollectible by creating a centralized contract for debt collection vendors.
- ♦ **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill to authorize state agencies to compensate a debt collection vendor for its services, but prohibit agencies from expending the remainder of these funds.

DISCUSSION

Texas state law requires each state agency and institution of higher education to submit an Annual Debt Report to the Office of the Attorney General (OAG) summarizing its debt. For fiscal year 2004, the OAG reported $2.7 billion in aggregate collectible debt and $1.8 billion in aggregate uncollectible debt for the state. Because of an internal agency review of the debt reporting process, the OAG did not prepare a report for fiscal year 2005.

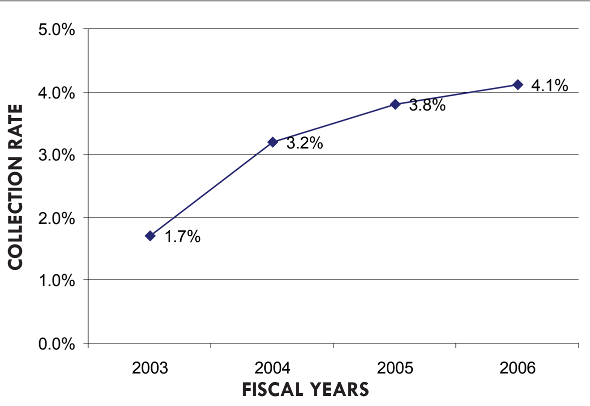
Each agency determines whether a debt is collectible with guidance from Texas Administrative Code §59.2 and §59.3. These rules are promulgated by the OAG to specify certain criteria agencies should consider when determining if a debt is collectible. These criteria include (1) if the debtor is in bankruptcy, (2) if the debtors' corporation has been dissolved, or (3) if the debtor is located out-of-state or deceased.

Collectible debts are those debts that meet the above criteria and agency-specific thresholds set by the OAG based on internal efficiency analysis of the age and amount of the debt. For instance, the OAG may set an agency's threshold at debts above $1,000 and delinquent for less than 18 months. If the agency has no reason to presume that the debtor is bankrupt, dissolved, relocated, or deceased, and the debt meets this threshold, the agency reports this debt as collectible and, upon referral, the Bankruptcy and Collections Division pursues the debt. If the agency finds proof of the debtor's insolvency or if the debt does not meet the OAG's threshold, the agency reports that debt as uncollectible and there are no additional efforts to collect the debt.

Government Code §2107.003 requires a state agency or institution of higher education to request that the OAG collect a debt before the agency may contract to collect the debt. The statute further allows the OAG to authorize the requesting agency to contract for the collections of a debt that the OAG cannot collect. In fiscal year 2006, two state agencies and 17 institutions of higher education or their components contracted for debt collection services.

The Comptroller of Public Accounts (CPA) has express statutory authority to contract with a debt collection vendor. The CPA out-sources to a private debt collection vendor those non-franchise tax accounts below $500 and franchise tax accounts below $2,500 that are at least 64 days past due. The CPA refers debt amounts higher than this threshold to the OAG for further collection efforts. The comptroller's contract agreement compensates the private debt collection vendor with 14.9 percent of the amount collected. As **Figure 1** shows, the CPA contractor's average monthly collection rate increased to 4.1 percent of average available debt in fiscal year 2006.

FIGURE 1
COMPTROLLER OF PUBLIC ACCOUNTS COLLECTION RATE
FISCAL YEARS 2003 THROUGH 2006



SOURCE: Comptroller of Public Accounts.

The Texas Commission on Environmental Quality (TCEQ) is the only state agency approved by the OAG to contract with a private debt collection vendor to collect past due administrative fines and fees. TCEQ entered into its contract in November 2004. The debt collection vendor receives 4 percent of the collected amounts as payment. Since the inception of its contract, TCEQ referred 49 percent of its debt that was below the OAG threshold and would have otherwise been reported as uncollectible to its debt collection vendor. The agency collected 27 percent, or 13 percent of total debts.

Seventeen institutions of higher education or their components contract with private debt collection vendors. The contract rates vary from 15 percent to 40 percent and the types of debt range from medical accounts at the health and science centers to unpaid student loans, tuition, and fees.

Debt collection industry standards suggest that earlier collection efforts could improve collection rates. Based on a survey conducted by the Commercial Collection Agency Association, the probability of collecting a delinquent account after:

- three months is 69.6 percent;
- six months is 52.1 percent; and
- one year is 22.8 percent.

Recommendation 1 would amend Chapters 2107 and 2254 of the Texas Government Code to require the OAG to contract for third-party collection of agency delinquencies that are categorized as uncollectible and to refer any uncollectible debt to the third-party vendor. This language should permit agencies with active contracts to continue their collection efforts if their collection rates are higher and payment to the contractor is lower than the rates established in the OAG contract.

House Bill 2233, Seventy-ninth Legislature, Regular Session, 2005, included language in the Second House Committee Substitute that would have amended statute to permit such third-party collection for debts delinquent beyond 120 days. Setting the threshold on delinquent debts at 64 or 90 days would likely improve the collection efforts of debt collection vendor. The bill would have also set the maximum payment rate for the debt collection vendor much higher than currently negotiated rates.

Recommendation 2 would include a rider in Article IX of the 2008–09 General Appropriations Bill to authorize state agencies to compensate a debt collection vendor. Without this rider, the agency may not have the authority to pay the vendor. The rider would permit agencies to expend funds within their appropriation authority when collected by the third-party vendor. Otherwise, funds would be deposited to the General Revenue Fund or to the appropriate dedicated or special fund or account. The rider makes no new appropriations, but does not preclude agencies from

exercising existing appropriation authority. The rider would appear as follows:

> **Debt Collections.** Contingent upon the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, and to the extent that a state agency contracts with one or more persons to collect delinquent or past due obligations in accordance with Section 2107.003, Texas Government Code, as amended, all proceeds from overdue and delinquent obligations collected by a contractor working on behalf of the agency to collect such funds are hereby appropriated to the agency from the collection proceeds. This appropriation shall be limited to the amount necessary to pay the contractor collecting such fees for its services and shall not exceed (a specified percent) of fine and fee proceeds collected by the contractor. All other amounts collected shall be deposited to the General Revenue Fund or to any dedicated or special funds or accounts to which the collection proceeds may belong, based on the applicable statutory provisions, and are only appropriated for use by the agency if they have current appropriation authority.

FISCAL IMPACT OF THE RECOMMENDATION

The recommendations would lead to an estimated revenue gain of $2.4 million in General Revenue Funds and General Revenue–Dedicated Funds for the 2008–09 biennium.

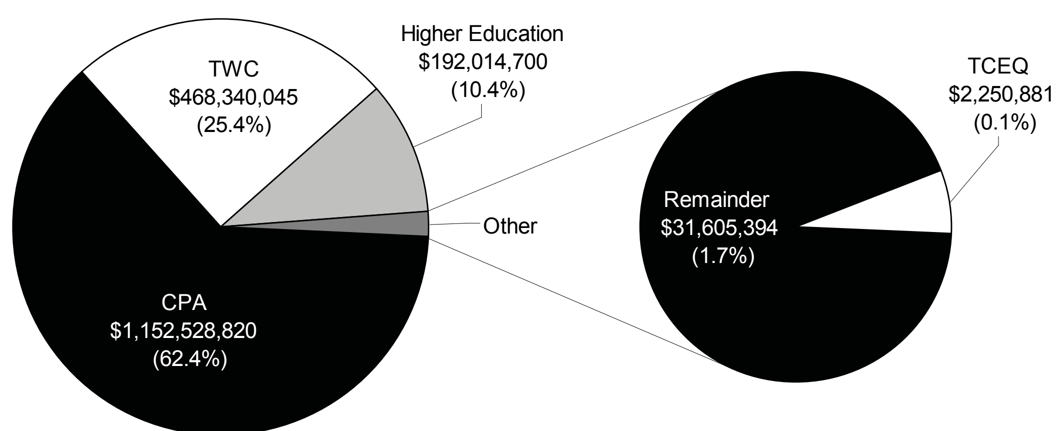
As **Figure 2** shows, of the $1.8 billion in reported uncollectible debt in fiscal year 2004, approximately 98 percent is either currently being pursued or is governed by federal legislation. $1.2 billion, or 62.4 percent, is tax debt reported by the Comptroller of Public Accounts (CPA). As mentioned above, the CPA is already pursuing this debt with a debt collection vendor. Another $470 million, or 25.3 percent, is uncollectible debt reported by the Texas Workforce Commission, which operates under federal statute to pursue and report uncollectible debt. Institutions of Higher Education pursued $190 million, or 10.4 percent, of the uncollectible debt. Another small fraction is covered under the Texas Commission on Environmental Quality's (TCEQ) current debt collection contract. After subtracting out the above, the remaining uncollectible debt reported for fiscal year 2004 is $31.6 million.

The growth rate for uncollectible debts fluctuated between minus 8 percent and nearly 200 percent for fiscal years 2000 through 2004. Disregarding outliers, the average growth rate for this period was 8.8 percent.

Although TCEQ has a 27 percent collection rate, the CPA's maximum collection rate is about 4 percent. To keep the estimate conservative, the fiscal impact assumes a 4 percent collection rate, an 8.8 percent annual growth in uncollectible debts, and a 15 percent compensation rate to the vendor out of the funds it collects. As shown in **Figure 3**, the recommendations would lead to an estimated revenue gain of $2.8 million in All Funds in the 2008–09 biennium.

The introduced General Appropriations Bill for the 2008–09 biennium does not address these recommendations.

FIGURE 2
UNCOLLECTIBLE DEBT IN 2004



SOURCE: Office of the Attorney General.

FIGURE 3
ESTIMATED IMPACT TO ALL FUNDS

FISCAL YEAR	NET REVENUE GAIN (LOSS) TO GENERAL REVENUE FUND	NET REVENUE GAIN (LOSS) TO GENERAL REVENUE–DEDICATED FUNDS	NET REVENUE GAIN (LOSS) TO OTHER FUNDS
2008	$480,000	$680,000	$180,000
2009	$520,000	$740,000	$200,000
2010	$560,000	$810,000	$220,000
2011	$610,000	$880,000	$240,000
2012	$670,000	$960,000	$260,000

SOURCE: Legislative Budget Board.

CREATE A CENTRALIZED OFFICE OF HUMAN RESOURCE MANAGEMENT

State employees are a large investment and valuable resource for the agencies they serve. Texas has 331,286 full and part-time employees statewide and spent $13 billion on salary and benefits in fiscal year 2006. The state of Texas does not have a single agency dedicated to oversee human resource functions, create policy, and manage the state's workforce. Currently, each state agency interprets state laws regarding workforce management, creating an environment in which state employees can be held to varying, often inconsistent, standards. Oversight agencies, including the State Auditor's Office and the Comptroller of Public Accounts, have enforcement authority over a portion of the laws that govern workforce management in Texas. However, human resource functions are not wholly evaluated or audited.

A single statewide Office of Human Resource Management focused on oversight, policy making, and strategic planning would provide support for current employees and attract qualified individuals to public service. Centralized oversight of human resource functions would allow the state to expand workforce practices that are being successfully implemented at some agencies, without limiting flexibility within an agency. Small agencies unable to staff a human resources professional would benefit from the human resources expertise and policy direction of a central office. By implementing a centralized Office of Human Resource Management, the state could retain qualified employees and avoid future costs by streamlining human resource oversight and decreasing employee turnover and litigation.

CONCERNS

- ♦ Employees at some small state agencies do not have a human resources professional on staff to assist them in understanding and making benefit decisions.
- ♦ Each state agency is allowed to interpret state laws regarding workforce management, creating an environment in which state employees can be held to varying standards.
- ♦ Various agencies identify workforce initiatives for the Legislature to evaluate, but there is no regular or comprehensive review of state employee workforce policies and practices.
- ♦ In more than half the states, one in five employees will retire in the next five years. For Texas to successfully staff state agencies it must consider implementing workforce policies that will attract qualified employees to public service.
- ♦ Some agencies do not have the appropriate number of human resource staff to manage its workforce.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Chapter 301, Texas Labor Code to create a statewide Office of Human Resource Management as a division of the Texas Workforce Commission.
- ♦ **Recommendation 2:** Amend Chapter 301, Texas Labor Code to require the Office of Human Resource Management to create a uniform state employee handbook that allows necessary flexibility while ensuring all state employees are treated fairly and consistently.
- ♦ **Recommendation 3:** Amend Chapter 301, Texas Labor Code to require the Office of Human Resource Management to study opportunities to strategically consolidate human resource administration.
- ♦ **Recommendation 4:** Amend Chapter 670, Texas Government Code to repeal the cap on human resource staff at state agencies, currently one human resources employee for every 85 agency employees.

DISCUSSION

Human resource management (HRM) is the deliberate approach an organization takes to manage its relationship with its employees. HRM emphasizes that employees are critical to achieving a competitive advantage and that corporate strategy and human resources practices are integrated. Human Resource professionals help organizations meet efficiency and equality objectives. HRM employs one of two philosophies: either focusing on controlling employees, or recognizing the needs of employees and their importance to the organization's success.

In the private sector, the quality of the workforce directly affects a company's success in the market place, and therefore its profit potential. The public sector is interested in effective

workforce management because successfully providing programs and services to the public are dependent upon maintaining employee motivation, skill sets, and customer service focus. An organization's approach to workforce management should ensure its relationship with its employees and its employment practices are aligned.

As baby boomers, Americans born between 1946 and 1964, reach retirement age in greater numbers, the demographics of the state's workforce will change. For Texas to attract and retain the next generation of workers to state employment, the work environment and employment practices must align with the preferences of younger workers. Employees seek employers who offer high pay, comprehensive benefits packages, a positive work environment, and the opportunity to demonstrate their strengths. According to a national survey conducted by Great Places to Work Institute and Fortune Magazine, the 100 best companies to work for in 2006 included companies that provided employees balance between their work and personal lives. Policies that allow employees to work from home, work alternative schedules, or share a job with someone who works part-time were highlighted in the results of the survey.

The state of Texas does not have a single agency dedicated to human resource functions, creating policy, and managing the state's workforce. According to the National Association of State Personnel Executives, an affiliate organization of the Council of State Governments, Texas has the most decentralized approach to human resource management of any state government. Texas has a human resource office in every state agency and does not have a state office that serves as a point of contact for agencies or current and prospective employees with regard to workforce issues.

The Texas Legislature develops and passes general laws to govern specific components of HRM throughout the state. The State Auditor's Office (SAO), the Comptroller of Public Accounts, the Employees Retirement System, the State Office of Risk Management, and the Texas Workforce Commission's Division of Human Rights each have rulemaking and enforcement authority over a portion of the laws that govern workforce management in Texas. Some HRM functions are periodically audited while others are not. Each state agency has the authority to interpret state laws regarding workforce management, creating an environment in which state employees are held to varying, often inconsistent, standards.

This decentralized approach to workforce management lacks coordinated guidance and enforcement required to ensure policies are consistently interpreted and applied. Instead of the state being one employer, it is broken into 184 individual human resource offices across the state with varying approaches to HRM. For example, an audit of workforce management at the Texas Lottery Commission found that agency employees would benefit from an employee ombudsman to serve as a credible objective party available to review grievances and policy decisions. Such a function allows an agency to quickly learn about employee concerns and resolve issues before it is faced with potentially costly litigation. In contrast, the Texas Department of Insurance has maintained an ombudsman program since 1994. The program allows employees to resolve complaints within the agency hierarchy, improving communication and reducing the number of formal complaints received. With a central human resources office, best practices like the ombudsman program that benefit one agency could be efficiently implemented at other agencies to benefit the entire state workforce.

The Government Performance Project states that Georgia may have the best-managed human resources operation in the country. Georgia uses a hybrid approach to oversee the human resource function. With a hybrid approach, each state agency has a human resources office that performs daily human resource duties and payroll transactions and a single human resource oversight agency to coordinate strategic workforce initiatives, policymaking, and enforcement. A state's central HRM oversight may be a stand alone agency or may be part of a state's Department of Management or Department of Administration. These entities provide comprehensive human resource services to all agencies and employees within their respective states. They are also the central point of contact for individuals interested in a career in state government. Day to day activities, such as processing newly hired staff, terminating employees, managing employee records, and processing salary actions, are managed by the human resources office within each state agency.

STATEWIDE HUMAN RESOURCE MANAGEMENT

Centralized human resource functions in Texas would improve oversight, policy making, and strategic planning. It would highlight workforce management as a statewide priority, enforce the consistent application of approved policies, and share workforce best practices without limiting flexibility within an agency. A single Office of Human Resource Management (OHRM) could oversee the state's workforce initiatives because effective human resources management is the same regardless of business type or agency

mission. Recommendation 1 would amend Chapter 301 of the Texas Labor Code to create the Office of Human Resource Management within the Texas Workforce Commission. This agency would be staffed with human resource professionals who would develop policy, provide guidance, and enforce state laws regarding human resource functions. Having a centralized statewide human resources office would ensure the state's current human resource laws and best practices are applied consistently to the benefit of state employees and agencies. The office would perform the following duties:

- Interpret human resource laws and rules
- Communicate legislative changes affecting state employees
- Implement strategic initiatives to improve workforce management
- Conduct studies of current workforce issues
- Establish best practices
- Conduct employee surveys to identify opportunities for improvement
- Coordinate audits of the human resources function

The OHRM would be responsible for coordinating the independent activities of multiple agencies. For example, the SAO maintains an electronic exit survey system and reports the results to agencies. State agency human resource staff are expected to direct terminating employees to take the exit survey. Created in 2001, the survey system helps the state identify why individuals leave state employment. During fiscal year 2005, only 4,053 of the 26,884 employees leaving state employment responded to the exit survey. The reason for the low participation rate is uncertain. Also, there is not a mechanism to verify whether a state agency evaluates the results or takes action based on the feedback. As part of its duties, OHRM would identify ways to increase participation in the survey in an effort to discover ways to reduce the rate of turnover among state employees.

OHRM would also approach workforce management strategically to identify opportunities to make the state a more attractive employer, by developing policies and practices designed to attract and retain employees. Recommendation 1 would require OHRM to evaluate the application of human resources at state agencies, including a comparison of varying recruitment, workforce planning, performance management, employee development, and retention efforts to identify best practices for statewide implementation.

Both employees and employers benefit when employees understand their total compensation packages. Employees prefer to work for employers with rich employment benefit packages but must understand the programs offered by an employer to appreciate them. The OHRM would promote the state's total compensation packages and expand existing programs to attract individuals to state employment. In fiscal year 2005, the average state employee salary was $32,848 not including the cost of non-salary benefits. Texas offers a comprehensive benefits package that includes health coverage, paid leave, longevity and merit pay, and a retirement plan. The total average compensation package was worth $48,761 in 2005. With clear communication of the state's complete benefits package to individuals seeking employment, agencies could attract more people to state employment.

Finally, the OHRM would evaluate current programs that could be expanded to benefit the state's workforce. For example, the Texas Department of Transportation (TXDOT) implemented a Rapid Hire program allowing the agency to hire college graduates and interns on the spot for high need positions such as civil engineers. In fiscal year 2006, TXDOT hired 571 of its 1,246 new employees through the Rapid Hire program. Other agencies experiencing workforce shortages may benefit from the same authority to recruit employees in high need areas.

BEST PRACTICES AND WORKFORCE POLICIES

Currently, each state agency independently interprets state employee legislation and publishes an employee policy manual. As part of the initiative to improve state workforce management, OHRM would create a single state employee manual providing consistent interpretations of state employment policies to all agencies. Recommendation 2 would amend Chapter 301 of the Texas Labor Code to require OHRM to create a single state employee handbook that allows agencies the flexibility necessary to manage its workforce and meet its goals and objectives while ensuring all state employees are treated fairly and consistently.

As part of its duties, the agency would evaluate existing state employment policies and practices to identify areas of improvement or options to increase the total compensation packages offered to state employees. OHRM would review current law and make recommendations to the Legislature biennially to improve the state's ability to attract and retain employees. In the past, the State Classification Office or other state agency groups have put forth various workforce initiatives for consideration by the legislature. **Figure 1** shows

FIGURE 1
EXAMPLES OF WORKFORCE TOPIC FOR EVALUATION BY THE OFFICE OF HUMAN RESOURCE MANAGEMENT

Workforce Issues 1. Telework

Background: The private sector uses remote working arrangements and telecommuting. With innovative technology available, agencies could maximize the use of employees by permitting them to work from home and accrue compensatory time for working hours other than their normal work schedule. Other benefits include reduced travel costs, lease expenses, and traffic congestion.

Impact: Currently, IT staff are required to come into the office on the weekends or during an emergency to address technical problems. Most IT staff could correct these problems by working from their homes, but to receive credit for their work time, they are required to drive to the office to correct the problem.

Improvement: Allow state employees who receive prior written authorization from the administrative head of the employing state agency to accrue state compensatory time for work conducted at the employee's personal residence.

Workforce Issue 2: Compensatory Time

Background: State employees can accrue state compensatory time balances but may be unable to use the time before transferring to another state agency due to workload requirements. The ability to transfer state compensatory time among agencies offers more flexibility in the use of time earned by employees.

Impact: Employees who have accrued a large balance of compensatory time may be unwilling to accept a position with another state agency because they would lose accrued time-off that they cannot be paid for or use before terminating.

Improvement: Allow for the transfer of state compensatory time from one state agency to another, if the administrative head of the hiring agency approves.

Workforce Issue 3: Holiday Pay for weekend schedules

Background: General state employees do not receive paid time off for holidays that fall on the weekend. In 2003, the holiday provisions were expanded to allow a commissioned peace officer or an employee who performs communication services related to traffic law enforcement to earn holiday compensatory time when required to work on a holiday that falls on a Saturday or Sunday.

Impact: The expansion in the law increased number of holidays to portion of the employees who work on the weekend. However, other state agencies have employees who work weekend schedules, but are not entitled to observe weekend holidays.

Improvement: Allow any state employee whose regular schedule requires them to work on the weekend to earn holiday compensatory if the employee works a holiday.

Workforce Issue 4: Federal Holiday Schedule

Background: The state observes nine national holidays; however, four of those sometimes fall on the weekend. These holidays are New Year's Day, the Fourth of July, Veterans Day, and Christmas Day. Since 2004, one or two of those federal holidays has fallen on a weekend day. Federal employees observe those holidays that fall on the weekend on the Friday before the holiday or the Monday after, but state employees are not allowed this benefit.

Impact: Schools and other businesses observe these holidays causing problems for parents who must take a vacation day or find care for dependents. Observing these holidays is a low-cost option to increase benefits to employees.

Improvement: Allow state employees to observe a national holiday that falls on the weekend on the Friday before the holiday or the Monday after the holiday in the same manner as federal government employees and other private institutions.

Workforce Issue 5: Alternative work schedule

Background: Some employees would benefit from working an alternative work schedule. A flexible schedule may be a compressed work week, such as a 10-hour schedule four times a week or a 32 hour work week. Currently, if an employee works less than 40 hours per week the employee loses longevity pay and state health benefits.

Impact: The State Auditor's Office reports that turnover is highest among employees under age 30 years and those who have worked for the state for 2 years or less. Turnover may be highest for this group because the state does not offer the flexibility workers with young families prefer.

Improvement: Allow employees to work a 32-hour work week and still be eligible for longevity pay and 100 percent payment for the member only health insurance premiums.

Sources: Legislative Budget Board; State Auditor's Office.

the workforce initiatives that the Legislature could address. These are typical human resource issues that require thorough review. The office's staff would research these issues and make recommendations as appropriate. As an employer, the state could benefit from flexibility in these areas allowing more progressive work practices and increased state employee job satisfaction.

STREAMLINING THE HUMAN RESOURCE FUNCTION

State agencies, other than health and human service agencies, use a variety of software programs to manage their workforce. Payroll information resides in one of the state's three payroll and personnel systems maintained by the Comptroller of Public Accounts. Health benefit information is kept updated through the Employee Retirement System's online data management application and other data is maintained

independently at each agency in one of a variety of internal software programs.

To increase efficiency, the Health and Human Services Commission consolidated enterprise administrative services and purchased "accessHR," a self-service human resources and payroll computer application. The accessHR application automates traditionally paper-based processes, a change popular with private sector employers. According to a recent survey, 91 percent of private companies use the Internet to communicate human resource policies to employees and 48 percent allow employees to manage benefits and training activities online.

Self-service HRM provides a number of benefits, including:

- decreases agency dependence on paperwork processes;
- increases data accuracy;
- simplifies the human resources process; and
- empowers employees with direct ownership of their benefits package

Self-service HRM permits employees to print earning statements, verify sick leave or vacation balances, and review benefits online. An employee can update personal information on-line and the agency's human resources office is automatically notified. The employee's action initiates the change in the system making the update immediate and more accurate than entering the change manually from a paper form or an email message. Self-service HRM benefits managers by making quality and timely data available up-to-the-minute allowing managers to more effectively manage overtime costs, vacation and sick leave balances, and performance issues.

Self-service HRM tools provide employers with increased ability to track employee data related to federal policies, such as the Family Medical Leave Act and the Fair Labor Standards Act, to ensure employee issues are handled properly and in a timely fashion, limiting possible legal and financial liabilities. Instead of data entry activities, human resource professionals are free to focus on reducing turnover and improving the skill sets of the organization's workforce. With human resources staff focused on strategic planning activities, an employer is more prepared to deliver services and improve programs.

Organizations choose self-service HRM because it reduces costs by automating processes and allowing reductions in the size of human resource departments. Without self-service HRM, information is produced by human resources staff and hand-delivered to an employee or sent by mail. This inefficient process is typical of how state agencies distribute earning statements and W-2 forms. A process that could take a few seconds online, now takes several days. Instead of salaried staff answering routine phone calls, employees and managers access accurate information online 24 hours a day.

Simple changes in routine processes, such as offering electronic pay stubs and change of address forms also reduce costs. After implementing self-service HRM, one employer using the PeopleSoft system reported the cost of processing a change of address for an employee dropped from approximately $10 per transaction to $0.25. The employer realized the savings as a result of decreased processing time and fewer employees handling paper work.

Consolidating operations prepares agencies for contracting or outsourcing on a larger scale. Towers and Perrin, an e-HR professional services firm, suggests that employers streamline human resource processes before considering purchasing new technology to improve services. A consolidated model would open the door for self-service human resource tools to replace manual processes in the future. Recommendation 3 would amend Chapter 301, Texas Labor Code to require the Office of Human Resource Management to study opportunities to strategically consolidate human resource administration. Two additional full-time staff would be assigned to OHRM in the 2008-09 biennium to conduct the study and report on option to improve services and efficiency.

Consolidation may include administratively attaching the HRM functions of a small agency to larger agencies that are similarly situated either by location or function. By law, some agencies and government entities are already administratively attached to larger agencies, including;

- the State Office of Risk Management, tied to the Office of the Attorney General;
- the Court Reporter Certification Board, tied to the Office of Court Administration; and
- the Office of Injured Employee Council, tied to the Texas Workers Compensation Commission.

The Office of Rural and Community Affairs is directed by statute to contract for administrative services and does with the Water Development Board, another agency in the same office building. Office of Rural and Community Affairs purchases human resource services from the Water Development Board through interagency contract at less

than half the cost of one full-time human resources specialist.

Consolidation is the first step toward successful outsourcing. However, if the state were to outsource the human resources functions at small agencies as currently organized, there would be little savings from staffing reductions, because small agencies seldom have full-time dedicated human resource professionals. In December 2004, the State Council on Competitive Government reviewed the possibility of consolidating human resource functions at 62 agencies with less than 500 employees. The Council estimated the state would save $243,408 by consolidating human resource functions and reducing 12.5 staff at small and medium size agencies.

Currently, if Texas implemented a self-service HRM tool statewide or outsourced human resources, the state would not have sufficient staff to focus on strategic initiatives, such as workforce planning and benefit consulting. By creating OHRM, the state would be in a better position to further optimize the human resources function through technology improvements and contracting opportunities.

As part of the requirement in Recommendation 3, OHRM would study consolidation options and report to the Legislative Budget Board and the Governor on the following issues:

- The benefit of consolidating the human resources function at similarly situated agencies, defined by either location or function, with a focus on enhancing consistency and efficiency.
- The costs and benefits of consolidation versus outsourcing at each agency's human resource functions.
- The costs and benefits of expanding use of the Health and Human Services self-service tool, accessHR.
- The value of administratively attaching, contracting, or outsourcing each agency's human resources function to improve state operations.

HUMAN RESOURCE STAFFING RATIO

The number of human resource professionals an agency needs to achieve its mission varies due to a number of variables including, an agency's size, location, and turnover rate. State agencies are limited to one human resources employee for every 85 agency staff members. The ratio was intended to align state human resource staffing ratios with national averages. Because state agencies vary from other types of employers and each other, this standard may not be appropriate for every agency. The ratio does not consider each agency's duties and responsibilities, level of automation, or other factors that affect an agency's workload.

Twenty-six state agencies staffed and managed more than 500 employees during fiscal year 2006. With an average turnover rate of 16 percent, large agencies are required to post positions, interview, hire, and train new employees regularly. At very large agencies, such as the Texas Department of Transportation or the Department of Aging and Disability Services, those tasks occur simultaneously at multiple offices across the state. Smaller agencies with fewer employees have fewer human resource duties to attend to on a regular basis.

Each agency is allotted a certain number of employees in the General Appropriation Act (GAA). Beyond the GAA cap, an agency may choose the number of employees it needs to staff a particular function or program based on its mission, budget, and other resources. However, the law limits the number of human resource employees an agency may have, but does not set similar detailed limits for other agency functions or program areas, such as information technology or support staff. Recommendation 4 would amend Chapter 670 of the Texas Government Code to repeal the limit on human resources staffing, from the current cap of one human resources employee for every 85 agency staff members. Removing the human resources staffing ratio would allow individual agencies to employ the appropriate number of human resources staff.

FISCAL IMPACT OF THE RECOMMENDATIONS

As shown in **Figure 2**, Recommendations 1 through 4 would result in a net cost of $741,000 in General Revenue Funds during the 2008–09 biennium.

FIGURE 2
FIVE-YEAR FISCAL IMPACT OF CREATING AN OFFICE OF HUMAN RESOURCE MANAGEMENT

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS	PROBABLE ADDITION/ (REDUCTION) OF FULL-TIME EQUIVALENTS
2008	($247,000)	9
2009	($494,000)	9
2010	($385,000)	7
2011	($385,000)	7
2012	($385,000)	7

Source: Legislative Budget Board.

Recommendation 1 would result in costs of $741,000 in General Revenue Funds during the 2008–09 biennium due to the creation of the Office of Human Resource Management. The costs are required for implementation and the additional nine full-time equivalent positions (FTEs) in the human resources occupational category. After the completion of a study of human resource consolidation required by recommendation 3, the agency would reduce staffing levels by two FTEs. Base-level program costs are reduced in the first year to reflect the time necessary to fully organize and staff OHRM.

Recommendations 2, 3, and 4 would have no fiscal impact during the 2008–09 biennium. However, centralizing human resource management could avoid future costs by improving human resource oversight resulting in decreased turnover and litigation.

The introduced 2008–09 General Appropriations Bill does not address these recommendations.

IMPACT OF THE FEDERAL DEFICIT REDUCTION ACT ON THE TEXAS CHILD SUPPORT ENFORCEMENT PROGRAM

The federal Deficit Reduction Act of 2005 changed several provisions affecting the Child Support Enforcement program at the Texas Office of the Attorney General. These provisions include prohibiting states from using federal child support enforcement incentive payments to "draw down" matching Federal Funds, reducing the federal match rate for paternity testing, requiring states to collect a new fee for child support enforcement activities, and offering states options regarding the distribution of child support collections. The Office of the Attorney General is requesting additional General Revenue Funds in the 2008–09 biennium to address these changes in Texas' Child Support Enforcement program. According to the Attorney General, without additional appropriations of General Revenue Funds, families will receive less in child support payments, and the state will collect less in repayments for families in the Temporary Assistance for Needy Families program, which provides cash assistance for low-income families.

CONCERNS

- Beginning October 1, 2007, the federal government will no longer allow states to use federal incentive payments as the state's share to draw down federal matching funds.
- Beginning October 1, 2006, the federal match rate for paternity testing decreased from 90 percent to 66 percent.
- The Texas Office of the Attorney General is requesting $55.4 million in General Revenue Funds to replace the loss of matching funds for the two provisions above, in order to "draw down" $107.5 million in Federal Funds that would not be obtained otherwise. Without the additional appropriations of General Revenue Funds, the total effect of these federal Deficit Reduction Act provisions will mean a loss of $162.9 million to Texas for the 2008–09 biennium.
- Beginning in fiscal year 2008, states must collect annual fees for assisting families in securing child support. Families who have received Temporary Assistance for Needy Families or who receive less than $500 in child support collections are exempt from paying fees. States have the option of (1) retaining fees from collected support; (2) charging the individuals applying for services; (3) recovering fees from noncustodial parents; or (4) paying fees with state funds.
- Under Texas law, the Office of the Attorney General may impose a $25 annual service fee, which is deducted from support payments. However, the agency has not initiated collection of the fees. For the 2008–09 biennium, the agency requested $11.5 million in General Revenue Funds to pay the fees that the federal government now requires.
- Without additional funding to address these issues, the Texas Office of the Attorney General estimates $1.6 billion less in child support would be collected for Texas families over the 2008–09 biennium.
- The federal Deficit Reduction Act provides options for states to pass through a portion of child support collections to current and former TANF recipients, with the federal government waiving the requirement to return its share of the collections. There are multiple ways to exercise the options, some with positive or neutral effects on the state budget, others with negative effects on the state budget.

RECOMMENDATIONS

- **Recommendation 1:** Increase appropriations of General Revenue Funds for child support enforcement by $66.9 million for the 2008–09 biennium to: (1) replace the loss of incentive payments as state match; (2) address the lower match rate for paternity testing; (3) and pay the federal share of the $25 fee for child support collections (drawing down a total of $129.8 million in Federal Funds).
- **Recommendation 2:** Require the Health and Human Services Commission and the Texas Office of the Attorney General to use child support collections no longer required to be returned to the federal government as part of funds passed through to current recipients of Temporary Assistance for Needy Families.

DISCUSSION

The federal Deficit Reduction Act (DRA) of 2005 contains provisions that affect the state's Child Support Enforcement

(CSE) program. These include prohibiting states from using federal incentive payments as state match to "draw down" Federal Funds, reducing the federal match for paternity testing, requiring states to collect a new fee for collecting child support, modifying child support distribution practices, and making other procedural changes to the program. Based on information from the Texas Office of the Attorney General (OAG), without additional funding to address these issues an estimated $1.6 billion less in child support would be collected for Texas families in the 2008–09 biennium.

The OAG administers the state's CSE program in Texas, authorized under Title IV, Part D of the Social Security Act. States receive Federal Funds to enforce support obligations owed by absent parents, locate absent parents, establish paternity, and obtain child and medical support. In fiscal year 2004, Texas families received 90 percent of all child support collections. About 30 percent of the remaining collections were sent to the federal government and half were sent to other states. The state's remaining retained collections, along with appropriations of General Revenue Funds for CSE, are used to "draw down" matching Federal Funds to run the program. A state match of 34 percent of program costs is required.

ELIMINATION OF FEDERAL MATCH FOR INCENTIVE PAYMENTS

In addition to reimbursement of enforcement activities, states receive incentive payments from the federal government based on performance in establishing paternity and child support orders and in collection of support. The OAG projects that incentive payments will be $37.9 million in fiscal year 2008 and $43.3 million in fiscal year 2009. These funds are also used for operating the CSE program in Texas, and states have been allowed to count incentive payments as state match for drawing federal child support enforcement funds. However, the DRA prohibits this practice beginning October 1, 2007. To compensate for the loss of using incentive payments as state match, the OAG is requesting $25 million in fiscal year 2008 and $28.6 million in fiscal year 2009 in General Revenue Funds. This amount would draw $48.5 million and $55.5 million in Federal Funds for the respective years. Without these additional General Revenue Funds to replace the loss of incentive payments as state match, the total effect of this DRA provision would be a loss of $157.7 million for the 2008–09 biennium. Recommendation 1 includes an appropriation of $53.6 million in General Revenue Funds to replace the loss of incentive payments as state match.

DROP IN FEDERAL MATCH RATE FOR PATERNITY TESTING

Until enactment of the DRA, laboratory costs related to establishing paternity were reimbursed at 90 percent by the federal government. This federal match for laboratory tests dropped to 66 percent, beginning October 1, 2006. In fiscal year 2007, total operating funds will decline about $2.6 million. The OAG estimates it will need an additional $0.9 million in each year of the 2008–09 biennium in General Revenue Funds to draw $1.7 million in Federal Funds annually and maintain the activity level for this service. Recommendation 1 also includes an appropriation of $1.8 million in General Revenue Funds for the 2008–09 biennium to address the higher state match requirement for paternity testing.

REQUIREMENT TO COLLECT ANNUAL FEE

The DRA requires states to impose a $25 annual fee to provide child support services for families that have never received payments from the Temporary Assistance for Needy Families program (TANF). Although the effective date of the provision is October 1, 2006, the federal Office of Child Support Enforcement indicates that states cannot implement the fee until the federal government releases final regulations (scheduled for October 2007). The fee may not be applied until the state collected at least $500 in child support payments for the family. There are four implementation options available to states: (1) retaining fees from collected support; (2) charging individuals applying for services; (3) recovering fees from noncustodial parents; or (4) paying fees using state funds.

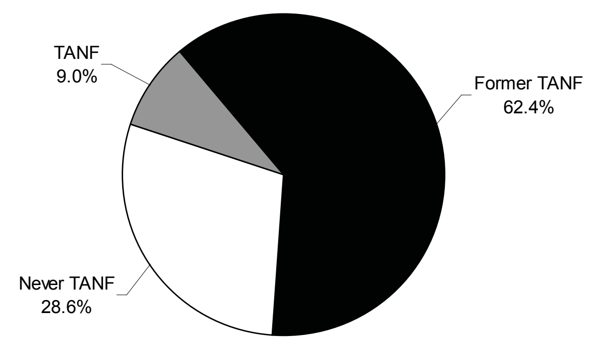
Texas Family Code, Section 231.103(a)(2) allows the OAG to impose a $25 annual service fee, which is to be deducted from support payments. State law also exempts TANF recipients from paying fees and sets a $500 minimum collection prior to imposing the fee. However, the OAG has not initiated collection of the fee and is requesting $11.5 million in General Revenue Funds for the 2008–09 biennium to pay the fees to the federal government. Recommendation 1 includes an appropriation of $11.5 million in General Revenue Funds for this purpose.

DISTRIBUTION REQUIREMENTS OF CHILD SUPPORT COLLECTIONS

In fiscal year 2005, the OAG collected $1.9 billion in child support. The state distributes the collections to the family or retains them, depending on whether the child has ever received public assistance through the TANF program, and whether the collection is for current or past-due child

support. Seventy-one percent of collections are for families currently or previously on TANF, with about 29 percent for families who never received TANF (**Figure 1**).

FIGURE 1
CHILD SUPPORT ENFORCEMENT CASELOAD
FISCAL YEAR 2006



SOURCE: Texas Office of the Attorney General.

Families currently receiving TANF must assign child support collections to the state as reimbursement to the state and federal governments for TANF benefits received by the family. The state may keep some of the child support collection for families that have received or are receiving TANF under certain circumstances. The state has been retaining collections up to the amount of TANF paid to the family. About 60 percent of such collections are sent to the federal government, based on the Federal Medical Assistance Percentage. Texas makes a supplemental payment each month to current TANF families of up to the first $50 of child support collected. The state also passes through to TANF families what is known as "First Excess" payments, which refer to child support collections (excluding alimony or child support payments) that exceed the family's monthly child support obligation plus the family's monthly TANF benefit amount. The Health and Human Services Commission (HHSC) makes supplemental payments using a combination of retained collections (transferred from the OAG) and TANF Federal Funds. However, the state must reimburse the federal government for its share of collections passed through to the family.

The DRA contains several options relating to assignment and distribution of child support collections. There are multiple ways to exercise the options, some with positive or neutral effects on the state budget, others with negative effects on the state budget. The amount of collections passed through to families can vary as well. Beginning October 1, 2008, the federal government will waive the federal share of the amount the state collects and passes through to current and former TANF recipients, up to $100 per month (or $200 for a family with two or more children). In return, states must disregard the pass-through amount as income in the determination of eligibility for TANF assistance (which Texas currently does for the supplemental payment).

For example, the state could continue its supplemental payments to current TANF recipients, replacing TANF Federal Funds with the portion of collections no longer required to be returned to the federal government. The payment to the family would remain constant, but the state would save approximately $2.3 million annually in TANF Federal Funds. Alternatively, the state could add the federal share of collections to the pass-through amount. Other approaches that would raise the pass-through amount further or extend the pass-through to former TANF recipients would require additional state expenditures. Recommendation 2 directs the HHSC and the OAG to exercise an option for passing through a portion of child support collections to current recipients of Temporary Assistance for Needy Families, using collections no longer required to be returned to the federal government. Options should be limited to those without negative effects on the state budget.

OTHER PROVISIONS AFFECTING CHILD SUPPORT ENFORCEMENT

The DRA includes other provisions that affect states' CSE programs. State child support offices intercept income tax refunds as a method of collecting delinquent child support. Effective October 1, 2007, states may intercept tax refunds for past-due child support on behalf of children who are no longer minors. Also effective October 1, 2007, the DRA mandates that child support orders for families receiving TANF be reviewed (and adjusted if appropriate) every three years or if a review is requested by either parent. Before this change, a review of orders for TANF families was required every three years only if requested by the agency operating the TANF program.

Another change in the DRA is that the amount of child support owed that triggers passport denials or revocations is lowered from $5,000 to $2,500 effective October 1, 2006. Also, the U.S. Department of Health and Human Services is given the authority to compare information concerning individuals owing past-due child support with data maintained by insurers, and then furnish information on

pending claims or settlements to state agencies responsible for collecting child support.

Finally, the DRA requires states to seek medical support for children from either parent rather than just the noncustodial parent. The DRA also defines medical support to include both health insurance and incurred medical expenses. None of these provisions will have a significant effect on the OAG's budget or operation.

FISCAL IMPACT OF THE RECOMMENDATIONS

Figure 2 shows the fiscal impact of Recommendation 1 to appropriate General Revenue Funds to replace the use of Federal Funds as state match, address the lower match rate for paternity testing, and pay the federal share of the $25 fee for child support collections. Recommendation 1 will maintain funding for 1,552 full-time-equivalent positions in fiscal year 2008 and 1,757 in fiscal year 2009. Recommendation 1 is incorporated into the introduced 2008–09 General Appropriations Bill. The introduced 2008–09 General Appropriations Bill does not address Recommendation 2.

FIGURE 2
FISCAL IMPACT OF THE DEFICIT REDUCTION ACT PROVISIONS

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS	PROBABLE REVENUE GAIN/(LOSS) FROM FEDERAL FUNDS
2008	($31,446,221)	$61,042,664
2009	($35, 425,912)	$68,767,947
2010	($35,425,912)	$68,767,947
2011	($35,425,912)	$68,767,947
2012	($35,425,912)	$68,767,947
2013	($35,425,912)	$68,767,947

USE AND MAXIMIZATION OF TANF FEDERAL FUNDS

The federal Deficit Reduction Act of 2005 reauthorized Temporary Assistance for Needy Families (TANF) and child-care programs. Changes in the calculation for determining work participation rates will result in higher participation rate targets for the Texas. However, given the continued declines in the TANF caseload, new work participation rate targets for all families receiving cash assistance should be achievable with level funding at the Texas Workforce Commission. The Deficit Reduction Act also extends federal TANF work participation requirements to Texas' program for two-parent, low-income families. Reaching the new two-parent work participation target will be a challenge; failing to reach it could result in penalties for Texas in fiscal year 2009. Restructuring the method of finance for two-parent families would allow Texas to avoid these penalties. Also, beginning October 1, 2006, parents who are ineligible for TANF cash assistance, but whose children receive TANF, now have a federal requirement to participate in employment-related programs.

As a result of further TANF caseload declines, the balance of available TANF Federal Funds at the end of the 2006–07 biennium is estimated to be $163.1 million. Although the state should reserve TANF Federal Funds to address future spending needs that exceed annual awards, there are numerous options for use of a portion of these funds. Finally, the Deficit Reduction Act extends the basic TANF block grant through 2010. However, TANF Supplemental funds are only extended through 2008. If not reinstated, this represents a significant loss in revenue to the state.

CONCERNS

- With the new requirement to include separate state programs in TANF work participation calculations, Texas may not reach the federal two-parent work participation rate target in federal fiscal year 2007. The estimated penalty of $0.8 million would be imposed in federal fiscal year 2009 unless the federal government allows the state to implement a corrective compliance plan.
- About 6,000 parents who are ineligible for TANF cash assistance themselves, but whose children receive TANF, will have a federal requirement to participate in employment-related activities and will be included in federal TANF work participation targets beginning October 1, 2006. These parents are currently exempt from participating in employment-related services in Texas.
- Without federal reauthorization of the TANF Supplemental Funds beyond 2008, Texas will receive $52.7 million less in Federal Funds each year.
- Based on funding levels in the introduced General Appropriations Bill, the projected TANF balance at the end of the 2008–09 biennium is estimated to be $128.1 million. TANF reserves could be used for numerous services or benefits, such as providing more education and training opportunities to clients receiving cash assistance, increasing the benefit amounts, or subsidizing child care for low-income families. Alternatively, TANF could be used to replace General Revenue spending in a number of areas.
- Any expanded use of TANF must be weighed against the ability to sustain spending in the future. In fiscal year 2009, recommended funding levels already exceed Texas' annual allocation by $45.3 million. Therefore, the state should reserve some funds to address future spending needs that exceed annual awards.

RECOMMENDATIONS

- **Recommendation 1:** Discontinue counting General Revenue Fund expenditures for cash assistance to two-parent families as TANF Maintenance-of-Effort in the 2008–09 General Appropriations Bill that avoids federal penalties related to work-participation rates for two-parent families.
- **Recommendation 2:** Amend Chapter 31, Human Resources Code, to require certain non-recipient parents to participate in employment-related programs to obtain TANF cash assistance for their children.
- **Recommendation 3:** Petition the U.S. Congress to continue funding TANF Supplemental Funds beyond fiscal year 2008 and to reinstate the growth in TANF Supplemental Funds as originally designed to account for population growth.

- ♦ **Recommendation 4:** Consider using a portion of the TANF reserves to expand education and training opportunities for TANF parents, increase the benefit level, subsidize child care for low-income families or replace General Revenue Funds.

DISCUSSION

Temporary Assistance for Needy Families (TANF) is a federal block grant program implemented in 1996 to provide Federal Funds to states to assist needy families care for children, promote job preparation and work, reduce and prevent out-of-wedlock pregnancies, and encourage the formation and maintenance of two-parent families. The block grant replaced the former Aid to Families with Dependent Children (AFDC) entitlement program. Texas' share of the federal block grant is $486.3 million per year. In addition, Texas currently receives a $52.7 million supplemental TANF grant each year to adjust for population increases and low historical state spending on welfare. Unspent TANF funds can be carried forward indefinitely until expended.

Figure 1 shows the distribution of TANF funding among state agencies in Texas for fiscal year 2006. While federal TANF funds in Texas are distributed among seven state agencies, three agencies accounted for 86.6 percent of total expenditures. The Department of Family and Protective Services (DFPS) accounted for 43 percent of annual TANF expenditures.

To draw down federal TANF funds, Texas must maintain 80 percent of federal fiscal year 1994 non-federal effort in funding programs for low-income families. Texas must spend $251.4 million a year in qualified state expenditures to meet this "Maintenance-of-Effort" (MOE) requirement. The MOE level is reduced to 75 percent of historic effort ($235.7 million) if the state meets federal work participation standards (described more fully below). Texas has met federal work participation standards since TANF began.

In Texas, three agencies account for most of the expenditures counted as MOE. Pre-kindergarten (pre-K) expenditures at the Texas Education Agency (TEA) account for the largest proportion of MOE, followed by cash assistance expenditures for low-income families at the Health and Human Services Commission (HHSC) and child-care expenditures at the Texas Workforce Commission (TWC). Additional pre-K funds could be counted, if needed.

TANF CASH ASSISTANCE CASELOADS

Texas has two programs that provide cash assistance to low-income families: TANF Basic and TANF-State Paid (TANF-SP). The TANF Basic program uses both Federal Funds and General Revenue Funds. On average, about 69,600 low-income families received cash assistance under

FIGURE 1
TANF DISTRIBUTION AMONG STATE AGENCIES, FISCAL YEAR 2006

IN MILLIONS

Health and Human Services Commission $138.0 (26%)
Texas Workforce Commission $89.5 (17%)
Other, $71.9 (13%)
Department of Family and Protective Services $239.3 (43%)
Department of State Health Services $20.7 (4%)
Department of Assistive and Rehabilitative Services $16.1 (3%)
Texas Education Agency $8.4 (2%)
Employee Benefits $26.7 (5%)

SOURCE: Legislative Budget Board.

the TANF Basic program each month in fiscal year 2006. Approximately 58,200 families per month are expected to receive cash assistance in fiscal year 2007, decreasing to 56,000 families per month by fiscal year 2009. Over 60 percent of these TANF families are child-only cases, meaning the adults are ineligible and do not receive TANF cash assistance for themselves.

To avoid potential federal penalties related to more stringent work participation requirements for two-parent families, in Texas the TANF-SP program currently uses only state funds, which count toward the MOE requirement. On average, 2,100 two-parent low-income families received cash assistance under the TANF-SP program each month in fiscal year 2006. About 1,500 families per month are expected to receive benefits in fiscal year 2007, followed by a further decline to 1,300 families per month by fiscal year 2009.

TANF WORK-RELATED ACTIVITIES REQUIREMENTS

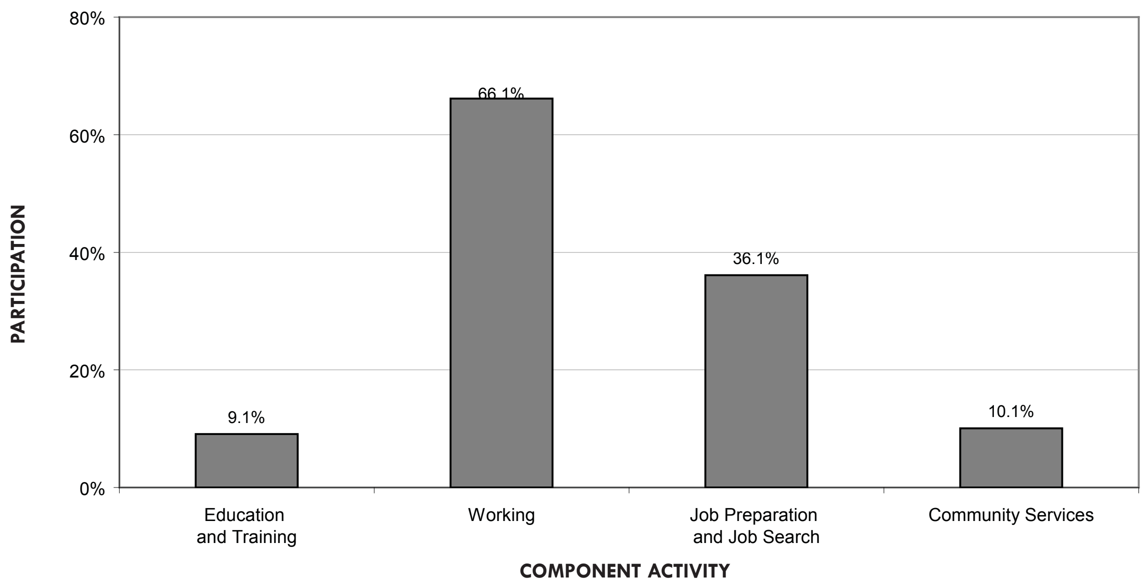
With passage of the Deficit Reduction Act of 2005 (DRA), families paid cash assistance with Federal Funds or with funds that count towards the state's MOE are required to participate in work or employment-related activities that lead to self-sufficiency. Prior federal law did not require families paid solely with state MOE funds to participate in these activities. In Texas, employment-related activities are directed by Local Workforce Development Boards (LWDBs) funded by and under the guidance of TWC through a program called Choices. The employment-related activities are collectively known as "components." The components include employment, job preparation and job search, education and training, and community service. According to TWC, about 75 percent of TANF and TANF-SP clients required to engage in employment-related activities were in one or more Choices components each month in fiscal year 2006. **Figure 2** shows the percentage of adults in each component activity in June 2006. The numbers do not add to 100 percent because many people are in more than one component in a given month. Nearly two-thirds of Choices clients were working at that time.

EXEMPTIONS FROM WORK REQUIREMENTS

Federal law allows states to exempt single custodial parents caring for children who have not attained 12 months of age from participating in employment-related activities. States are allowed to disregard such individuals for up to 12 months. Texas adopted this exemption.

Under federal regulation, two-parent families with an incapacitated adult are not counted in the two-parent participation rate calculations. HHSC defines an incapacitated adult as an adult that is unable to work due to a mental or physical disability expected to last more than 180 days. The adult must provide a physician's statement to qualify for this

FIGURE 2
PERCENTAGE OF CHOICES ADULTS BY TYPE OF EMPLOYMENT-RELATED ACTIVITY, JUNE 2006



SOURCE: Texas Workforce Commission.

exemption. Most of the exemptions in two-parent households are for this reason. Federal regulations also allow a parent that is caring for an incapacitated family member to be excluded from the work participation rate calculations if the incapacitated family member is living in the home of the TANF-SP family, medical documentation indicates the TANF-SP parent is needed to care for the incapacitated person in the home, and the incapacitated family member is not attending school full-time. However, in both of these cases—where there is an incapacitated adult or an adult required to care for an incapacitated family member—the family must meet the overall federal requirements for TANF work participation if one of the parents is otherwise "work eligible."

Texas state law also exempts caretakers of disabled children from participating in work-related programs. By HHSC regulation, incapacitated individuals unable to work, pregnant women unable to work, people caring for an incapacitated person or an ill child, people age 60 or older, and single grandparents age 50 or over caring for a child under the age of three are also exempt in Texas. In addition, good cause for non-participation can be granted for such things as illness in the home, injury, transportation problems, or other events that temporarily hinder the person from active participation in work activities. Under federal regulation, the individuals given good cause or exempt under Texas state law or regulation are still included in the count of families required to participate in employment-related activities in the TANF program.

Roughly 36 percent of the 26,310 TANF cases with an adult in fiscal year 2006 had an adult exempt for one of the aforementioned reasons; about 40 percent of TANF-SP cases had one or both adults exempt for one of these reasons. **Figure 3** shows the number of adults exempt, by reason. Over 16 percent of TANF adults and 22 percent of TANF-SP adults are exempt because of incapacity. About 3 percent of TANF adults and 7 percent of TANF-SP adults are caring for an incapacitated adult. Another 9 percent of TANF adults are exempt to care for a child under one.

WORK PARTICIPATION RATES AND CASELOAD REDUCTION CREDITS

To count towards meeting federal work requirements, single parents must engage in an average of 30 hours of countable component activities per week. Adults in two-parent families under the TANF program must engage in an average of 35 hours of countable component activities per week if subsidized child care is not provided, or 55 hours per week if it is provided. Because two-parent families in Texas have been fully paid with state funds, these families have not been

FIGURE 3
TANF AND TANF-SP ADULTS EXEMPTIONS BY REASON, JUNE 2006

Reason	TANF	TANF-SP
Not Exempt	14,611	2,264
Caring for Disabled Child	948	44
Incapacitated	3,695	727
Caring for Child Under 1	2,191	0
Caring for Incapacitated Adult	709	243
Pregnant	303	15
All Other Exemptions	501	49

Total TANF Adults: 22,958
Total TANF-SP Adults: 3,342
Total Exempt Adults: 9,425

SOURCE: Health and Human Services Commission.

subject to the federally mandated hours of activity. Nonetheless, Texas required these families to meet the federal standards. Failure to achieve these activity levels can result in a loss of cash assistance to the family.

Federal law requires that 50 percent of all TANF families (including both one-parent and two-parent families) and 90 percent of two-parent TANF families meet the work participation requirements. The 50 percent and 90 percent participation rate targets can be reduced by the percentage point drop in the caseload from federal fiscal year 2005 to the target year, adjusted for state and federal changes that reduced the caseloads. For example, a drop in the caseload from federal fiscal year 2005 to 2006 is used to determine the caseload reduction credit for federal fiscal year 2007. The combined TANF and TANF-SP caseload is projected to decline 19 percent between federal fiscal years 2005 and 2006, resulting in a revised federal all TANF family target of 31 percent for federal fiscal year 2007. **Figure 4** shows the estimated revised work participation rate target for federal fiscal year 2007 after incorporating the impact of caseload reduction. The revised federal all TANF family targets for federal fiscal years 2008 and 2009 are estimated to be 26 percent and 28 percent, respectively, based on estimated caseload changes.

As a result of the DRA, TANF-SP families will become subject to the 90 percent work participation rate requirement beginning in federal fiscal year 2007. As with the TANF program, a caseload reduction credit can be applied to reduce the work participation rate target. Federal regulations allow states to use the reduction in overall caseloads (TANF and TANF-SP combined), or only the TANF two-parent caseload in this calculation. The estimated caseload decline in the TANF-SP program from federal fiscal year 2005 to 2006 is 32 percent. This is more than the 19 percent overall TANF caseload decline, so Texas would use the reduction in the TANF-SP caseload alone in calculating its revised target. The estimated effective federal work participation rate target for TANF-SP, after applying the caseload reduction credit, is 58 percent for federal fiscal year 2007.

Prior to passage of the DRA, 1995 was the base year for this caseload reduction credit. Significant drops in the TANF caseload since 1995 resulted in Texas having had a zero effective work participation rate requirement for its TANF population for the past several years. Nonetheless, 39.7 percent of Texas' TANF families met the federal TANF work participation requirements in federal fiscal year 2005. Texas' participation rate for federal fiscal year 2006 (through March 2006) is about 43 percent, and is likely to be higher by the end of the year.

While the revised target for fiscal year 2007 is near or below the rate achieved in federal fiscal year 2006, families previously not included in the participation rate calculation will now count in the calculation. This is discussed further below. Furthermore, considerably more adults receive employment-related services than the numbers who meet work participation requirements. According to TWC, LWDBs serve two adults for every one that is counted as a federal work participant. This occurs because people are granted good cause for not participating, it takes time to get people fully engaged, or people participate but fail to complete the required hours of activities in the month for numerous reasons.

Failure to achieve the work participation rate targets for all TANF families can result in a penalty to the state starting at a 5 percent reduction in the TANF block grant, or $24.3 million. This increases two percentage points for each subsequent year the state fails to achieve the work participation rate targets. The reduction in the TANF block grant must be

FIGURE 4
FEDERAL WORK PARTICIPATION RATE TARGETS AND ADJUSTMENTS, FISCAL YEAR 2007

All Families
100%, all families with a work requirement
2006 Performance 43%
50% Target
-19% Caseload Reduction
31% Revised Target

Two-Parent Families
100%, all families with a work requirement
2006 Performance 58%
90% Target
- 32% Caseload Reduction
58% Revised Target

Caseload Reduction Credit

Source: Legislative Budget Board.

replaced with state spending; failure to do so results in an additional penalty of 2 percent of the TANF block grant, or $9.7 million. In addition, the state's MOE requirement remains at 80 percent rather than being lowered to 75 percent.

MEETING THE FEDERAL REQUIREMENTS FOR TWO-PARENT FAMILIES

While the TANF-SP program in Texas provides financial assistance to two-parent low-income families, it is a non-federal program. Until now, it has not been subject to a federal work requirement. As a result, Texas has been able to tailor its employment services program to the needs of two-parent families without the threat of federal penalties for failing to meet the two-parent federal work participation target. Approximately 35 percent of two-parent TANF-SP families reside in counties on the Mexican border or adjacent to these counties, with most of the remaining families in the larger cities in the state. The border counties are among the least economically robust ones in the state and hence present great challenges in developing employment programs and jobs. In spite of this, the TANF work participation rate for TANF-SP families would have been about 56 percent in federal fiscal year 2005. Through March of federal fiscal year 2006, the calculated federal rate for two-parent families would be about 58 percent.

Since TANF-SP cases with incapacitated adults or with a person caring for an incapacitated family member are not included in the two-parent family participation rate calculations, the LBB estimates that only about 770 TANF-SP families per month in fiscal year 2007 will need to meet work participation requirements. This is comparable to the number of two-parent families meeting participation requirements in fiscal year 2006. While families with incapacitated adults or with a person caring for an incapacitated family member may be included in the overall TANF work participation rate, the impact of their non-participation in employment programs, in terms of meeting federal targets and avoiding a penalty, is minor. Since removing the exemption for incapacitated adults in the TANF-SP program will adversely affect Texas' ability to achieve the two-parent target rate, these exemptions, where legitimate, should remain. These families should be encouraged, but not required to participate in employment-related programs. This would allow the LWDBs to help the families with an incapacitated member address barriers to employment without putting the state at a greater risk of a penalty.

Based on information on client exemptions from HHSC, about 1,300 TANF-SP cases in fiscal year 2007 will have two adults required to participate. This pool of TANF-SP adults may not be sufficient for Texas to reach the two-parent participation target in federal fiscal year 2007. Failure to achieve the two-parent work participation rate targets can result in a penalty to the state starting at a 5 percent reduction in the TANF block grant, but is prorated based on the two-parent caseload's percentage of the total caseload. In Texas, two-parent cases make up only about 3 percent of the total caseload. Consequently, the penalty for the two-parent caseload not meeting work participation rate targets is estimated to be about $0.8 million in the first year. Penalties increase by about $0.3 million in each subsequent year the two-parent target is not met. As described earlier, the reduction in the TANF block grant must be replaced with state spending or the state will be subject to an additional penalty. In addition, the MOE requirement remains at 80 percent of 1994 funding rather than being reduced to 75 percent. Funding for pre-K could be counted to meet the higher MOE requirement and to replace the reduction in federal funding. It is likely that the federal government would allow Texas to develop and implement a corrective compliance plan after the first failure to meet either work participation rate target, and thereby avoid initial penalties.

Avoiding the penalty for not meeting the TANF two-parent work participation rate target might be achieved with additional funding that resulted in more supportive services to entice voluntary participation. Any improvements to ensure that information on new and ongoing TANF-SP cases is transmitted as quickly as possible between HHSC and TWC data systems could improve participation rates. TWC should continue to encourage LWDBs to closely monitor activities of their two-parent clients so that barriers can be identified and addressed, or the TANF-SP case can be terminated quickly when clients do not meet their work requirements. TWC should also expand the list of activities that count towards meeting work participation requirements, within federal guidelines. Substance abuse treatment, mental health treatment, and rehabilitation activities for those otherwise employable which are now allowable job readiness activities under the DRA, should be allowable activities. If funding were available, LWDBs could be encouraged to purchase more of these services for their clients with skills and experience to get a job, but who need help to keep the jobs.

Another possible way to avoid the penalty would be to increase the number of months during which earnings of TANF-SP families is disregarded in calculating eligibility for cash assistance. Currently, TANF and TANF-SP families that go to work continue to get cash assistance for four months as a ramp to self-sufficiency. Extending the period to six months for TANF-SP families would increase the participation rate achieved while providing more time for the families to achieve economic independence. However, this would increase the cost of cash assistance and child care by several million dollars a year. The cost would increase dramatically if it were also applied to TANF families.

Alternatively, the state could discontinue counting expenditures on cash assistance in the TANF-SP program as TANF MOE (Recommendation 1). Funding for pre-K for low-income children in Texas is greater than the amount used towards the TANF MOE requirement. Consequently, additional pre-K funding is available to be used for TANF MOE in place of the General Revenue Funds appropriated for the TANF-SP program. The state would increase the amount of pre-K funds claimed as MOE by $4.2 million in fiscal year 2008 and by $4.3 million in fiscal year 2009. This change in the method of finance would allow Texas to avoid the two-parent participation rate penalties altogether. General Revenue Funds could continue to be appropriated for providing cash assistance to two-parent low-income families. And because the families have low income, they still qualify for employment-related services, subsidized child care, and Medicaid. All policies in effect for the TANF-SP program could be retained. There would be no change in overall funding and no change in services provided.

EXTENDING CHOICES SERVICES TO PARENTS INELIGIBLE FOR CASH ASSISTANCE

The DRA required the Secretary of the U.S. Department of Health and Human Services (DHHS) to develop regulations concerning "the circumstances under which a parent who resides with a child who is a recipient of assistance should be included in the work participation rates." As a result, some parents who are not included in the TANF cash assistance unit are now required to participate in employment-related activities. Because they were ineligible for TANF cash assistance, these parents were not previously required to participate in employment-related programs, and were not outreached.

The U.S. DHHS regulations published on June 29, 2006 specify that parents who are ineligible for TANF cash assistance because of state time limits or program violations, but whose children receive TANF, are now required to participate in employment-related activities. In Texas, this extends a work participation requirement to about 6,000 individuals. States have the option to include or exclude individual parents from the requirement to participate in employment-related activities if the parents are ineligible for TANF cash assistance because they receive Supplemental Security Income (SSI). Many parents with the new requirement previously participated in employment-related programs when they were eligible for TANF cash assistance, but were not successful in becoming employed and leaving TANF before they reached a state-imposed time limit on their TANF benefits. The adult was removed from receiving cash assistance, but the children continued receiving cash assistance. Most of these parents are associated with child-only TANF cases, though some are on TANF cases in which the other parent receives cash assistance. This latter group will increase the number of cases in the two-parent participation rate denominator slightly.

HHSC indicated that they will be providing information to TWC to allow LWDBs to outreach these ineligible parents. However, Recommendation 2 would amend the Human Resources Code to make their participation in employment-related programs mandatory. Section 31.0031, which discusses the requirements of the TANF Responsibility Agreement, would need to be modified to require ineligible parents to engage in employment-related activities if they are required to participate under federal regulations. Numerous sections of the Human Resources Code (for example, Sections 31.0095, 31.001, 31.012, 31.0121, 31.0125, 31.0126, 31.0127, and 31.0128) mention "an adult … receiving financial assistance" or "recipients" with regard to required participation in employment activities. These sections would need to be modified to include the parents who are ineligible for TANF cash assistance.

Until these changes are made, only a small number of these parents are expected to participate in the programs. Assuming a six-month start-up period after the statutory changes are made, with slight voluntary participation prior to changing the statutes, an estimated 5,200 more adults in fiscal year 2008 will be required to participate and will engage in employment-related programs.

The estimated cost of providing services for this new group is shown in **Figure 5**. The cost of employment-related programs is estimated at $965.76 per client served based on information from TWC. The estimate assumes that all of

FIGURE 5
ESTIMATED COST OF PROVIDING PARENTS INELIGIBLE FOR CASH ASSISTANCE WITH EMPLOYMENT AND CHILD CARE SERVICES
FISCAL YEARS 2008 AND 2009 (IN MILLIONS)

	2008	2009
Employment Programs	**$4.9**	**$0.9**
TANF Child Care	$16.2	$3.2
Transitional Child Care	$4.9	$13.9
At-Risk Child Care	$0.3	$5.0
Child Care Subtotal	**$21.4**	**$22.1**
Grand Total:	**$26.3**	**$23.0**

SOURCE: Legislative Budget Board.

the current ineligible adults will receive services by the end of fiscal year 2008, so only the small group of new ineligible parents will remain to be served in fiscal year 2009. Consequently, the total cost of the new group falls considerably in fiscal year 2009, and remains fairly constant thereafter. For the 2008–09 biennium, the cost to provide services to adults ineligible for cash assistance is estimated to be $5.8 million.

Because the estimated participation rate targets for federal fiscal years 2007 through 2009 (31 percent, 26 percent, and 28 percent, respectively) are considerably lower than the participation rate expected to be achieved in federal fiscal year 2006 (43 percent), fewer clients will have to be provided with employment services to meet the revised federal target in federal fiscal year 2007 and beyond. Not serving this group of parents would lower the participation rate achieved, but the new federal target should still be achievable if funding at TWC during 2008–09 is maintained at the 2006–07 biennium level.

Due to anticipated caseload reductions, the total number of Choices clients in the 2008–09 biennium, including these ineligible parents, will be less than the number of clients TWC is now serving. TWC should have sufficient funds to provide employment-related services and child care so all TANF-related adults with a work requirement can be assisted in becoming self-sufficient.

FUNDING FOR CHILD CARE IN TEXAS

TANF families cannot be required to participate in employment-related activities if they need child care, unless subsidized child care is available. Funding for subsidized child care in Texas comes from the federal Child Care and Development Block Grant, federal Child Care Mandatory funds, federal Child Care Matching grants (which require a state or local match), state funds that are used for maintenance of effort requirements or as the match to draw down the Federal Funds, and Local Funds that may also be used as the match to draw down Federal Funds. TWC rules require LWDBs to secure local public and private funds to maximize resources for child-care needs in the community.

Subsidized child care in Texas is provided to four groups: families receiving TANF, families transitioning off of TANF after becoming employed (known as "Transitional" child care), low-income families that are at risk of getting on TANF (known as "At-Risk" child care), and children in foster care. Total funding for state-subsidized child care in Texas in fiscal year 2006 was $469.3 million (excluding $30.7 million in Federal Funds used to provide child care for hurricane evacuees). Of this, Texas budgeted $70.4 million for TANF families.

The DRA increased total federal funding of Matching Child Care grants by $200 million per year. Texas' annual share of Matching Child Care grants increased an estimated $19.4 million. To take advantage of these additional Federal Funds, $12.9 million per year in state match will be needed, since $1.00 of matching funds is needed to draw $1.50 of these Federal Funds for child-care. In fiscal year 2006, Texas received a waiver of the matching requirement for drawing down some of the federal Matching Child Care grants due to the high demand for child care of families impacted by Hurricanes Katrina and Rita.

TWC requires LWDBs to secure local public and private funds as the match for federal child care funding. LWDBs have been successful in identifying Local Funds and thus increasing child care funding for their communities. This increased the amounts of federal child care funding used in Texas for low-income families. TWC anticipates that sufficient Local Funds will be available to draw all available Federal Funds for child care in the upcoming biennium.

Many families on TANF that become employed retain their TANF eligibility for four months, during which time 90 percent of their earnings are not counted in calculating their TANF benefits. During this time, they can still receive subsidized child care if they are working. Once they leave TANF, most can receive 12 months of "Transitional" child care if they continue to work. TANF families must have received TANF for at least 3 of the last 6 months to be eligible for Transitional child care.

TANF recipients and "Transitional" clients get priority for child care funding. Because of this, increases in child care funding for TANF families without increases in overall child care funding results in less funding being available for the "At-Risk" child care group. In fiscal year 2005, an estimated 27,675 children per day in "At-Risk" families were on waiting lists. Due to significant reductions in the TANF caseloads in fiscal year 2006, more funding was available to serve children in the "At-Risk" child care group. Consequently, TWC estimates that over 19,000 more children per day were served through "At-Risk" or "Transitional" child care in fiscal year 2006 than was estimated in the 2006–07 General Appropriations Act. In spite of this, TWC estimates that the number of children on waiting lists increased in fiscal year 2006 to 30,997.

CHILD CARE FUNDING FOR CHILDREN OF PARENTS INELIGIBLE FOR CASH ASSISTANCE

In order for the non-recipient parents to participate in employment-related programs, the state must provide subsidized child care if needed. **Figure 5** shows the cost of TANF child care to allow non-recipient parents to participate in employment-related programs. These estimates are based on TWC's estimated cost per child per day in fiscal years 2007 through 2009, an average of 1.25 children in child care per Choices enrollee, and 4 months of TANF child care. It also assumes that 90 percent of these families will get an additional three months of TANF after becoming employed (due to policy disregarding earnings), during which time they will continue to get TANF child care. The LBB estimates the cost of TANF child care for these families to be $16.2 million in fiscal year 2008. By fiscal year 2009, most of the original families would have become employed or sanctioned off of TANF after receiving employment-related services and TANF child care, so the cost drops to $3.2 million. "Transitional" child care would also increase as these people become employed and leave TANF. This cost is estimated to be $4.9 million in fiscal year 2008 and $13.9 million in fiscal year 2009 (**Figure 5**).

Because families receiving TANF or "Transitional" child care receive priority for child care services some child care funding will shift from "At-Risk" families to these families. The waiting lists for children in "At-Risk" families would grow by about 4,800 children in fiscal year 2008 (from roughly 29,900 to 34,700 children) without additional funding. In addition, the demand for "At-Risk" child care in fiscal year 2009 will rise as families receiving "Transitional" child care exhaust their 12 months of benefits. An additional 1,300 children can be expected to need "At-Risk" child care in fiscal year 2009, resulting in even longer waiting lists without additional funds. The cost for these children is estimated at $5.0 million in fiscal year 2009 (**Figure 5**).

TANF SUPPLEMENTAL FUNDS TO TEXAS

TANF Supplemental Funds were established to address the disparities in TANF funding among states. An annual 2.5 percent increase to block grants was authorized for states with high population growth and low benefit levels. TANF Supplemental Funds to Texas increased from $12.7 million in fiscal year 1998 to $52.7 million in fiscal year 2001. Congress continued to appropriate Supplemental Funds, but froze appropriations at the fiscal year 2001 level. With passage of the DRA, Congress extended Supplemental Funds at the level frozen in 2001 through fiscal year 2008 only (even though the TANF program was reauthorized through 2010). If allowed to increase as designed in the 1996 federal welfare law, Texas' allocation in fiscal year 2008 would have been $158.5 million, triple the current level.

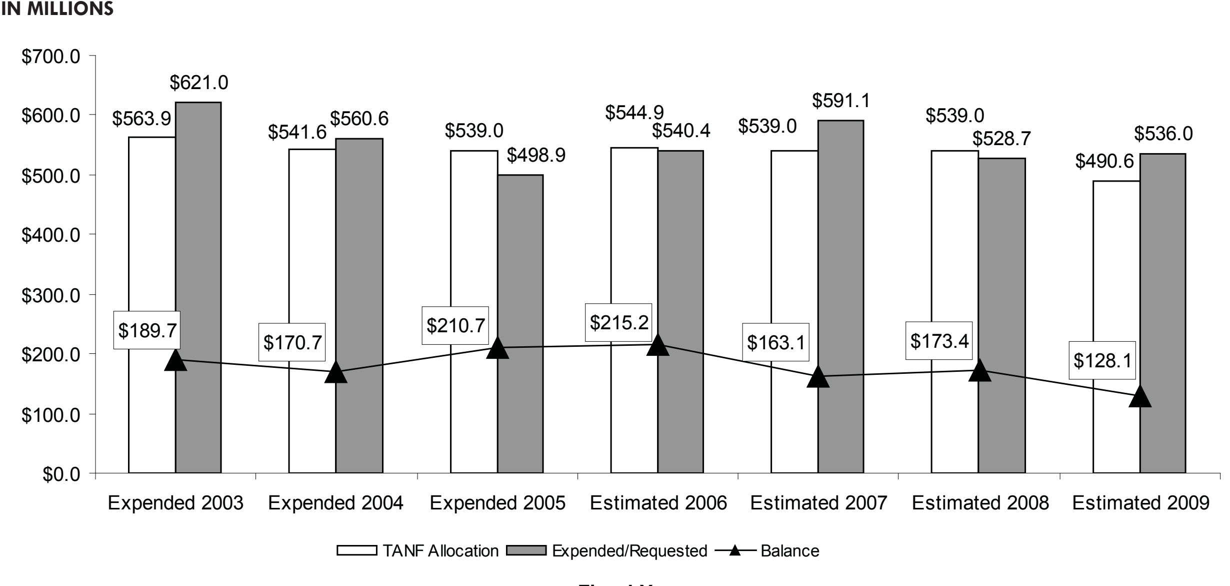
Recommendation 3 would encourage the Texas Legislature to petition the U.S. Congress to continue TANF Supplemental Funds beyond 2008 and to reinstate the growth in funds as originally designed. This could be accomplished by: (1) passing a resolution; (2) directing the Texas Office of State-Federal Relations to establish restoration of TANF Supplemental Funds as a priority initiative; (3) directly contacting members of the Texas congressional delegation and members of the Administration; and (4) working with organizations such as the National Conference of State Legislatures and other states seeking similar action.

ALTERNATIVE USES OF TANF FUNDING

States may use TANF for a variety of purposes, as long as the broad purposes of the block grant are met. **Figure 6** provides annual TANF funding, expenditures and projected amounts, and the net TANF balances from fiscal years 2003 to 2009. Due to fewer families receiving cash assistance, the estimated balance of available TANF at the end of the 2006–07 biennium is $163.1 million. Based on funding levels in the introduced 2008–09 General Appropriations Bill, the estimated balance at the end of the 2008–09 biennium would be $128.1 million.

There are numerous options available to the state for use of TANF reserves. As **Figure 2** showed, only 9.1 percent of clients in TWC's Choice's program participate in education and training activities. Many families leaving the TANF rolls

FIGURE 6
TANF FEDERAL FUNDING ESTIMATED EXPENDITURES, FISCAL YEARS 2003 TO 2009



Note: Assumes $52.7 million supplemental TANF grant is not reauthorized after 2008; does not include TANF funding or expenditures for hurricanes.
Source: Legislative Budget Board.

do not obtain wages that push the family above the poverty level. An investment in this area, for example, might assist more clients in achieving self-sufficiency and have the long-term effect of reducing future costs for cash assistance. Another potential use of TANF reserves is to increase the amount of cash assistance provided to families. In Texas, the maximum monthly cash grant for a family is set at 17 percent of the federal poverty level. For fiscal year 2005, this equated to a maximum monthly cash grant for a family of three of $223. Texas' TANF benefit level is one of the lowest in the nation. Another option for consideration of the TANF balance is child care. Many states use TANF for subsidizing child care for low-income families. TWC projects that in fiscal year 2008 there will be approximately 30,000 children from low-income families on a waiting list for child care.

Alternatively, TANF could replace General Revenue Funds in numerous places in the state budget. Any expanded use of TANF must be weighed against the ability to sustain spending in the future. In fiscal year 2009 recommended funding levels already exceed Texas' annual allocation by about $45.3 million. Therefore, the state should reserve some funds to address future spending needs that exceed annual awards. Given these policy choices, Recommendation 4 would encourage the Legislature to consider alternate uses of a portion of the TANF balance.

ADDITIONAL REQUIREMENTS OF THE DEFICIT REDUCTION ACT

The DRA broadened federal regulatory power regarding employment-related activities. On June 29, 2006, the U.S. DHHS published interim final rules defining what constitutes employment-related activities, uniform methods for reporting hours of work, and the type of documentation needed to verify reported hours of work. The new rules more narrowly define work activities that count as participation. Previously, these were broadly defined, with more discretion left to the states. Work activities (including education) must be closely tied to the ability to get and retain unsubsidized employment. Activities such as substance abuse treatment, mental health treatment, or rehabilitation activities for those otherwise employable are now allowed as job readiness activities. Most of the component activities must be supervised daily. However, hours of unsubsidized or subsidized employment and on-the-job training may be projected for up to six months based on prior, documented actual hours of work. Compared to the existing requirement for tracking employment, this will reduce the workload on LWDBs, since about two-thirds of Choices participants are employed. In addition, the new rules allow up to 10 days of excused absences from component activities in a 12-month period, in addition to holidays allowed by the state. This should also

reduce the workload on LWDBs and increase the success of TANF adults participating in component activities. Finally, parents receiving SSI and who meet work participation requirements are now allowed to be included in federal participation rate calculations. This is not expected to have much impact on Texas' federal participation rates.

By September 30, 2006, Texas had to establish procedures and internal controls to ensure compliance with these regulations. The penalty for failing to develop procedures and controls is 5 percent of the TANF block grant, or $24.3 million. Failing to adhere to the procedures can result in a penalty of 1 percent of the TANF block grant ($4.9 million), rising to 5 percent with subsequent infractions. TWC indicated that they are confident that their current procedures meet, or can be easily modified to meet, the federal requirements.

FISCAL IMPACT OF THE RECOMMENDATIONS

Projected cost and savings for replacing General Revenue Funds used for TANF MOE with General Revenue Funds for pre-Kindergarten funding is shown in **Figure 7**.

Two-parent low-income families would continue to receive cash assistance funded with General Revenue Funds but the General Revenue Funds would not be identified as TANF MOE. The introduced 2008–09 General Appropriations Bill includes a method-of-finance change to avoid penalties related to two-parent families pursuant to Recommendation 1. The introduced 2008–09 General Appropriation Bill does not address Recommendations 2, 3, or 4.

FIGURE 7
FISCAL IMPACT OF CHANGING THE METHOD OF FINANCE FOR CASH ASSISTANCE TO TWO-PARENT FAMILIES

FISCAL YEAR	PROBABLE GAIN/(LOSS) (GENERAL REVENUE FUNDS)	PROBABLE SAVINGS/(COST) TO TANF MAINTENANCE-OF-EFFORT (GENERAL REVENUE FUNDS)	TOTAL
2008	($4,206,811)	$4,206,811	$0
2009	($4,290,276)	$4,290,276	$0
2010	($4,290,276)	$4,290,276	$0
2011	($4,290,276)	$4,290,276	$0
2012	($4,290,276)	$4,290,276	$0

Source: Legislative Budget Board.

STRENGTHEN THE SOLVENCY OF THE CRIME VICTIMS' COMPENSATION FUND

The Crime Victims' Compensation Fund provides funding for the victims' compensation program administered by the Office of the Attorney General and for a variety of victim services programs. This fund is a constitutionally dedicated account and must first be used for victims' compensation. Any excess funds beyond amounts needed for compensation payments may be appropriated for other victim services programs. At current revenue and expenditures projections, the fund will become insolvent by the end of fiscal year 2011. For the fund to be deemed solvent, the fund must have enough money to pay approved victim compensation claims each year.

A combination of factors led to the increased use of the revenues deposited into the Crime Victims' Compensation Fund, including greater demand for compensation payments, increased appropriations to the Victim Assistance grant program at the Office of the Attorney General, and increased appropriations to other state agencies for victim services. The Seventy-ninth Legislature in 2005 reduced appropriations from the Crime Victims' Compensation Fund by $105.6 million for the 2006–07 biennium to other agencies for victim services and substituted the Crime Victims' Compensation Fund monies with General Revenue Funds. By increasing the revenues to and reducing specific expenditures from the Crime Victims' Compensation Fund, $6.1 million more in funds would be available for victim compensation payments in the 2008–09 biennium and the long term solvency of the fund would be improved.

CONCERNS

- Collection rates of courts costs and fees in some jurisdictions have been as low as 33 percent. The consolidated court cost is the single largest source of revenue for the Crime Victims' Compensation Fund, bringing in over $75.0 million each year to the fund.
- The lack of complete information about restitution at the state level, including amounts charged and collection rates, affects the fund's revenue and the state's ability to make more effective restitution policies.
- The Crime Victims' Auxiliary Fund, into which unclaimed restitution paid by probationers is deposited, has a balance that grows every year by $750,000 to $1.4 million. On average, less than $26,000 per year in claims are made to the fund.
- There are no statutory provisions or guidance to maintain a minimum fund balance in the Crime Victims' Compensation Fund for victim compensation.
- The appropriation of excess funds to various victim assistance programs reduces the amount available for compensation payments in future years.

RECOMMENDATIONS

- **Recommendation 1:** Include rider language in the 2008–09 General Appropriations Bill for the Office of Court Administration to report the progress in implementing the Collection Improvement Program, a program that assists with best practices in court collections.
- **Recommendation 2:** Amend Texas Government Code §76.013 and the Texas Code of Criminal Procedure §42.037 to improve the collection of restitution by establishing reporting requirements for the county and district courts, local community supervision and corrections (probation) departments, the Community Justice Assistance Division of the Texas Department of Criminal Justice, the Parole Division of the Texas Department of Criminal Justice, and the Juvenile Probation Commission.
- **Recommendation 3:** Amend the Texas Code of Criminal Procedure, Chapter 56, to allow 25 percent of the end of year fund balance in the Crime Victims' Compensation Auxiliary Fund to be transferred to the Crime Victims' Compensation Fund for compensation payments as long as the Auxiliary Fund balance is greater than $5.0 million.
- **Recommendation 4:** Amend the Texas Code of Criminal Procedure §56.541 to create a minimum end of fiscal year reserve in the Crime Victims' Compensation Fund from excess funds that equals at least 10 percent of the next fiscal year's projected compensation payments.
- **Recommendation 5:** Consider reducing appropriations for fiscal years 2008–09 for victim services funded from

the Crime Victims' Compensation Fund to ensure sufficient funding for victim compensation payments in future years.

DISCUSSION

The Crime Victim's Compensation (CVC) Fund provides victims' compensation. The Texas Code of Criminal Procedure §56.54 (e) prohibits the use of General Revenue Funds for compensation payments. The CVC Fund is a General Revenue–Dedicated account established by the Texas Constitution, Article III, Section 31. Statute permits excess funds to be appropriated for victim services and defines excess funds as funds beyond the amounts needed for compensation payments in a given year.

From the fund's inception in 1980 through March 2005, Texas paid over $670 million on behalf of crime victims. The Victim Compensation Program run by the Office of the Attorney General (OAG) acts as a payer of last resort to crime victims. Victims who exhausted other means, such as insurance, can apply for payment for specific out-of-pocket expenses. Covered benefits include hospital care and other medical needs, counseling, loss of wages or support, funeral, relocation, dependent care, crime scene clean-up, travel, and emergency awards.

MAXIMUM VICTIM AWARD AND PAYMENT TRENDS

The Texas Code of Criminal Procedure §56.42 sets the state's maximum victim compensation award at $50,000, plus up to an additional $75,000 for catastrophic injury resulting in permanent disability. Texas' maximum award is higher than most other states. The average maximum award of 48 states is $25,854 and the median maximum award is $25,000. Of a group of peer states (the nine most populous states), the average maximum award is $35,778 and the median maximum award is $27,000. New York is excluded from these amounts because it does not have a maximum award limit.

The demand for compensation payments from the CVC Fund in Texas for the 2006–07 biennium is estimated to total $139.1 million. Though the state's maximum victim award is $50,000, the average total victim compensation payments are less than $5,000. **Figure 1** shows the average victim compensation awards from fiscal years 2000 to 2005.

Examining victim awards and the total award patterns is also important to understanding the demands to the CVC Fund for victim compensation. As **Figure 2** shows, over 75 percent of victim awards are $5,000 or less.

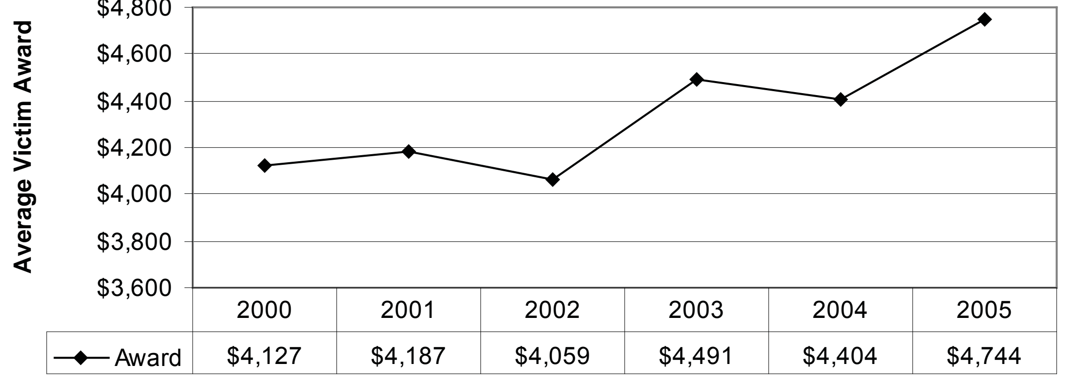
REVENUES SOURCES FOR THE CVC FUND

The CVC Fund receives revenue from a variety of sources. The primary revenue sources include:

Consolidated Court Cost: As laid out in the Texas Local Government Code §133.102(a), the CVC Fund receives 37.63338 percent of revenues from the Consolidated Court Cost. The court costs total $40 for Class C Misdemeanors, $83 for Class A and B Misdemeanors, and $133 for felonies.

Restitution: Restitution provides reimbursement from offenders to victims for costs incurred as a result of the crime and is ordered by a judge. If a victim also receives payment from the compensation program, he or she is required to submit any restitution payments to the fund. Also, the OAG

FIGURE 1
AVERAGE VICTIM AWARD FROM COMPENSATION PROGRAM, FISCAL YEARS 2000 TO 2005



	2000	2001	2002	2003	2004	2005
Award	$4,127	$4,187	$4,059	$4,491	$4,404	$4,744

SOURCE: Legislative Budget Board.

FIGURE 2
VICTIM COMPENSATION AWARDS TOTALS
FISCAL YEARS 2000–2006

DOLLARS PAID RANGE*	NUMBER OF VICTIM AWARDS WITHIN THE PAYMENT RANGE	PERCENTAGE OF VICTIM AWARDS WITHIN DOLLAR RANGE
$1 to $5,000	49,065	75%
$5,001 to $10,000	6,736	10
$10,001 to $20,000	4,588	7
$20,001 to $30,000	1,854	3
$30,001 to $40,000	883	1
$40,001 to $50,000	1,898	3
$50,001 to $75,000	137	0
$75,001 to $100,000	43	0
$100,001 to $125,000	11	0
$125,001 to $150,000	3	0
Total victim awards	**65,218**	**100%**

*The data provided by the Office of the Attorney General includes payments for fiscal years 2000 to 2006. Any payments made to victims outside that timeframe are excluded.
SOURCE: Office of the Attorney General.

works with local prosecutors to provide information about victim compensation payments prior to a judgment, so that restitution payments by the offender may be included in the judgment and can reimburse the fund up to the amount of a compensation award.

Restitution Installment Fee: For offenders needing to pay restitution in installments, a one-time fee of $12 may be charged. Half of this amount is deposited to the CVC Fund. This new fee was established by House Bill 1751, Seventy-ninth Legislature, Regular Session, 2005.

Federal VOCA Grant: The federal Victims of Crime Act (VOCA) allows the collection of fines, fees, and forfeitures for federal convictions. Passed in 1984, VOCA awarded grants to the state's compensation program since 1986. These grants are made on the basis of a formula that gives each state 60 percent of the state's fund paid to victims two years prior. The VOCA grant received by the OAG can only be used for compensation payments.

Parole Administrative Fee: This fee is an $8 administrative fee paid each month by all parolees on active supervision for crimes occurring after September 1, 1993.

Donations: Jurors receive information about the CVC Fund and have the option to donate their daily reimbursements to the fund.

Subrogation: When a court awards a crime victim money in a settlement or a civil suit, the OAG shall ask that the victim or claimant reimburse the fund for the amount paid on behalf of the victim, up to the amount of the civil award.

Figure 3 shows the amounts for each of these revenues sources for fiscal years 2004 to 2007.

CAUSES OF POTENTIAL INSOLVENCY

At current expenditure levels, the OAG projects insolvency of the CVC Fund by the end of fiscal year 2011. Several factors have contributed to its depletion:

- The demand for compensation payments under the Victim Compensation Program increased dramatically. Compensation payment expenditures from the CVC

FIGURE 3
REVENUES TO CRIME VICTIMS' COMPENSATION FUND, FISCAL YEARS 2004 TO 2007

REVENUE SOURCE	REVENUE CODE	2004	2005	2006	2007
Consolidated Court Cost	3713	$76,882,164	$78,919,506	$77,904,317	$87,671,000
Restitution	3734	1,019,533	1,061,706	1,158,280	1,256,000
Restitution Installment Fee	3801	n/a	n/a	30	10,000
Federal VOCA Grant	3700	28,319,354	39,341,339	23,731,211	23,743,000
Parole Supervision Fee	3727	2,505,539	2,932,635	3,217,040	3,414,000
Donations	3740	192,837	191,342	218,565	205,000
Subrogation	3805	473,872	668,260	697,304	727,000
Total Revenue		**$109,393,299**	**$123,114,788**	**$106,926,747**	**$116,089,472**

SOURCES: Legislative Budget Board; Comptroller of Public Accounts; Office of the Attorney General.

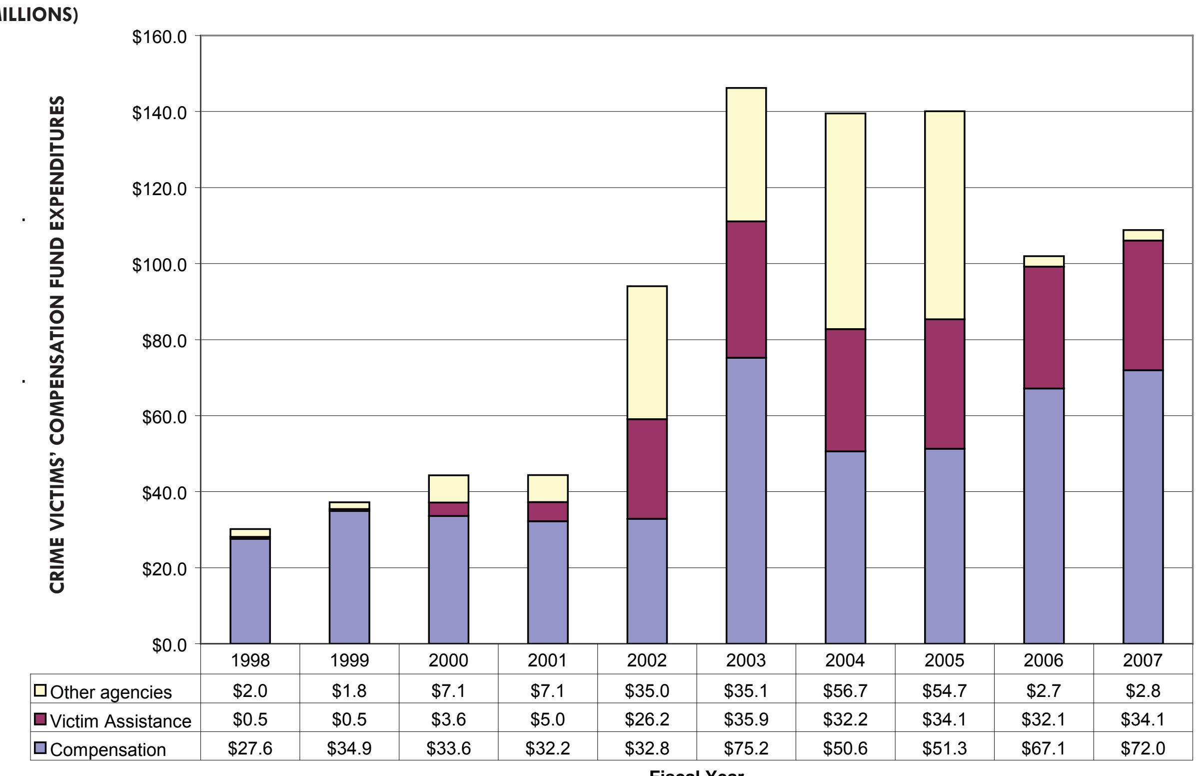
Fund have increased 161 percent in the last 10 years, from $27.6 million in fiscal year 1998, to a budgeted $72.0 million in fiscal year 2007. The OAG attributes this increase in part to better communication with victim service providers, who in turn can better educate victims about their options.

- Expenditures of the Victim Assistance Program, a grant-based victim services program at the OAG, have increased 6,717 percent from fiscal years 1998 to 2007. The OAG's Victim Assistance Program began in the 1998–99 biennium and grants funds to victim services providers. During the 1998–99 biennium, $1 million was expended for Court Appointed Special Advocates (CASA), which was the only provider to receive grant funding. These expenditures represented 1 percent of the total Crime Victims Compensation Fund expenditures for the biennium. Over the next four biennia, grant funding to victim services providers substantially increased. For the 2006–07 biennium, estimated expenditures for the Victim Assistance Program from the CVC Fund total $66.1 million. These estimated expenditures represent 31 percent of the total Crime Victims Compensation fund appropriations for the biennium. **Figure 4** shows these expenditures.

- Appropriations from the CVC Fund to state agencies other than the OAG to pay for victim services programs substantially increased over a 10-year period. During the 1998–99 biennium, $3.8 million was expended by other state agencies, which represented 6 percent of the total Crime Victims' Compensation Fund expenditures. During the 2004–05 biennium, CVC Fund expenditures by other state agencies totaled $111.5 million, which represented 40 percent of the total the fund's expenditures during the biennium. To prevent the depletion of the fund, the Seventy-ninth Legislature in 2005 reduced appropriations to other state agencies by $105.6 million over 2004–05 levels. An estimated $5.5 million is expected to be expended during the 2006–07 biennium. **Figure 4** shows the

FIGURE 4
CRIME VICTIMS' COMPENSATION FUND EXPENDITURES, FISCAL YEARS 1998 TO 2007

(IN MILLIONS)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Other agencies	$2.0	$1.8	$7.1	$7.1	$35.0	$35.1	$56.7	$54.7	$2.7	$2.8
Victim Assistance	$0.5	$0.5	$3.6	$5.0	$26.2	$35.9	$32.2	$34.1	$32.1	$34.1
Compensation	$27.6	$34.9	$33.6	$32.2	$32.8	$75.2	$50.6	$51.3	$67.1	$72.0

Source: Legislative Budget Board.

three major categories of expenditures for fiscal years 1998–2007.

Ensuring the solvency of the Crime Victims' Compensation Fund will require improving the collection rate of court costs, fees, and restitution and establishing a fund reserve policy and limiting future expenditures from the fund.

CONSOLIDATED COURT COST

One of the primary sources of revenue for the CVC Fund is the Consolidated Court Cost. The consolidated court cost is charged to offenders convicted of misdemeanors and felonies. An estimated $165.6 million in revenues is expected to be deposited to the Crime Victims Compensation Fund from the consolidated court cost in the 2006–07 biennium.

Collection of court costs, fees, and fines has been an area where many court jurisdictions have struggled. In 1996 the Office of Court Administration (OCA) created a program to improve court collections, based on experience at Dallas County. The new Collection Improvement program emphasized:

- a clear line of responsibility for the collection of court costs, fees, and fines;
- uniform collections policy;
- establishment of realistic collection goals and targets; and
- judicial commitment to the program.

The collections program was available for municipal, justice of the peace, county, and district courts and was implemented on a voluntary basis. For programs entering the Collection Improvement Program, the average collection rate for those participating was 33 percent. At the end of fiscal year 2005, the average post-implementation collection rate for participating programs was 62 percent. To continue improving collection rates, the Seventy-ninth Legislature, Regular Session, 2005, passed legislation requiring counties over 50,000 in population and cities over 100,000 in population to operate a Collection Improvement Program. From this legislation, 78 jurisdictions are required to implement collections programs. As of October 2006, 34 mandatory programs have been implemented with more expected during fiscal year 2007 and 40 voluntary programs are in operation.

Recommendation 1 would create a reporting requirement for the Office of Court Administration to the Legislative Budget Board and the Governor's Office that includes the number of voluntary programs implemented each year under the Collection Improvement Program. The following rider could be included in the 2008–09 General Appropriations Bill to implement this recommendation:

> **Performance Reporting for the Collection Improvement Program.**
> The Office of Court Administration shall report on an annual basis the following information to the Legislative Budget Board and Governor: (1) the number of mandatory Collection Improvement programs in operation, (2) the number of mandatory programs not in compliance, (3) the number of voluntary programs in operation, (4) the number of new voluntary programs in operation, (5) the total additional state revenue per voluntary program, and (6) per program revenue from all participating programs. The Office of Court Administration should seek to increase the number of voluntary programs by five each fiscal year.

Establishing five new voluntary programs per year would continue the expansion of best practices in court collections. By expanding the Collection Improvement Program on a voluntary basis to other jurisdictions, the state could continue to improve its collection of not only the consolidated court cost, but other court costs, fees, and fines. The OCA should identify counties and municipalities interested in expanding and provide them with assistance to implement a Collection Improvement Program. If implemented, five new programs per year for the biennium would provide an estimated $111,267 in additional revenue to the CVC Fund. Given the agency's established staff and efforts on this program, the OCA would not require any additional resources for this recommendation.

VICTIM RESTITUTION

Restitution is payment made by the offenders to a victim to reimburse him or her for costs incurred due to the crime. Restitution has historically been difficult to track and collect, and Texas does not have a statewide system to collect information on the amount of restitution ordered or collected.

Multiple parties are involved in the restitution process including local courts, community supervision and corrections departments (CSCDs), the Parole Division and the Community Justice Assistance Division (CJAD) of the Texas Department of Criminal Justice, the OCA, the Juvenile Probation Commission (JPC), and the OAG. The courts

order and determine restitution amounts, yet they do not have to report the amounts they order to the state. There is no information available that can identify the total amounts of court-ordered restitution statewide.

Though statewide data is unavailable, there are a few sources of information that help provide some insight on restitution. From the Legislative Budget Board's Texas Community Supervision Revocation Project, September 2006, a sample of 227 revoked probationers in four counties (Bexar, Harris, Tarrant, and Travis) were assessed $332,254 in restitution and at the time of revocation, only $68,132 had been paid, reflecting a 21 percent collection rate. The average amount owed by these probationers was $1,464, with an average of $300 collected. Approximately 40 percent of the revoked probationers in the study owed restitution. In addition, 68.6 percent of revoked probationers in this study had received technical violations for failure to pay fees or restitution.

The CJAD estimates that over 90 percent of those paying restitution are under community supervision. Though the division has been gathering restitution collection information from CSCDs since 1999, the reporting by CSCDs of restitution ordered for offenders under community supervision and the overall amounts collected is not mandatory. Since 2001, voluntary reporting on restitution by the 121 CSCDs has ranged from a low of 74 percent in 2005 to a high of 95 percent in 2002. During this five-year period, reported restitution collections ranged from $38.8 million to $48.9 million per year. A small percentage of offenders paying restitution are on parole. For parole, restitution collected included $1 million each fiscal year from 2004 to 2006. **Figure 5** shows the restitution amounts collected in the last three fiscal years. CSCDs and the Parole Division have expressed concern about restitution amounts that far exceed an offender's ability to pay during the supervision term served.

FIGURE 5
RESTITUTION COLLECTED STATEWIDE
FISCAL YEARS 2004–2006

COLLECTING ENTITY OR FUND	2004	2005	2006
Parole, TDCJ (Fund 984)	$1,031,264	$995,803	$973,915
Community Supervision and Corrections Departments	$41,916,685	$38,811,079	Data not available
OAG (CVC Fund 469)	$1,019,533	$1,061,706	$1,158,280

SOURCES: Legislative Budget Board; Texas Department of Criminal Justice; Comptroller of Public Accounts.

Restitution has an important relationship with the Crime Victims' Compensation (CVC) Fund. If a victim has not received restitution payments, he or she can apply to receive reimbursement for crime-related costs falling within any approved benefit areas. Though the OAG attempts to cross-check compensation applicants with those who have received restitution, there is not a unified system of reporting for the courts, parole and community supervision, so there is a possibility of duplication in payments.

To make effective long term restitution reform, the state needs accurate information about restitution to develop policies that can make a significant impact regarding amounts ordered, improving collection, and improving distribution to victims. In the absence of good, reliable information it is difficult to craft effective policies for restitution ordered and collected.

The Texas Code of Criminal Procedure §42.037 outlines the requirements for ordering restitution or, if restitution is not ordered or provides only partial reimbursement, it requires the courts to state on the record the reasons for not making the order or for the limited order. If restitution is not ordered, a judge can require the offender to make a one-time payment to the CVC Fund in the amount of $50 for misdemeanors and $100 for felonies. The Seventy-ninth Legislature passed House Bill 1751, which assisted the restitution process and the CVC Fund in two ways. First, it allowed offenders to pay the CVC Fund directly if compensation payments have already been made to a victim. Second, if the court requires the defendant to make restitution in specified installments, in addition to the installment payments, the court may require the defendant to pay a one-time restitution fee of $12, $6 of which is deposited to the CVC Fund.

At the outset, judges need to order restitution that balances cost incurred by a victim and an offender's ability to pay. Information about how much restitution is ordered for a given crime, about a victim's costs, under what circumstances an offender is paying restitution (community supervision or parole), and the amount collected would be helpful to the state in developing restitution policies that are more effective. Recommendation 2 would amend the Texas Government Code §76.013 and the Texas Code of Criminal Procedure §42.037 to require OCA, CJAD, OAG, and the Parole Division to develop reporting requirements for all the involved entities and build upon existing computer systems

for electronic reporting. **Figure 6** summarizes some of the information that may be useful to collect for making future policy.

FIGURE 6
REPORTING REQUIREMENT CONSIDERATIONS FOR RESTITUTION

PERSONS OR ENTITIES INVOLVED IN RESTITUTION	RECOMMENDED DATA COLLECTION FOR ANNUAL REPORTING ON RESTITUTION
Local courts and judges Community Supervision and Corrections Departments Parole Offender Victim	How much is ordered in each case? Aggregate? Are there trends in amount of restitution ordered (based on crime and level of offense)? Where is the offender paying restitution placed (community supervision, jail, etc.)? What is the collection rate for individual cases and aggregate?

Source: Legislative Budget Board.

One system that may be useful to build upon is the Office of Court Administration's Collections System. This system is in the development and training stage. Of the courts participating in the Collection Improvement Program, mandatory programs are required and voluntary programs are encouraged to report monthly data on court cost and fees collected via the Collection System. Courts could be required to report the amounts of ordered restitution on a monthly basis. However, using this collection mechanism would only provide aggregate information on amounts ordered. It would not provide a better method of cross-checking victim restitution payments with reimbursements from the victim compensation program. The OCA also has a judicial database system that could be used.

CRIME VICTIMS' AUXILIARY FUND

Local community supervision departments, according to Texas Government Code §76.013, must retain money paid by an offender for a period of five years and make a good faith effort to locate the victim if the money goes unclaimed. After five years, the community supervision department may retain 5 percent as a fee and then remit the remainder to the Comptroller, where it is deposited into the Crime Victims' Compensation Auxiliary Fund (494). After this time, a victim seeking the restitution must apply to the Comptroller. As of the end of fiscal year 2006, a balance of $12.2 million remained in the fund.

In the last five years, only a small amount of the funds have been claimed. **Figure 7** shows the amounts claimed, deposited, and end of year balances.

Recommendation 3 would amend the Code of Criminal Procedures, Chapter 56 to transfer up to 25 percent of each previous end of fiscal year's fund balance to the Crime Victims' Compensation Fund for compensation payments if the fund balance was higher than $5 million. This recommendation would provide an additional $6.1 million in funding in the 2008–09 biennium.

CVC FUND RESERVE POLICY

Currently, all monies in the CVC Fund can be spent. There is no policy for requiring a minimum balance in the fund at the end of each fiscal year. For many years the CVC Fund had a very large fund balance. From fiscal years 1998–2006 the CVC Fund end-of-year balances ranged from $67.0 million to $269.5 million. **Figure 8** shows the end-of-year fund balances.

Recommendation 4 proposes creating a mandatory reserve policy for the CVC Fund by amending the Code of Criminal Procedure §56.541 during fiscal years when insolvency is

FIGURE 7
CRIME VICTIMS' COMPENSATION AUXILIARY FUND (494), FISCAL YEARS 2000 TO 2006

FINANCIAL INFORMATION	2000	2001	2002	2003	2004	2005	2006
Beginning balance	$4,302,104	$5,062,441	$6,121,528	$6,860,132	$8,033,380	$9,337,429	$10,439,637
Restitution deposits	514,950	765,670	546,472	1,017,130	1,203,125	884,590	1,355,903
Warrants Voided	0	0	0	616	1,359	0	214
Interest	264,043	305,948	212,025	147,755	124,660	239,817	470,697
Claims paid	(18,655)	(12,531)	(19,892)	(7,726)	(25,094)	(22,198)	(21,656)
Ending balance	5,062,441	6,121,528	6,860,132	8,017,907	9,337,429	10,439,637	12,244,795

Note: This chart is based on 2000 to 2006 Annual Cash Reports and additional claims information provided by the Comptroller of Public Accounts.
Source: Comptroller of Public Accounts.

FIGURE 8
CRIME VICTIMS' COMPENSATION FUND END OF YEAR BALANCES, FISCAL YEARS 1998 TO 2006

FUND INFORMATION	1998	1999	2000	2001	2002	2003	2004	2005	2006
End of Year Fund Balance	$167,882,912	$205,351,021	$234,869,494	$269,461,671	$260,526,166	$191,711,244	$137,460,021	$84,524,849	$67,058,646
Change in Fund Balance	n/a	37,468,110	29,518,473	34,592,177	(8,935,505)	(68,814,922)	(54,251,223)	(52,935,172)	(17,466,203)
Compensation payments	$ 27,619,111	34,915,132	33,582,918	32,235,285	32,845,001	75,232,263	50,603,489	51,282,971	67,148,545
Payments as a percentage of balance	16.5%	17.0%	14.3%	12.0%	12.6%	39.2%	36.8%	60.7%	100.1%

SOURCES: Legislative Budget Board; Comptroller of Public Accounts.

projected. Reserving 10 percent at the end of each fiscal year for the next year's compensation payments would provide a cushion to help pay for increasing demand of compensation payments. To prevent excessive fund balances, the Code of Criminal Procedure §56.54(h) limits the fund balance carried forward to the next fiscal year to 25 percent of the current year's compensation payments. If no minimal reserve mechanism is in place, it makes insolvency more likely after several years of high demand for compensation and victim services funding. The Code of Criminal Procedure §56.54(i) also provides for an emergency contingency of $10 million if there are available funds in the CVC Fund, but the language is permissive. This recommendation would only be implemented during years when insolvency is likely. In years when this occurs, victim services expenditures would need to be reduced to create the 10 percent reserve for victim compensation payments. The CVC Fund is not projected to become insolvent until fiscal year 2011, so there would not be a fiscal impact for the 2008–09 biennium.

CVC VICTIM SERVICES FUNDING

Victim services funding has comprised an increasing amount of CVC Fund expenditures over the last seven fiscal years. As shown in **Figure 8**, for several years the CVC Fund had significant fund balances. During tight budget times, more of these funds were appropriated to victim services programs at the OAG and other state agencies. The Victim Assistance program at OAG funds eight different grant programs for various services including counseling, staff training, sexual assault prevention, and victim advocacy. During the period fiscal year 1998 to 2007, eight programs at seven state agencies (other than the OAG) received CVC funds. Though victim services programs provide needed assistance to crime victims, all monies appropriated to these programs are funds that cannot be used for compensation payments, which is the primary purpose of the fund. **Figure 9** shows the money expended for victim assistance programs.

A reduction in victim services expenditures from the CVC Fund over the long term would assist in maintaining the fund's solvency. During the 2004–05 biennium, expenditures by other states agencies peaked at $111.5 million, which included seven agencies. For the 2004–05 biennium, Victim Assistance expenditures at the OAG totaled $66.2 million.

For the 2006–07 biennium, estimated CVC Fund expenditures at other state agencies totals $5.5 million. These expenditures were restricted to the Employees Retirement System (ERS) for Public Safety Death Benefits and the Texas Department of Criminal Justice (TDCJ) for victim notification of offender status once in the correctional system and other victim services. For the 2006–07 biennium, estimated CVC Fund expenditures for Victim Assistance at the OAG total $66.1 million.

Recommendation 5 suggests consideration of long term small appropriation reductions for victim services from the CVC Fund beginning in the 2008–09 biennium over fiscal year 2007 expenditures. Small reductions in appropriations for victim services, which are not the primary funding purpose of the fund, would ensure funds for compensation as well as level funding for victim services in future years. Over time, small reductions can have a major impact.

For example, a 10 percent reduction in victim services funding from the fiscal year 2007 level would total $3.8 million per year. Based on current and projected revenues and expenditures through fiscal year 2013, this reduction over the long term would help maintain the solvency of the fund through 2011 with a $4.7 million deficit by the end of 2012. Without this reduction, the fund would be insolvent by the end of fiscal year 2011 and would have a negative

FIGURE 9
VICTIM ASSISTANCE PROGRAM EXPENDITURES, FISCAL YEARS 1998–2007

TYPE OF VICTIM SERVICE	1998–99	2000–01	2002–03	2004–05	2006–07
OAG VICTIM ASSISTANCE					
Victim Coordinator/Liaison	$0	$1,512,741	$4,827,523	$4,707,671	$4,837,553
Statewide Victim Notification System	0	0	3,761,850	6,828,305	6,961,622
Sexual Assault and Crisis Prevention	0	853,592	12,050,287	13,789,311	13,674,637
Other Victim Assistance	0	0	23,557,728	21,164,764	20,915,430
Children's Advocacy Centers	0	2,748,749	7,997,068	7,998,006	7,998,006
CASA	1,000,000	3,000,000	4,122,795	5,969,737	6,000,000
Legal Services Grants	0	0	5,035,738	5,000,000	5,000,000
Sexual Assault Services (TAASA)	0	453,682	750,000	750,000	750,000
OAG Victim Assistance total	**$1,000,000**	**$8,568,764**	**$62,102,989**	**$66,207,794**	**$66,137,248**
OTHER AGENCIES					
SHSU (Crime Victims' Institute)	$245,881	$1,054,235	$430,566	$555,534	$0
Texas Department of Criminal Justice - BIPP	0	1,900,000	2,494,432	2,499,999	0
Texas Department of Criminal Justice - Victim Services	0	2,708,747	2,847,086	2,699,337	3,006,661
HHSC - Family Violence Shelters	3,600,000	8,600,000	30,725,641	34,693,696	0
DFPS - Foster Care & Adult Protection	0	0	31,965,418	65,565,418	0
ERS	0	0	0	3,291,976	2,512,500
OCA - Foster Care Courts	0	0	1,599,139	2,161,691	0
CPA	0	1,835	167	16,750	70
Other agency total	**$3,845,881**	**$14,264,817**	**$70,062,449**	**$111,484,401**	**$5,519,231**

SOURCES: Legislative Budget Board; Office of the Attorney General.

balance of $36.3 million by the end of fiscal year 2012. This example assumes the revenue gains from Recommendations 1 and 3, which total $6.2 million in revenue gains to the fund for the 2008–09 biennium. A higher reduction in CVC funding for victim services would lessen or eliminate the deficit.

For the 2008–09 biennium, implementing this recommendation would require reducing appropriations for victim services to the OAG, ERS, and TDCJ. Alternative sources of funding for the reduction, such as General Revenue, could be sought.

The recommendations provided in this report involve a combination of short and long term strategies. While the short term strategies may assist in preventing the Crime Victims' Compensation Fund's insolvency during the 2008–09 biennium, incorporating more long term strategies will help ensure victims will be able receive needed compensation payments in future years.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementing these recommendations would result in a gain to the CVC Fund of $6.1 million and a cost to the CVC Auxiliary Fund of $6.1 million in the 2008–09 biennium.

Implementing Recommendation 1 would make an additional $111,267 available to the Crime Victims' Compensation Fund during the 2008–09 biennium by establishing five new collections programs each year. This recommendation assumes $28,530 per program for a total $142,650 in fiscal year 2008 and $285,308 in fiscal year 2009 in additional revenue from collected courts costs and fees. Of this amount, approximately 26 percent would be deposited to the CVC Fund. The fiscal impact from Recommendation 1 constitutes a revenue gain to the CVC Fund, but due to the voluntary nature of these program expansions, the projected revenue gains are not included in the five-year fiscal impact.

Implementing Recommendation 2 would have no significant fiscal impact for the 2008–09 biennium. This

recommendation is intended to develop better reporting practices and develop more effective restitution policies in future years based on new data.

Implementing Recommendation 3 would make an additional $6.1 million available to the Crime Victims' Compensation Fund during the 2008–09 biennium by allowing 25 percent of the fund balance from the Crime Victims' Compensation Auxiliary Fund (494) to be transferred to Fund 469. The fiscal impact from Recommendation 3 constitutes a revenue gain to the CVC Fund.

Implementing Recommendation 4 would reserve 10 percent of the projected compensation payments for the year prior to a fiscal year in which the Crime Victims' Compensation Fund is projected to go insolvent. Current projections for the fund do not indicate insolvency during the 2008–09 biennium, so there is no fiscal impact reflected in **Figure 10**.

Implementing Recommendation 5, which proposes a small long term reduction in CVC Fund appropriations for victim services, would have a fiscal impact equivalent the to the dollar amounts reduction. The example used is a ten percent reduction, which would constitute a savings of $7.6 million to the CVC Fund for the 2008–09 biennium, if implemented at that level. This reduction is not included in the fiscal impact table.

FIGURE 10
FIVE YEAR FISCAL IMPACT

FISCAL YEAR	PROBABLE REVENUE GAIN/(LOSS) TO THE CRIME VICTIMS' COMPENSATION FUND (GENERAL REVENUE–DEDICATED FUNDS)	PROBABLE SAVINGS/(COST) TO CRIME VICTIMS' AUXILIARY FUND (GENERAL REVENUE–DEDICATED FUNDS)
2008	$3,344,314	($3,344,314)
2009	2,791,350	(2,791,350)
2010	2,376,628	(2,376,628)
2011	2,065,586	(2,065,586)
2012	1,832,304	(1,832,304)

SOURCE: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendation 1. The introduced 2008–09 General Appropriations Bill does not address Recommendations 2, 3, 4, or 5.

UPDATE ON HEALTHCARE SERVICES FOR TEXAS ACTIVE DUTY PERSONNEL, RETIRED MILITARY AND VETERANS

The U.S. Department of Defense and the U.S. Department of Veterans Affairs provide healthcare benefits and services to veterans, active duty personnel, retired military and their dependents residing in Texas. TRICARE is the health benefits program operated by the U.S. Department of Defense. Humana-Military is the regional contractor providing healthcare services and network provider support in the TRICARE South Region, which includes most of Texas. The southwestern corner of Texas, including El Paso, is included in the TRICARE Region West. TRIWEST Healthcare Alliance is the regional contractor that supports the TRICARE Region West. Active duty and retired military personnel also receive medical care through the U.S. Department of Defense Military Health System at Military Treatment Facilities located on or near certain military installations.

The Veterans Health Administration within the U.S. Department of Veterans Affairs provides healthcare benefits and services to eligible veterans and their dependents. An individual eligible for veteran healthcare services may receive medical care through hospitals, community-based outpatient clinics and other facilities the Veterans Health Administration operates or through the department's health benefits plan, the Civilian Health and Medical Program of the Department of Veterans Affairs. Nationally, there are 21 Veterans Integrated System Networks that provide medical and healthcare services for veterans. Three of the Veterans Integrated System Networks cover parts of Texas.

Veterans may also receive healthcare and other services through the State Veterans Homes Program in Texas. These skilled-nursing facilities provide services such as rehabilitation programs that offer physical, occupational and speech therapies and social services. State Veterans Homes provide long-term and short-term care. As of October 2006, 849 veterans and spouses of veterans reside in the six State Veterans Homes located in Texas.

FACTS AND FINDINGS

- According to the U. S. Department of Veterans Affairs, there were 1.65 million veterans residing in Texas in 2005. The U.S. Census Bureau indicates that Texas is one of the six states with 1 million or more veterans. About 34 percent of veterans are age 65 and older. In 2004, the U.S. Department of Veterans Affairs spent $1.9 billion for medical care provided to 360,000 Texas patients.
- Medicaid is the payor of last resort when an individual is eligible for TRICARE or Civilian Health and Medical Program of the Department of Veterans Affairs coverage. According to the Health and Human Services Commission, individuals applying for Medicaid in Texas and determined to be eligible for TRICARE or Civilian Health and Medical Program of the Department of Veterans Affairs coverage increased from 77,363 in fiscal year 2001 to 134,261 in fiscal year 2006.
- In the Heart of Texas Veterans Integrated Services Network that includes 134 Texas counties, the percentage of enrolled veterans with Medicaid coverage increases with age. This increase may have fiscal implications for the Texas Medicaid program as the number of veterans age 65 and older increases.
- Since December 2000, the number of State Veterans Homes in Texas has grown from two to six, with a seventh home expected to open in spring 2007.
- For Medicaid-eligible residents of State Veterans Homes in Texas in fiscal year 2006, the state provided a Medicaid payment of $133 per day. About 12 percent of residents are Medicaid-eligible.
- The U.S. Department of Veterans Affairs per diem payments no longer offset Medicaid reimbursment. The Texas Veterans Land Board has received an additional $4.2 million as of the end of 2006, retroactive to December 1, 2004, for per diem payments. As of December 2006, the Veterans Land Board had not determined the use of these additional funds.
- The demand for healthcare services and the cost of providing these services will likely increase as the number of veterans age 65 and older increases and as Operation Enduring Freedom and Operation Iraqi Freedom service members return from deployment with more complex service-connected disabilities and conditions such as Post Traumatic Stress Disorder and Traumatic Brain Injuries.

DISCUSSION

The U.S. Department of Defense (DOD) operates the Military Health System that is comprised of direct care services provided at Military Treatment Facilities, such as medical centers, hospitals and clinics and purchased care services that include regional civilian provider networks that provide contracted care. TRICARE is the health benefits program operated by DOD. TRICARE serves active duty and retired uniformed services personnel and their families. There are four programs under TRICARE including:

- TRICARE Prime: a managed care option, where Military Treatment Facilities are the principal source for healthcare;
- TRICARE Extra: a preferred provider option;
- TRICARE Standard: a fee-for-service option (formerly CHAMPUS); and
- TRICARE for Life: a supplemental healthcare option providing coverage for TRICARE beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B.

In 2001, U.S. Congress expanded TRICARE to include the TRICARE for Life supplemental coverage that pays for services Medicare only partially covers. Beneficiaries do not pay for TRICARE for Life but pay premiums for Medicare Part B. A TRICARE beneficiary may also have a TRICARE supplement that pays the beneficiary's out-of-pocket expenses. A pharmacy benefit was implemented beginning April 1, 2001, for Medicare-eligible military retirees and their dependents. DOD also offers a mail order pharmacy benefit. Also effective April 1, 2001, DOD removed co-payment requirements in the civilian network for all active duty service members and their families in TRICARE Prime except for pharmacy services. A TRICARE beneficiary's participation in the Medicare Part D pharmacy benefit is voluntary.

The TRICARE Management Activity is the field agency within the DOD that administers the TRICARE healthcare plan. Most of Texas is included in the TRICARE South Region. Humana-Military is the regional contractor providing healthcare services and network provider support in the TRICARE South Region. The southwestern corner of Texas, including El Paso, is included in the TRICARE Region West. The regional contractor that supports the TRICARE Region West is TRIWEST Healthcare Alliance.

OTHER THIRD PARTY RESOURCES AND TRICARE

Other third-party resources available to TRICARE beneficiary are considered the primary health insurance plans for beneficiaries. However, an exception exists for TRICARE beneficiaries enrolled in Medicaid. In these instances, TRICARE is the primary payor. Conversely, Medicare is considered a primary health insurance plan for TRICARE beneficiaries who are eligible for Medicare. If services are covered under TRICARE only and not Medicare, the TRICARE beneficiary is responsible for any TRICARE deductibles or cost sharing. If the reverse is true, the TRICARE beneficiary must pay any Medicare deductibles or cost sharing. If the TRICARE beneficiary also has a Medicare Supplement, TRICARE becomes the third payor.

On October 17, 2006, the President signed the John Warner National Defense Authorization Act of 2007 that contains a provision that prohibits the offering of financial or other incentives to TRICARE-eligible employees to not enroll in employer group health plans that would become the primary plan.

EFFECTS OF BASE REALIGNMENT AND CLOSURE PROCESS ON TRICARE PROGRAM

According to the DOD, the TRICARE program has undergone significant redesign to adapt to changes in beneficiary needs and direct service infrastructure caused by the DOD Base Realignment and Closure (BRAC) process. The BRAC process began in 1988, following the end of the Cold War-era. Between federal fiscal years 1995 and 2005, the number of DOD Military Health System hospitals nationally decreased from 130 to 52. During this period, some military hospitals were closed or downsized to ambulatory clinics. The number of DOD Military Health System clinics was also reduced from 388 clinics in 1995 to 309 clinics in federal fiscal year 2000.

Several recommendations from the 2005 BRAC process affect facilities in Texas, including the following:

- Closure of Brooks City Base (BCB), San Antonio, Texas and relocation of the combat casualty care research activities at BCB with the military clinical activities at the trauma center located at Brooke Army Medical Center, Fort Sam Houston, Texas;
- Relocation of the Army Medical Research Detachment at BCB to the Army Institute of Surgical Research at Fort Sam Houston, Texas;
- Realignment of Lackland Air Force Base, Texas by relocating the inpatient medical function of the 59th

Medical Wing (Wilford Hall Medical Center) to the Brooke Army Medical Center at Fort Sam Houston, Texas to become the San Antonio Regional Military Medical Center and converting the Wilford Hall Medical Center into a ambulatory care center; and

- Relocation of basic and specialty enlisted medical training to Fort Sam Houston, Texas from Sheppard Air Force Base, Texas and two other facilities outside of Texas.

Texas beneficiaries receiving direct healthcare services provided by the DOD Military Health System may receive care at Military Treatment Facilities listed in **Figure 1**.

DEPARTMENT OF VETERANS AFFAIRS HEALTHCARE SERVICES

The U.S. Department of Veterans Affairs (VA) offers healthcare benefits and services to eligible veterans and their dependents. The VA Healthcare System (VHS) includes hospitals, community clinics, nursing homes, counseling centers, and domiciliary care, that is, treatment and rehabilitative care provided in a residential bed-based setting.

FIGURE 1
MILITARY TREATMENT FACILITIES IN TEXAS, OCTOBER 2006

MILITARY INSTALLATION	MILITARY TREATMENT FACILITY
Brooks City Base	311th Medical Squadron
Dyess Air Force Base	7th Medical Group-DAFB Clinic
Fort Hood	Carl R. Darnall Army Medical Center
Fort Sam Houston	Brooke Army Medical Center
Goodfellow Air Force Base	17th Medical Group-GAFB Clinic
Lackland Air Force Base	59th Medical Wing-Wilford Hall Medical Center
Laughlin Air Force Base	47th Medical Group-LAFB Clinic
Naval Air Station, Corpus Christi	Naval Hospital-Corpus Christi
Naval Air Station, Kingsville	Branch Medical Clinic-Kingsville
Naval Air Station, Fort Worth	Branch Medical Clinic-Fort Worth
Naval Station, Ingleside	Branch Health Clinic-Ingleside
Randolph Air Force Base	12th Medical Group-RAFB Clinic
Sheppard Air Force Base	82nd Medical Group-SAFB Clinic
Fort Bliss	William Beaumont Army Medical Center-El Paso

Sources: Legislative Budget Board; U.S. Department of Defense.

Unlike patients in hospitals and nursing homes, patients in domiciliaries do not require bedside nursing care and are capable of performing activities of daily living. VHS provides inpatient care, outpatient medical, dental, pharmacy and prosthetic services. Other services include health and rehabilitation for homeless veterans, alcohol and drug dependency counseling and treatment, specialized healthcare for women veterans, and emergency medical care in non-VA facilities, among other services.

The VA also conducts a financial assessment to determine whether a veteran that is determined eligible to receive VA healthcare will be charged co-payments for services received. Veterans below the VA adjusted national and geographic thresholds may be eligible for reductions in co-payment rates of 80 percent. If a VA facility cannot provide the care needed, prior authorization of the VA is needed to access the non-VA fee program health benefits.

CHAMPVA is the health benefits plan offered by the VA. The VA Health Administration Center, in Denver, Colorado, is the benefits program administrator. CHAMPVA covers most healthcare services and supplies that are medically and psychologically necessary. To be eligible for CHAMPVA, an individual would not be eligible for TRICARE but would be one of the following:

- The spouse or child of a veteran rated by the VA as permanently or totally disabled from a service-connected disability; or
- The surviving spouse or child of a veteran who:
  - Died from a VA-rated service-connected disability
  - Was totally or permanently disabled from a service-connected disability at the time of death; or
- The surviving spouse or child of a military member who died in the line of duty. (Usually, the family members are eligible for TRICARE and not CHAMPVA.)

A military retiree or the spouse of a veteran who was killed in action is eligible for TRICARE and not VA benefits. A VA-eligible individual may receive medical care through the Veterans Health Care System or CHAMPVA. A veteran's family members who are enrolled in CHAMPVA may also receive medical care at VA medical centers when space and capacity are available after serving veterans.

CHAMPVA is a fee-for-service program. Beneficiaries select their own medical and healthcare providers. Providers who elect to participate in CHAMPVA are required to accept the

CHAMPVA allowable rate and cannot bill beneficiaries for any difference in the rate and their charges. CHAMPVA has a partnership with Medical Matrix for pharmacy services and offers a medication by mail program.

OTHER THIRD PARTY RESOURCES AND CHAMPVA

CHAMPVA is the secondary payor to all other health or supplemental insurance coverage except for the State Victims of Crime Compensation and Medicaid. In June 2001, the federal administration extended CHAMPVA benefits to veterans over the age of 65, effective October 1, 2001. CHAMPVA is the secondary payor to Medicare. The following provisions address Medicare recipients' eligibility for CHAMPVA coverage:

- If age 65 before June 21, 2001, an individual with Medicare Part A only is eligible for CHAMPVA without having Medicare Part B;
- If age 65 before June 21, 2001, an individual with Medicare Part A and Part B is eligible for CHAMPVA but must continue the Medicare Part A and Part B coverage; or
- If age 65 after June 21, 2001, an individual must enroll in Medicare Part A and Part B to be eligible for the CHAMPVA extension.
- Enrollment in the Medicare Part D Prescription Drug Coverage is not required for CHAMPVA eligibility.

EFFECTS OF CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES PROCESS ON CHAMPVA

In February 2004, the federal Capital Assets Realignment for Enhanced Services (CARES) Commission issued a report to the Secretary of Veterans Affairs that included several recommendations for realigning VA medical centers and health facilities, nationally. The recommendations followed a review of the Under Secretary of Health's Draft National CARES Plan. The report stated that the goal of the commission was to enhance healthcare services for veterans. The report indicated that the process needed to ensure that adequate capacity was available to meet the needs of veterans in communities where VA medical centers or VA healthcare facilities were closed or realigned. The report looked at VA inpatient care, community-based outpatient clinics, and mental health services. In summary, the Commission recommendations and suggestions included the following:

- The CARES Commission recommended that the VA increase the number of community-based outpatient clinics or to expand or add services at existing community-based outpatient clinics based on need to improve access to veterans and in response to workload increases.
- The CARES Commission suggested that the VA regions identify and revise plans to address gaps in mental health services based on revised projections regarding demand. The commission felt that demand was underestimated in the draft plan.
- The CARES Commission suggested that the VA collaborate with states to leverage VA and other public funds through the State Veterans Home program.
- Although not included in the CARES process, the CARES Commission suggested that the VA develop a strategic plan for providing long-term care, including care provided in nursing homes, domiciliaries, non-acute inpatient facilities and residential mental health facilities.

The CARES Commission report included specific recommendations that affected Texas VA medical facilities including the South Texas Health Care System – Kerrville Campus, and the VA medical centers located in San Antonio and Waco located in VISN 17, and the Big Spring VAMC in VISN 18.

The May 2004 CARES Decisions report included the decisions of the Secretary of Veterans Affairs regarding the recommendations presented by the CARES Commission. The report indicated that the VA would close the acute care services at the South Texas Health Care System – Kerrville Campus (VISN 17) and transfer these services to the San Antonio Veterans Affairs Medical Center (VAMC) after renovations to the San Antonio facility are completed. Kerrville would retain its nursing home care services and expand its outpatient care services.

Rather than accept the Commission's recommendations, the VA conducted feasibility reviews regarding the Waco VAMC in VISN 17 and the Big Spring VAMC in VISN 18. As of April 2006, the VA determined that inpatient services at the Big Spring VAMC would continue and that the VA would look to expand the inpatient care and residential mental health services provide at this facility. As of December 2006, the VA also determined that the Waco VAMC would remain open and noted the importance of the center's partnership with VA residential care homes in the Waco area to provide outpatient services and periodic inpatient care for residents of the homes. It was noted that the Waco VAMC was recently

designated as a Center for Excellence in outpatient post-traumatic stress disorder services.

VA HEALTHCARE SERVICES IN TEXAS

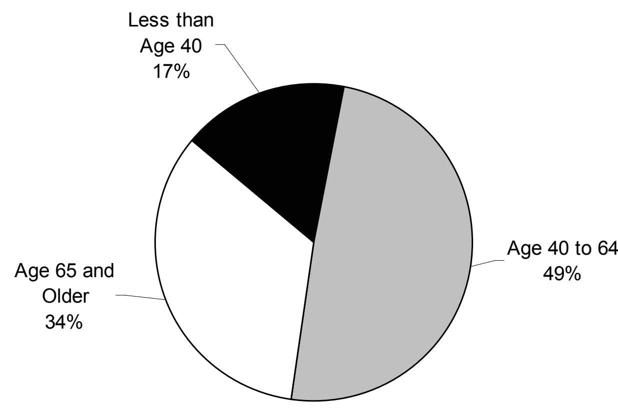
According to the U.S. Census Bureau, as of September 2005, Texas has 1.7 million veterans. According to the VA, the number of veterans in Texas has not changed considerably since 2000. Of the total number of veterans in Texas, 0.3 million are under age 40, 0.8 million are age 40 to 64 and 0.6 million are age 65 and older, as of September 30, 2006. Male veterans represent 1.5 million of the total number of veterans in Texas. **Figure 2** shows the percentage of Texas veterans by age categories.

VA expenditures in Texas for medical care in 2001 were $1.6 billion serving 328,000 patients. By 2004, the amount of VA expenditures for medical care in Texas increased to $1.9 billion serving 360,000 patients.

VA healthcare services are provided in various facilities. These facilities include VA medical centers, VA outpatient centers, VA community-based outpatient clinics, and VA Veteran Centers and State Veterans Homes. **Figure 3** shows the location of these facilities in Texas.

According to the VA, 21 regional Veterans Integrated Services Networks (VISNs) are structured to manage and allocate resources to VA healthcare facilities. Each VA network includes two to six markets. The healthcare markets are geographic areas that have sufficient population and geographic size that planning and coordination of healthcare services provided by VA or non-VA facilities is considered beneficial. By design, a healthcare market can support a continuum of services including inpatient and outpatient care. The regional VISNs and markets that include Texas and the number of veterans provided healthcare services are shown in **Figure 4**.

FIGURE 2
TEXAS VETERANS BY AGE CATEGORIES
AS OF SEPTEMBER 2006



SOURCES: Legislative Budget Board; U.S. Department of Veterans Affairs.

The federal General Accountability Office (GAO) reports that following the CARES process, the VA made alignment decisions affecting 120 locations and deferred decisions for 16 locations pending further study. For example, the VA

FIGURE 3
VA HEALTHCARE FACILITIES SERVING TEXANS, AS OF JANUARY 2007

FACILITY TYPE	IN TEXAS	OUTSIDE OF TEXAS
VA Medical Centers	Amarillo, Big Springs, Bonham, Dallas, Houston, Kerrville, Marlin, San Antonio, Temple, and Waco	Albuquerque, NM; Fort Sill, OK; Oklahoma City, OK; and Shreveport, LA.
VA Outpatient Clinics	Austin, Beaumont, Corpus Christi, El Paso, Fort Worth, Laredo, Lubbock, Lufkin, McAllen, San Antonio, and Victoria	
VA Community-based Outpatient Clinics	Abilene, Aledo, Alice, Beeville, Bridgeport, Brownwood, Bryan/College Station, Cedar Park, Childress, Denton, Eastland, Fort Stockton, Galveston, Greenville, Harlingen, Kingsville, Longview, Marlin, Odessa, Palestine, Paris, San Angelo (closed for remodeling), Sherman, Stamford, Stratford, Texas City, Tyler, Waxahachie, and Wichita Falls	Clovis, NM; Hobbs, NM; Las Cruces, NM; and Texarkana, AR.
VA Veteran Centers	Amarillo, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston (2), Laredo, Lubbock, McAllen, Midland, and San Antonio	
State Veterans Homes	Big Spring, Bonham, El Paso, Floresville, McAllen, and Temple	

SOURCES: Legislative Budget Board; Texas Veterans Commission.

FIGURE 4
VETERANS INTEGRATED SERVICE NETWORKS (VISN) AND MARKETS THAT INCLUDE PARTS OF TEXAS

NETWORK	VISN	VETERANS SERVED	MARKET	PART OF TEXAS INCLUDED IN MARKET
South Central	16	0.4 million	Central Lower	Eastern Texas
			Upper Western	Northeast Texas
Heart of Texas	17	1.0 million	Central	Central Texas
			North	North Texas
			Southern	South Central Texas
			Valley-Coastal Bend	Southern Texas
Southwest	18	0.2 million	New Mexico-West Texas	Western Texas

SOURCES: Legislative Budget Board; U.S. Department of Veterans Affairs.

determined that Network 16, which includes eastern Texas, had limitations in geographic access to specialized inpatient care to treat spinal cord injury and disorder and for blind rehabilitation. To improve access to care in these specialty areas, VA alignment decisions include adding inpatient VA services for blind rehabilitation and to study options for care for this network. (Limitation to access is based on analysis of driving times from veterans' residences to the nearest VA-owned or VA-affiliated medical facility.)

The GAO report mentions other alignment decisions that affect Texas. A decision was made to enter into agreement with non-VA providers of tertiary and acute care in the Network 18 New Mexico—West Texas market because the VA identified limitations in geographic access for inpatient services in this network. The decision to contract with non-VA providers for acute care services was also made to address similar limitations in Network 17 North, which includes central Texas.

ENROLLMENT ELIGIBILITY DETERMINATION IN TEXAS

Sections 358.305 and 358.465 of the Texas Administrative Code requires that to be eligible for Medicaid, individuals must apply for other benefits to which they may be entitled, such as Workers Compensation, Social Security and veterans' benefits. According to the Health and Human Services Commission (HHSC), the state's Third Party Resources (TPR) Reporting System can determine other third-party resources that may be responsible for a Medicaid recipient's medical bills. When a person applies for Medicaid, a state health and human services advisor completes the process of identifying current or potential insurance coverage available to the person. Eligibility files sent to the Medicaid claims administrator, Texas Medicaid Healthcare Partnership, are coded to designate the third party responsible for payment of claims. Medicaid pays only as a "last resort."

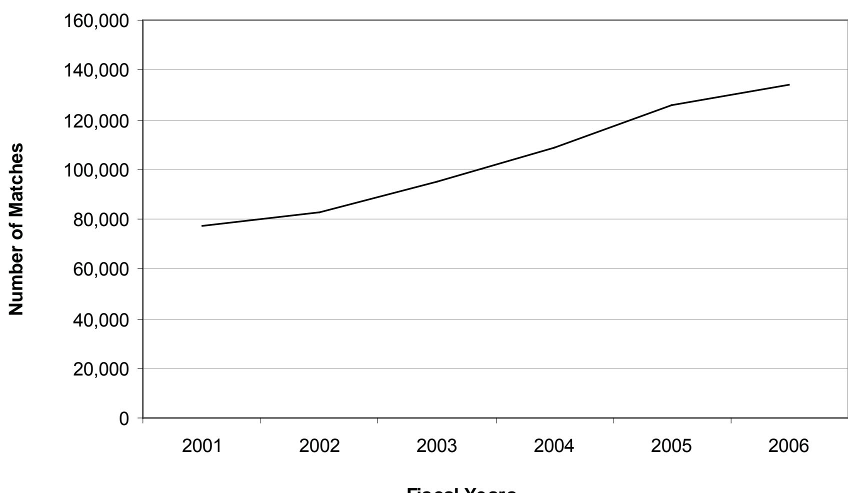
In addition to the TPR process, HHSC contracts with Health Management Systems to annually query the DOD Defense Enrollment Eligibility Reporting System (DEERS) database to certify TRICARE and CHAMPVA client eligibility. The federal system can identify individuals potentially eligible for TRICARE and CHAMPVA benefits. State Medicaid programs can access DEERS through electron batch file transmission or a web-based application, which provides real-time access to healthcare, dental and pharmacy enrollment coverage. The HHSC Office of Inspector General maintains the list of clients identified that have both Medicaid and TRICARE or CHAMPVA coverage.

Figure 5 shows the number of DEERS third-party liability matches, between TRICARE or CHAMPVA and Medicaid in fiscal years 2001 through 2006. According to HHSC, the numbers represent an unduplicated count and are the result of DEERS Third Party Liability Match prior to any edits. The edits would relate to lapses in coverage or other events where TRICARE, CHAMPVA or Medicaid coverage would not be active for a period of time in each year.

The 2005 VA survey findings on veterans health insurance coverage suggests the following regarding veterans enrolled in Network 17, the Heart of Texas Health Care Network (which covers the majority of Texas veterans):

- The number of enrolled veterans with private insurance coverage is likely to be greater among the enrolled veterans who are age 45 and older compared to enrolled veterans who are less than age 45.
- The number of enrolled veterans with Medicaid coverage is greatest among the enrolled veterans who are age 65 and older.
- The number of enrolled veterans with TRICARE or TRICARE for Life coverage is greater among veterans

FIGURE 5
NUMBER OF THIRD PARTY LIABILITY MATCHES BETWEEN TRICARE OR CHAMPVA AND MEDICAID, FISCAL YEARS 2001 AND 2006



SOURCES: Legislative Budget Board; Health and Human Services Commission.

in the age categories age 45 and older than in the under age 45 category.

Figure 6 shows number of Texas veterans enrolled in the Heart of Texas Health Care Network by type of insurance coverage and by age categories.

The federal Veterans Health Care Eligibility Reform Act of 1996 (Public Law 104-262) required the VA to establish and implement a national enrollment system for managing VA healthcare delivery, effective October 1, 1998. The law also required the VA to ensure sufficient capacity to care for veterans with specified conditions including spinal cord injuries and diseases, blindness, amputations, and chronically disabling mental illness. There are eight VA Health Care Enrollment Priority Groups. Veterans assigned to Priority Group 1 receive maximum consideration in receiving VA healthcare services. Individuals assigned to this priority group have service-related disabilities rated 50 percent or more disability and/or are determined by VA to be unemployable due to the disability. The "service-related" designation means that the VA determined that the disability or condition was incurred or aggravated by military services. In contrast, individuals assigned to Priority Group 7 do not have any service-connected disability, or are not service-connected veterans. Effective January 17, 2003, no new veterans have been assigned to Group 8. According to the VA, individuals in Group 8 have higher incomes and are more likely to have insurance and other care options.

The survey finding also suggests the following regarding insurance coverage among veterans enrolled in the Heart of Texas Health Care Network by VA priority ratings:

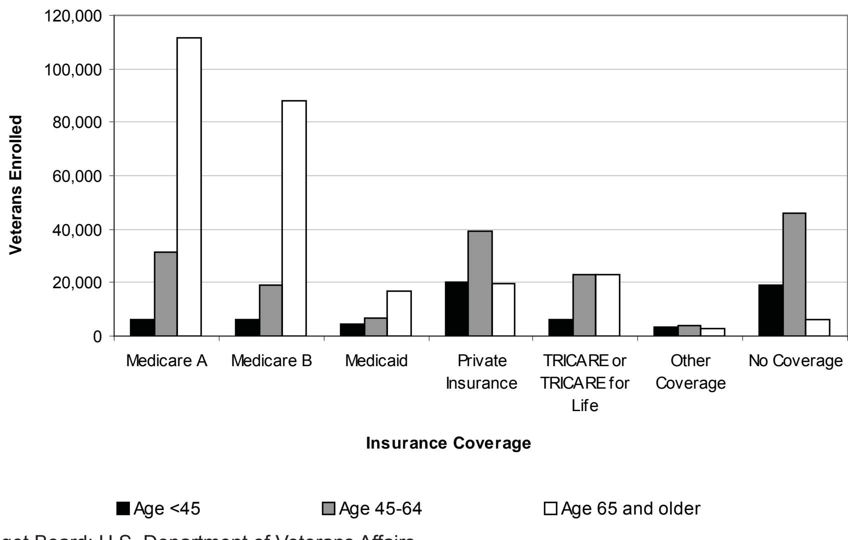
- Private insurance coverage is greatest among veterans in Priority Group 1–3.
- The number of enrolled veterans who are less likely to have private insurance and more likely to have Medicaid coverage is greatest for veterans in Priority Group 4–6.
- The number of enrolled veterans with TRICARE or TRICARE for Life coverage is greatest for the enrolled veterans in Priority Group 1–3.

Figure 7 shows the number of Texas veterans with insurance coverage enrolled in the Heart of Texas Health Care Network by VA priority groups.

FEDERAL COORDINATION OF HEALTHCARE FOR CERTAIN SERVICE MEMBERS AND VETERANS

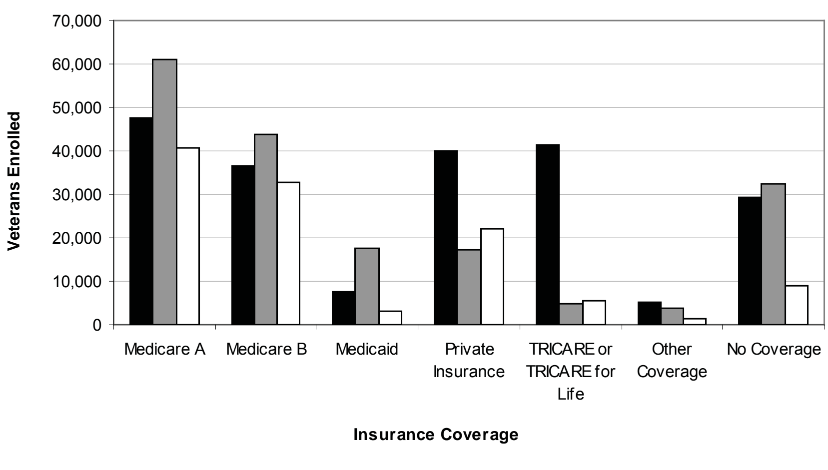
Although service members receive healthcare services provided under the DOD through TRICARE (formerly CHAMPUS), federal legislation passed in May 1982 authorizes the VA to provide healthcare services to service members in time of war or national emergency. According to GAO, through December 2005, approximately 193 active duty service members from Operation Enduring Freedom and Operation Iraqi Freedom who received spinal cord injury, traumatic brain injury or visual impairment received

FIGURE 6
INSURANCE COVERAGE OF VETERANS ENROLLED IN THE HEART OF TEXAS HEALTH CARE NETWORK BY AGE, 2005



SOURCES: Legislative Budget Board; U.S. Department of Veterans Affairs.

FIGURE 7
INSURANCE COVERAGE OF VETERANS ENROLLED IN THE HEART OF TEXAS HEALTH CARE NETWORK BY PRIORITY GROUP, 2005



SOURCES: Legislative Budget Board; U.S. Department of Veterans Affairs.

medical and rehabilitative services at VA facilities. (As of April 2003, these service members were to receive priority over veterans and others eligible to receive VA healthcare except those with conflict-related injuries.)

Title 38 of the United States Code provides for veterans' benefits and was amended to include provisions set forth in the Veterans Millennium Healthcare and Benefits Act of 1999 and the Veterans Health Programs Improvement Act of 2004. The Veterans Millennium Healthcare and Benefits Act of 1999 included, among other things, provisions regarding access to extended care services, such as geriatric evaluations, adult day healthcare and respite; treatment and services for drug or alcohol dependency; counseling and treatment for sexual trauma; care for veterans injured in combat; and specialized mental health services such as Post-Traumatic Stress Disorder. Other medically related provisions the act covers include reimbursement for emergency treatment at non-VA facilities and TRICARE coverage for eligible military retirees. The act allows for increases in medical care co-payment amounts and the establishment of maximum monthly and annual pharmaceutical co-payments.

The Veterans Health Programs Improvement Act of 2004 includes various health-related provisions such as authorized payments to states to assist them in hiring and retaining nurses, reducing the nurse shortage for State Veterans Homes and offering employee incentive scholarships or other employee incentive programs; permanent authority for the Sexual Trauma Counseling Program; and the designation of cooperative centers providing healthcare services and related rehabilitation and education services to eligible veterans with complex multi-trauma due to combat injuries. The centers must provide services that include amputation care and rehabilitation, pain management programs, comprehensive brain injury rehabilitation and upgraded blind rehabilitation services.

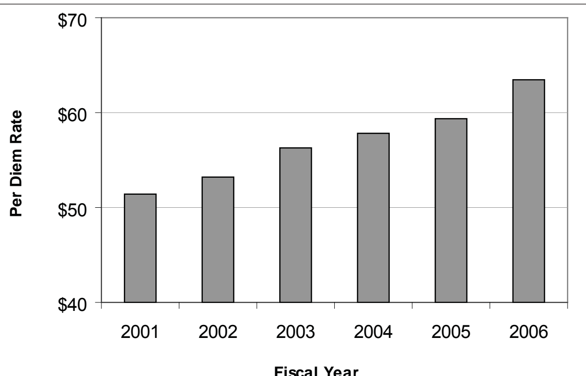
In November 2004, the VA directed all of its medical facilities to become TRICARE network providers. DOD relies on TRICARE network providers to care for military service members engaged in Operation Iraqi Freedom and Operation Enduring Freedom. If a DOD Military Treatment Facility is unable to provide appropriate care the DOD will refer casualties to the TRICARE Network.

STATE VETERANS HOME PROGRAM

The State Veterans Home Program is a partnership between the VA and states to construct or acquire nursing home, domiciliary and adult day healthcare facilities. The program first started shortly after the Civil War to provide assistance to a large number of indigent and disabled veterans who could no longer earn a living or provide for their own care. Originally, homes were built or acquired and operated entirely at the state's expense. The first enactment that provided for payment of federal aid to states occurred on August 1888. Under the Act of 1888, the federal government provided $100 per year for each eligible veteran in a state home. In 1960 per diem rates were established by Congress and increased periodically. In 1988, Congress authorized the Secretary of the VA to evaluate per diem rates and increase them as appropriate. Currently, the VA may participate in up to 65 percent of the cost of construction, acquisition, or renovation of these facilities and provides a per diem of $63.40 for nursing home care. **Figure 8** shows the increase in per diem amounts for fiscal years 2001 through 2006.

The State Veterans Homes Program is the largest provider of long-term care for our nation's veterans. There are 119 State Veterans Homes in 47 states and the commonwealth of Puerto Rico. Nursing home care is provided in 114 homes, domiciliary care in 52 homes, and hospital-type care in 5

FIGURE 8
U.S. DEPARTMENT OF VETERANS AFFAIRS PER DIEM RATES FISCAL YEARS 2001 TO 2006



SOURCES: Legislative Budget Board; Texas General Land Office.

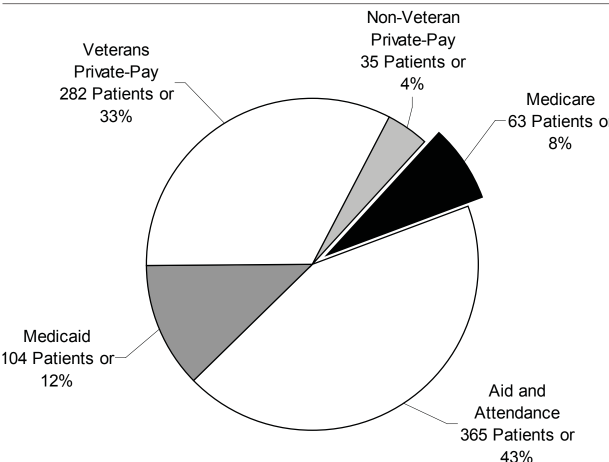
homes. These homes provide approximately 27,500 resident beds for veterans of which more than 21,000 are nursing home beds. The Seventy-fifth Texas Legislature, Regular Session, 1997, authorized the construction of four State Veterans Homes in Texas. The first two homes in Temple and Floresville began admitting clients in December 2000, while the homes in Big Spring and Bonham began accepting residents in 2001. A few years later in 2005, the McAllen and El Paso homes opened. A seventh home is expected to open in Amarillo in spring 2007.

As required by federal statute, no less than 75 percent of all patients served are veterans. Texas State Veterans Homes provide long-term care to all qualifying veterans; however, more than 95 percent of those served are over the age of 65. Individuals are admitted for both long-term and short-term stays depending on their diagnosis and attending physician's orders. Each home has a capacity of 160 beds.

In addition to the per diem amount provided by the VA (**Figure 8**), Texas also provides an additional Medicaid daily supplement of $133 for eligible clients. Effective December 1, 2004, Section 202 of the Veterans Health Programs Improvement Act of 2004 prevents using the Veterans Affairs per diem payment to offset Medicaid reimbursement. Prior to this enactment, the per diem payment lowered Medicaid reimbursement. As a result of this federal requirement the Veterans Land Board received an additional $4.2 million, retroactive to December 1, 2004, for per diem payments. As of December, 2006, the Veterans Land Board had not determined the use of these additional funds. The Medicaid rate is authorized by HHSC for all Texas State Veterans Homes. The homes contract with the Department of Aging and Disability Services (DADS) to provide nursing facility

services to Medicaid-eligible residents, who in most cases are spouses of veterans, admitted to the home. This rate is set and paid by DADS to reimburse the Veterans Land Board for nursing facility services. As **Figure 9** shows, Medicaid residents now account for only 12 percent of all residents in the State Veterans Homes in Texas.

FIGURE 9
TEXAS STATE VETERANS HOMES BY PAYOR SOURCES
OCTOBER 2006



NOTE: Chart is based on 849 patients registered at Texas State Veterans Homes as of October 2006.
SOURCE: Texas General Land Office.

To be eligible for admission into a Texas State Veterans Home an applicant must be recognized as an "eligible veteran" by the VA and

- require long-term nursing care as determined by a physician and concurred by the VA,
- be at least age 18,
- be a bona fide resident of Texas at the time of application for admission,
- have been a legal resident of Texas at the time of entry into military service, or have resided in Texas continuously for at least one year immediately prior to application for admission (residence based solely on military assignment is excluded), and
- not have been dishonorably discharged.

Additionally, eligibility for admission is extended to persons over the age 18 who have been bona fide residents of Texas continuously for at least one year immediately prior to application for admission, and who are one of the following:

- the spouse or unmarried surviving spouse of a veteran, or
- Gold Star parents, all of whose children died while serving in the United States Armed Forces.

Texas State Veterans Homes provide a variety of services and amenities that include:

- Semi-private and private rooms;
- Alzheimer's units with separate, secured courtyards;
- specialized diets;
- comprehensive rehabilitation programs, including physical, occupational, and speech therapies; and
- social services.

QUALITY OF CARE ISSUES REGARDING VETERANS HEALTHCARE

A GAO report summarized efforts by the VA to improve the quality of services to veterans and their families. According to GAO, the VA healthcare delivery system provides care to over 5 million veterans at over 800 locations; one in five veterans receive medical care from the VA. The number of new enrollees unable to get an appointment decreased from 176,000 in 2000 to 22,494 in 2005. The number of deaths within 30 days of surgery fell by 27 percent over nine years. The number of days to process a disability claim declined 167 days in 2005 from a high of 230 days. Not unlike the American healthcare system, VA transformed from a hospital-based system to a community-based system that provides outpatient and home services. VA also recognized that their patient population was migrating to warmer climates as many were moving to the South and Southwest. Through the Capital Asset Realignment for Enhanced Services (CARES), the VA evaluates its capital assets and service needs. The 2004 CARES Commission's final report contains numerous recommendations to reconfigure the VA system to increase access to care and to improve operational efficiency.

HEALTHCARE CONSIDERATIONS FOR VETERANS OF OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM

The U.S. House Committee on Veterans Affairs, Subcommittee on Health heard testimony on the mental health needs of military personnel returning from Iraq and Afghanistan and their families. The VA estimates that 30 percent of returning military personnel will exhibit mental health symptoms of Post Traumatic Stress Disorder (PTSD)

such as nightmares and agitation, and 10 to 15 percent of returning military personnel will be diagnosed with PTSD. Other estimates suggest that 33 percent of the returning military personnel will have mental health conditions within one year of returning. These conditions may include depression, anxiety, and alcohol abuse. Another 15 percent will be diagnosed with PTSD, of whom 25 percent will have significant symptoms requiring extensive psychotherapy and/or medication such as antidepressants.

According to the GAO, the Secretary of Veterans Affairs approved a mental health strategic plan for improving the delivery of mental health services within the VA healthcare system in November 2004. The plan was designed to address service gaps in the treatment of veterans with serious mental illness, female veterans, and veterans returning from combat in Operation Iraqi Freedom and Operation Enduring Freedom. The services outlined in the plan were in addition to the baseline of mental health services that the VA was already providing. Because of Congressional concerns about the provision of mental health services for active duty and veterans, the GAO was asked to review the spending for VA mental health plan initiatives in fiscal years 2005 and 2006 and the extent to which the VA tracked the funds used for the plan initiatives.

Subsequently, a November 2006 GAO report was issued that concluded the VA allocated additional resources for mental health strategic plan initiatives in fiscal years 2005 and 2006. These allocations resulted in some new and expanded mental health services at selected medical centers. However, the report also concluded that the VA had difficulty spending all of the funds allocated for the initiatives because of a lack of guidance concerning the allocations for plan initiatives and because some of the funds were allocated too late in the year, hampering efforts to hire staff needed for implementation. The GAO indicates that in fiscal year 2005 the VA allocated $88 million of the $100 million above the fiscal year 2004 level and $158 million of the $200 million above the fiscal year 2004 level. The GAO recommended that the VA track expenditures for mental health strategic plan initiatives to ensure that the funds allocated are used as intended and expended in a timely manner.

RECENT FEDERAL LEGISLATION

In December 2006, Congress passed the Veterans Benefits, Health Care and Information Act of 2006 (S. 3421). Upon enactment, the legislation extends the authorization for certain major medical facility construction projects including projects in Texas previously authorized in connection with the CARES initiative. Texas projects authorized by S. 3421 include ward upgrades and expansion at the VAMC in San Antonio with expenses not to exceed $19.1 million, and blind rehabilitation and psychiatric bed renovation and new construction at the VAMC in Temple with expenses not to exceed $56 million. The legislation authorizes major medical facility leases in Texas including a lease for an outpatient clinic in Smith County not to exceed $5.1 million in fiscal year 2006 and a lease for an outpatient and specialty care clinic in Austin not to exceed $6.2 in fiscal year 2007.

S. 3421 authorizes appropriations in the amounts of:

- $5 million for each fiscal year 2007 and 2008 to carry out a pilot program to assess the feasibility and advisability of providing services such as respite care, hospice services and home care services to expand and improve assistance to caregivers of veterans.
- $3.5 million in each of fiscal years 2007 through 2012 to increase the provision of blind rehabilitation services. As many as 1,500 blind veterans were on waiting lists to receive these services in 2004.
- $2 million for fiscal year 2007 for the improvement and expansion of mental health services including hiring additional marriage and family therapists and licensed professional mental health counselors to provide services at VA community-based outpatient clinics or to monitor the provision of mental health services, and expanding the use of telehealth services in readjustment counseling service facilities.

The legislation requires the VA and DOD to collaborate to enhance clinical training related to post-traumatic stress disorder and to promote resilience and readjustment among service members of Operation Iraqi Freedom and Operation Enduring Freedom.

S. 3421 modifies the federal provisions regarding nursing home care and prescription medications for veterans with service-connected disabilities who receive care in state homes. For nursing home care provided to veterans in need of nursing home care because of a service-connected disability, and to veterans who have service-connected disabilities rated at 70 percent or more, the VA will pay the lesser of the applicable or prevailing rate payable in the geographic area where the state home is located, or the amount not to exceed the daily cost of care reported by the state home to the VA. The amount paid would constitute payment in full to the state home. For veterans not being provided nursing home

care that is paid by the VA who are in need of drugs and medicines for a service-connected disability, or have service-connected disabilities rated at 50 percent or more, prescription drugs and medicines will be furnished by the VA.

FISCAL IMPACT OF HURRICANES KATRINA AND RITA ON STATE SERVICES

The 2005 Atlantic hurricane season began on June 1, 2005 and quickly became the most active and costly to date with 28 named storms and more than $100 billion in damages. On August 29, 2005, Hurricane Katrina made landfall as a Category Four hurricane on the Louisiana-Mississippi coast, sending more than 450,000 evacuees from coastal states into Texas. Less than one month later on September 24, 2005, Hurricane Rita made landfall as a Category Three hurricane near Sabine Pass, Texas, resulting in the evacuation of nearly 3 million residents (including Katrina evacuees) from the Gulf Coast region.

Although federal assistance offset most of Texas' hurricane costs, in many cases, reimbursement of these expenditures took more than six months. For most state agencies this delayed reimbursement was not an issue because the hurricanes struck at the beginning of the fiscal year; however, if a disaster occurred at the end of the fiscal year when funds are not as readily available, state agencies may have insufficient funds to meet funding obligations or fulfill agency responsibilities without interruption.

FACTS AND FINDINGS

- ♦ More than 40 state agencies responded to Hurricanes Katrina and Rita, by providing a variety of goods and services including evacuation assistance, debris removal, shelter, food, and clothing.
- ♦ The impact on state agencies reached a combined total of $1.8 billion in fiscal year 2006.
- ♦ Federal Funds that flowed through state agencies totaled $1.5 billion and accounted for approximately 83 percent of all hurricane expenditures.
- ♦ Of the $1.5 billion in Federal Funds, $1.2 billion (74.8 percent) passed through to local entities, $302.6 million (19.7 percent) was for services or assistance to hurricane victims, $69.8 million (4.5 percent) was for reimbursing state entities for disaster relief, and $15 million (1 percent) was for road repairs.
- ♦ Texas school districts enrolled more than 45,000 Katrina evacuee students during the 2005–06 school year, at a cost to the state estimated at more than $161 million in General Revenue Funds.
- ♦ An additional $428.6 million in Community Development Block Grant funds were awarded to the state in August 2006 (not included in fiscal year 2006 totals), to be used for housing infrastructure, public facilities, and business needs in areas hit by Hurricanes Katrina, Rita, and Wilma.

CONCERN

- ♦ Texas state agencies responding to a disaster that occurs at the end of a fiscal year may not have the resources for an appropriate response because they lack the authority to transfer appropriations from one fiscal year to another.

RECOMMENDATION

- ♦ **Recommendation 1:** Amend Article IX, Section 14.04, Disaster Related Transfer Authority, in the 2008–09 General Appropriations Bill to authorize the transfer of funds appropriated in fiscal year 2009 to fiscal year 2008 and provide Unexpended Balance authority between fiscal years, subject to the requirements in the existing rider.

DISCUSSION

In late August 2005, the Gulf Coast states braced for the possible landfall of Hurricane Katrina. As the storm strengthened to a Category Four hurricane in the Gulf of Mexico and made its way towards the Louisiana Coast, Texas opened an invitation to neighboring Louisiana and its residents seeking refuge from the storm. In anticipation of the eminent landfall of Hurricane Katrina and the mandatory evacuations in Louisiana, the Governor of Texas declared a State of Emergency on August 29, 2005.

Although Hurricane Katrina did not make landfall on the Texas coast, the impact was felt throughout the state. Nearly a half-million evacuees from Louisiana, Alabama, and Mississippi entered the state in the days before and after the hurricane's landfall on August 29, 2005. Texans throughout the state organized to provide evacuees with shelter, food, clothing, and other various forms of assistance. In an effort to ensure that the state would not suffer for its generosity, the President issued an Emergency Declaration on September 2, 2005, for all 254 counties in the state.

Less than one month later, Texas was threatened by another hurricane. Hurricane Rita became a Category Five hurricane in the Gulf of Mexico in mid-September with a projected landfall near the Texas-Louisiana border. In preparation for one of the strongest hurricanes on record, the President issued another Emergency Declaration for all 254 Texas counties on September 21, 2005. On the same day, Texas coast residents began voluntary and mandatory evacuations. The difficulty of this process was intensified by the presence of nearly a half-million Katrina evacuees.

Governor Perry recalled emergency personnel from Katrina recovery efforts in anticipation of Hurricane Rita's arrival. On September 22, 2005, at the Governor's request, the Texas Department of Transportation began contra-flow lane reversal on Interstates 45, 10, and U.S. Highway 290. Despite congested highways, fuel shortages, and medical emergencies, Texas managed to evacuate nearly 3 million individuals from harm's way. Two days later on September 24, 2005, Hurricane Rita made landfall as a Category Four hurricane near Sabine Pass, Texas.

STATE HURRICANE RESPONSE

Since Hurricanes Katrina and Rita hit the Gulf Coast, more than 40 state agencies have been involved in some capacity providing shelter, security, equipment, and supplies. The Governor's Division of Emergency Management (GDEM) is responsible for mobilization and deployment of state resources in response to major disasters. During both hurricanes the GDEM coordinated the efforts of state agencies, local governments, schools, hospitals, and other entities (such as the Red Cross and the Salvation Army) through the State Operations Center at the Department of Public Safety (DPS).

The Texas National Guard, the Texas Engineering Extension Service, the Texas Parks and Wildlife Department, and the Texas Forest Service all deployed units to perform search and rescue operations in areas affected by the hurricanes. Multiple agencies shared the responsibility of evacuating individuals. The Texas Building and Procurement Commission developed a contract for transportation and lodging of displaced persons. The Department of State Health Services provided emergency medical service personnel and ambulances to evacuate hospital and nursing home patients, while the Department of Aging and Disability Services made arrangements for evacuees requiring nursing facility care. Approximately 8,200 offenders from eight units of the Texas Department of Criminal Justice required evacuation, as well as 323 offenders at Texas Youth Commission facilities. DPS, in conjunction with the Texas Department of Transportation (TXDOT), performed highway transport and traffic management, particularly for evacuating Texas residents in the path of Hurricane Rita.

More than 17 short- and long-term shelters were initially set up in east and southeast Texas to accommodate individuals displaced by Hurricane Katrina. As the number of evacuees increased, the number of shelters would eventually expand to include more than 95 shelters across the state including the Astrodome, Reliant Center, and George R. Brown Convention Center in Houston; Reunion Arena in Dallas; and Kelly USA in San Antonio. In addition to working with the Texas Apartment Association to identify vacant apartments for long-term housing, state officials also requested and received waivers that allowed an estimated 18,000 vacant eligible housing units to be used by Katrina evacuees.

To handle the influx of victims seeking information and referrals, the Health and Human Services Commission (HHSC) expanded its 2-1-1 hotline system, with the volume of calls expanding from roughly 2,500 per day to 10,000 per day following Hurricane Katrina. The HHSC field offices also extended office hours to help evacuees with Medicaid and Food Stamp needs, while the Department of State Health Services worked to provide Louisiana clients in the Women, Infants, and Children Program with access to their food nutrition benefits in Texas.

The Texas Workforce Commission (TWC) hired temporary staff and began processing claims for Unemployment Insurance and Disaster Unemployment Assistance. TWC had a presence at evacuation shelters and created toll-free hot lines to assist evacuees trying to find jobs and to connect them with employers trying to hire displaced people.

The Texas Education Agency (TEA), in conjunction with local schools districts, attempted to bring a sense of normalcy to the thousands of children that were evacuated in the wake of Hurricane Katrina. Under federal law, families relocated because of the Gulf Coast hurricanes met the definition of "homeless." This designation allowed parents to register more than 45,000 children in Texas schools without having to meet residency requirements. With such an influx of students the TEA set up toll-free hotlines to answer questions, assist local schools districts with registering evacuees for school, and respond to questions from Louisiana teachers seeking teaching opportunities in Texas.

Following Hurricane Rita, various state agencies began the reconstruction process. TxDOT and the Texas Forest Service were involved in clearing debris from highways and rights of way, while the Public Utility Commission monitored the restoration of electric power to more than 1.6 million Texans. The Texas Commission on Environmental Quality monitored refineries and chemical plants in the Beaumont-Port Arthur-Orange areas; inspected Superfund sites and the Lake Livingston and Conroe Dams; provided daily public water supply system information; and responded to spills and other environmental concerns. The General Land Office responded to coastal spills and oversaw the cleanup of large commercial fishing and recreational vessels in the Sabine Pass area. The Texas Department of Agriculture conducted crop assessments and the Texas Civil Air Patrol surveyed critical infrastructure.

SOCIAL SERVICE NEEDS OF KATRINA EVACUEES

To better understand and meet the needs of Katrina evacuees, the HHSC hired the Gallup Organization to conduct a survey of Katrina evacuees in Texas. Gallup surveyed a random sample of approximately 6,400 evacuees living across the state. The survey results were released in August 2006. **Figure 1** shows a comparison of pre-Katrina and post-Katrina evacuee conditions in relation to social service needs in Texas.

Additionally, the Gallup survey revealed the following findings about Katrina evacuees:

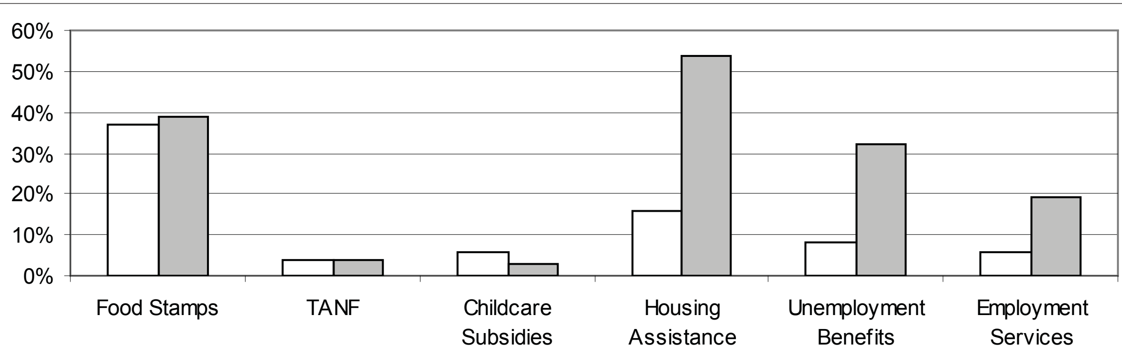
- More than 251,000 Katrina evacuees still resided in Texas as of June 2006.
- 61 percent of all evacuees are adults; 60 percent of those are women.
- 39 percent of all evacuees are children.
- 54 percent of households surveyed include at least one child.
- 29 percent of evacuees were unemployed before Katrina compared to 70 percent after the storm.
- 61 percent of evacuee households earned less than $20,000 per year before Katrina; 40 percent of households now receive less than $500 per month.
- 18 percent of evacuees were uninsured prior to Katrina compared to 36 percent after the storm.
- 50 percent of evacuees believed that they would still be in Texas one year from June 2006; 40 percent believed the same would be true two years later.

COST TO STATE AGENCIES

Costs in fiscal year 2006 related to the Gulf Coast hurricanes totaled $1.8 billion (**Figure 2**). Federal Funds account for approximately 83 percent of the total, with General Revenue Funds accounting for 12 percent or approximately $215.3 million. The TEA, the Texas State University System, and the HHSC account for approximately 96 percent ($205.6 million) of all General Revenue Funds expended for the hurricanes.

Texas school districts reported that approximately 45,000 Katrina evacuees registered for school throughout the state during the 2005–06 school year, at a cost to the state

FIGURE 1
PRE- AND POST-KATRINA SOCIAL SERVICE NEEDS OF KATRINA EVACUEES



SOURCE: Texas Health and Human Services; Gallup Survey.

FIGURE 2
FISCAL YEAR 2006 COST IMPACT OF GULF COAST HURRICANES (IN MILLIONS)

AGENCY	GENERAL REVENUE FUNDS	GENERAL REVENUE–DEDICATED FUNDS	OTHER FUNDS	FEDERAL FUNDS	TOTAL
Texas Department of Public Safety[1]	$0.0	$0.0	$0.1	$711.0	$711.1
Texas Education Agency[2]	161.2	0.0	1.6	333.6	496.4
Health and Human Services Commission	10.4	0.0	0.1	185.6	196.1
Texas Workforce Commission	0.0	0.0	0.9	137.5	138.4
Institutions of Higher Education[3]	1.1	8.1	35.4	2.5	47.1
Texas Department of Transportation	0.0	0.0	19.3	15.0	34.3
Department of Housing and Community Affairs[4]	0.0	0.0	0.1	1.4	1.5
Texas State University System[5]	34.0	0.0	0.0	14.8	48.8
Office of Rural Community Affairs[4]	0.1	0.4	0.0	80.1	80.6
Texas Building and Procurement Commission	0.0	0.0	0.0	19.5	19.5
Department of Aging and Disability Services	0.0	0.0	0.0	7.9	7.9
Department of State Health Services	0.0	0.1	0.0	11.4	11.5
Department of Criminal Justice	4.7	0.0	7.9	0.5	13.1
Texas Parks and Wildlife Department	0.2	2.7	3.1	0.1	6.1
Adjutant General's Department	1.0	0.0	0.0	3.6	4.6
Texas Engineering Extension Service	0.4	0.0	1.0	3.2	4.6
Texas Youth Commission	0.6	0.0	1.2	0.0	1.8
Employees Retirement System	0.0	0.0	1.6	0.0	1.6
Texas Forest Service	0.3	0.0	0.0	1.4	1.7
Texas Commission on Environmental Quality	0.0	0.6	0.0	0.8	1.4
Department of Assistive and Rehabilitative Services	0.0	0.2	0.0	0.8	1.0
Texas Department of Insurance	0.5	0.3	0.0	0.0	0.8
Department of Family and Protective Services	0.0	0.0	0.1	0.6	0.7
Office of the Attorney General	0.1	0.0	0.0	0.2	0.3
Texas Alcoholic Beverage Commission	0.2	0.0	0.0	0.2	0.4
Department of Information Resources	0.0	0.0	0.0	0.3	0.3
General Land Office and Veterans' Land Board	0.0	0.3	0.0	0.1	0.4
Texas State Library and Archives Commission	0.0	0.0	0.0	0.0	0.0
Texas Military Facilities Commission	0.0	0.0	0.1	0.0	0.1
Structural Pest Control Board	0.0	0.0	0.0	0.0	0.0
All Other Agencies	0.5	0.2	0.2	0.0	0.9
GRAND TOTAL	**$215.3**	**$12.9**	**$72.7**	**$1,532.1**	**$1,833.0**

[1]Amounts do not include FEMA Public Assistance Grants received after August 24, 2006.
[2]General Revenue amounts include $92.6 million in "Settle Up" funds to be paid in fiscal year 2007.
[3]Amounts reflect figures compiled by the Higher Education Coordinating Board, excluding costs for the Texas State University System (shown separately). Foregone tuition is recorded as "Other," but may include statutory tuition (General Revenue–Dedicated Funds). Distinction between costs for Hurricanes Katrina and Rita was not available; amounts have been recorded as impacts from Hurricane Katrina.
[4]Amounts do not include $428.6 million in Community Development Block Grant funds awarded to Texas in August 2006.
[5]Texas State University System costs include $5.9 million in lost revenue. FEMA reimbursements should eventually total $30.2 million.
SOURCE: State agency reports on hurricane costs as submitted by April 25, 2006, and agencies' Legislative Appropriation Requests for 2008–09.

estimated by TEA to be more than $161 million in General Revenue Funds for fiscal year 2006. This amount includes an estimated $92.6 million in "Settle Up" funds to be paid in fiscal year 2007. Districts' formula state aid is paid based on average daily attendance (ADA) as projected in the General Appropriations Act (GAA). When a district's actual ADA differs from the projected amount, the state "settles up" with that district the following year. Since the ADA in the 2006–07 GAA was based on pre-Katrina figures, many districts did not receive additional state aid for their fiscal year 2006 Katrina ADA until settle up in fiscal year 2007; however, some districts applied for and received a current

year ADA adjustment so that they could receive their Katrina-related state aid in fiscal year 2006. The TEA's funding models estimated that each of the Katrina average daily attendees would earn approximately $4,200 in state aid or additional recapture retained by wealthy school districts for fiscal year 2006.

Four institutions within the Texas State University System (TSUS) sustained substantial damage from Hurricane Rita: Lamar University, Lamar Institute of Technology, Lamar State College-Orange, and Lamar State College-Port Arthur. TSUS reported $34 million in General Revenue Fund expenditures. More than 80 percent ($24.1 million) of that amount is directly attributable to damages sustained from flood waters and hurricane winds that exceeded 120 mph. Services such as debris removal, building repairs, demolition, and reconstruction were essential to returning the institutions to working condition as soon as possible. Despite these efforts a few of the institutions were closed for several weeks before reopening for classes. Many students transferred to other institutions temporarily or permanently, resulting in lost revenues of more than $5.9 million from tuition, fees, sales, and services.

The HHSC reported expending $10.4 million in General Revenue Funds related to the hurricanes. This amount is primarily attributable to the state matching portion for the Federal Assistance to Individuals and Households for Texas residents affected by Hurricane Rita.

MAJOR FEDERAL FUNDING SOURCES

In response to states' hurricane needs, a number of federal appropriations were made. Funds that flow through Texas state agencies from the following sources total $1.5 billion:

- FEMA Public Assistance
- Aid for Public Education
- Community Development Block Grant (CDBG) Disaster Recovery
- Social Services Block Grant—Disaster Relief
- Workforce Investment Act National Emergency Grant
- FEMA Individuals and Households Program
- Medicaid
- Other Federal Funding Sources

Approximately 75 percent of these funds will pass through to local entities (e.g., cities, counties, school districts, electric cooperatives, etc.); 20 percent will provide services or assistance to hurricane victims; 4 percent represents reimbursements to state agencies for disaster relief activities; and 1 percent for emergency highway relief. In addition, about 58,000 families who fled to Texas following Hurricane Katrina received 3 months of Food Stamp benefits worth $48.3 million (not reflected in the state budget).

FEMA Public Assistance Grants: Although the federal government provides various sources of funding, in the wake of a natural disaster, the Federal Emergency Management Agency (FEMA) is tasked with coordinating the federal government's assistance efforts. Under the Public Assistance (PA) program, FEMA provides supplemental aid to communities and states to facilitate their recovery efforts. As of August 24, 2006, Texas had received $706 million in PA grants for fiscal year 2006 (primarily for hurricane-related expenses). Of that amount, approximately 92 percent or $650.2 million was passed through to local entities with the remainder being allocated to state agencies. **Figure 3** shows the pass-through amounts of PA grants to local entities. Approximately three-fourths of pass-through amounts to local entities went to the 12 entities listed in **Figure 3**. The City of Houston alone received 41 percent of the funding. **Figure 4** shows the distribution of PA grants to Texas state agencies.

The PA program provides assistance for debris removal, implementation of emergency protective measures, and permanent restoration of infrastructure. The program is centered on a partnership between FEMA and state and local officials. The federal share of the program is 75 percent, with state and local agencies making up the remaining 25 percent. This percentage is subject to change, as was the case in June 2006 when the President signed the Emergency Supplemental Appropriations Act of 2006 into law, effectively increasing the federal share of all costs related to Hurricane Rita to 90 percent and decreasing the state and local percentage to 10 percent.

To facilitate the processing of public assistance grants, FEMA divided disaster-related work into seven categories. These categories are divided into emergency work and permanent work as shown in **Figure 5**.

All work related to **Figure 5** must be detailed in a Project Worksheet that must be submitted to FEMA for review. Once FEMA reviews all requests for assistance and determines that no further action by an agency is required, payments are processed through the Governor's Division of Emergency

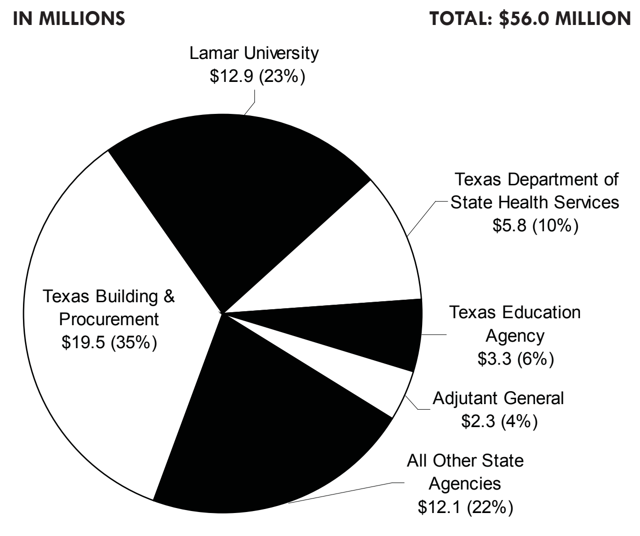
FIGURE 3
FEMA PUBLIC ASSISTANCE GRANTS (FISCAL YEAR 2006)

PASS-THROUGH TO LOCAL ENTITIES (EXCEEDING $7 MILLION)	2006
City of Houston	$263,476,287
City of San Antonio	32,531,291
Dallas Housing Authority	31,180,687
Jefferson County	30,656,591
Sam Houston Electric Coop. Inc.	26,678,937
Tyler County	23,961,293
Jasper Newton Electric Coop. Inc.	20,535,072
City of Austin	16,467,309
Harris County (County + Treasurer)	12,854,865
Hardin County	12,335,809
City of Fort Worth	9,605,152
City of Dallas	7,035,954
Subtotal	*487,319,247*
All Others	162,870,692
Total to Local Entities	**$650,189,939**

Source: Texas Department of Public Safety.

FIGURE 4
FEMA PUBLIC ASSISTANCE GRANTS TO STATE AGENCIES FISCAL YEAR 2006

IN MILLIONS **TOTAL: $56.0 MILLION**



Source: Texas Department of Public Safety.

Management at the DPS. If, however, FEMA finds that additional action by an agency is required, all payments are suspended until those requirements are met. Such contingencies include the purchase of insurance.

Four agencies, Texas State University System, Texas Youth Commission, Texas Parks and Wildlife Department, and Texas Department of Criminal Justice, had facilities that Hurricane Rita damaged which were subject to insurance requirements under the federal Stafford Act. The Act requires "an applicant to purchase and maintain insurance, where that insurance is reasonably available, as a condition of receiving disaster assistance." FEMA requires that any structure that sustains either flood or wind damage, be insured for that type of damage.

In Texas, wind insurance can be purchased through the Texas Wind Insurance Association. Flood insurance, particularly if a structure is in a special flood zone, can be purchased through the National Flood Insurance Program. Any state agencies with uninsured structures sustaining flood damage which are within the 100-year floodplain, are subject to a

FIGURE 5
FEMA PUBLIC ASSISTANCE GRANTS

		FEDERAL PARTICIPATION	
CATEGORY	TYPE OF WORK	KATRINA	RITA
Emergency Work:			
A	Debris Removal	100%	100% first 34 days, 90% thereafter
B	Emergency Protective Measures	100%	100% first 34 days, 90% thereafter
Permanent Work:			
C	Roads and Bridges	100%	100% first 34 days, 90% thereafter
D	Water Control Facilities	100%	100% first 34 days, 90% thereafter
E	Buildings and Equipment	100%	100% first 34 days, 90% thereafter
F	Utilities	100%	100% first 34 days, 90% thereafter
G	Parks, Recreational Facilities, and Other Items	100%	100% first 34 days, 90% thereafter

Sources: Legislative Budget Board; Federal Emergency Management Agency.

reduction of assistance equal to the amount that they would have received had the structure been insured.

Texas state agencies are self-insured. To comply with FEMA's insurance requirement, several state agencies turned to the State Office of Risk Management's (SORM) Statewide Property Insurance Program. This program allows agencies to buy into an umbrella policy that meets FEMA's minimum insurance requirements, while providing the agency protection from future damages.

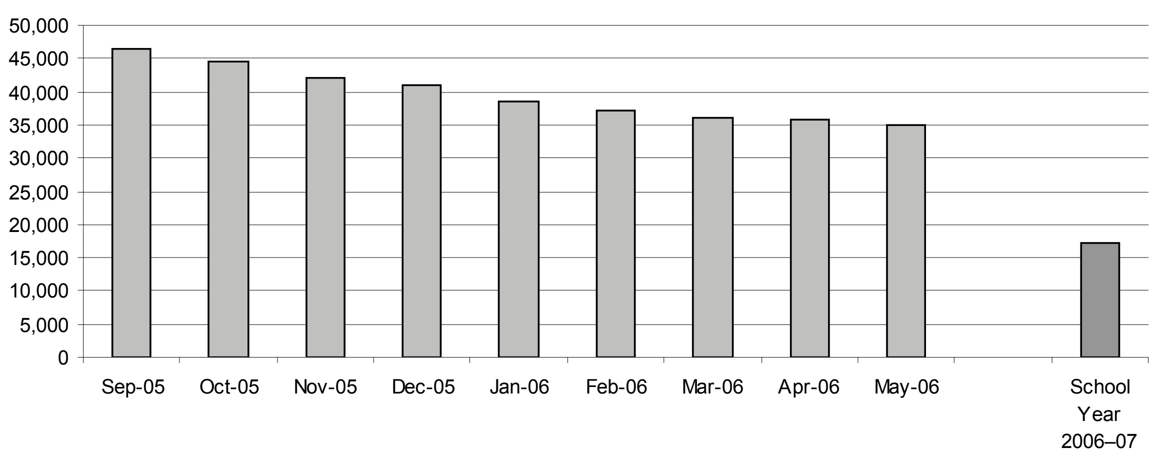
The federal Stafford Act also allows applicants to appeal FEMA's insurance requirement to their state's insurance commissioner. The Act provides that an applicant for federal assistance may be exempt from FEMA's insurance requirement if the State Insurance Commissioner determines that insurance is not reasonably available, adequate, and necessary. FEMA regulations further state that "*the Regional Director shall not require greater types and amounts of insurance than are certified as reasonable by the State Insurance Commissioner.*" If granted a waiver, FEMA would lift the insurance requirement for an agency and allow them to draw down Public Assistance grants without having to purchase insurance. In October 2006, the Texas Parks and Wildlife Department submitted and was granted such a request.

Aid for Public Education: Congress appropriated enough funds to provide school districts with Hurricane Katrina evacuees with $5,983 per student ($7,483 for children in special education). This amount is approximately $1,800 more than the original estimate of $4,200 in April 2006. Texas schools received $250.9 million of Emergency Impact Aid in fiscal year 2006. In addition, $78.0 million in Immediate Aid to Restart School Operations was available for Texas schools affected by Hurricane Rita. All funds were distributed to school districts, rather than offsetting state funds for education.

According to Federal Funds Information for States (FFIS), about 29 percent of all Katrina-displaced students were enrolled in Texas schools during the 2005–06 school year. Katrina-displaced student enrollment dropped by approximately 25 percent by the end of the school year. Current reports from TEA estimate that less than 50 percent of these students returned to class in the Fall of 2006 (**Figure 6**). The Texas Assessment of Knowledge and Skills scores for Katrina evacuees indicate that school districts face tremendous challenges in educating these students. TEA reports that only 45 percent of fifth grade Katrina evacuees who took the math test in 2006 passed, compared to 82 percent of Texas students. Likewise, 47 percent of evacuees passed the reading test, compared to 80 percent of Texas students.

Community Development Block Grant (CDBG) Disaster Recovery: An action plan for disbursement of $74.5 million in CDBG funds was designed to address housing, infrastructure, public facility and business needs in the 29 counties affected by Hurricane Rita. At least 55 percent of the funds must be used for unmet housing needs. The Texas Department of Housing and Community Affairs (TDHCA) and four Councils of Government (COG) were responsible for prioritizing the use of housing funds. The four grant

FIGURE 6
KATRINA DISPLACED STUDENT ENROLLMENT IN TEXAS PUBLIC SCHOOLS
SEPTEMBER 2005 TO FALL 2006

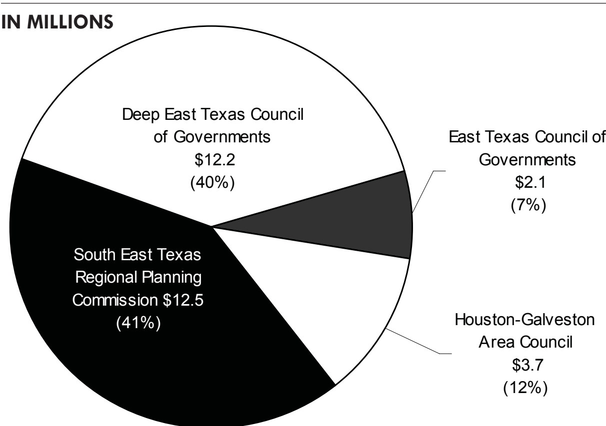


SOURCE: Texas Education Agency.

awards for unmet housing needs totaling $30.5 million (**Figure 7**) include $12.2 million to Deep East Texas Council of Governments, $2.1 million to East Texas Council of Governments, $3.7 million to the Houston-Galveston Area Council, and $12.5 million to South East Texas Regional Planning Commission. For non-housing related damage, approximately $44 million will flow through the Office of Rural Community Affairs and be distributed to local entities through the four COGs affected by Hurricane Rita.

FIGURE 7
COMMUNITY DEVELOPMENT BLOCK GRANT FUNDING BY COUNCILS OF GOVERNMENT

IN MILLIONS



SOURCE: Texas Department of Housing and Community Affairs.

In late August 2006, the State of Texas was awarded an additional $428.6 million in CDBG funds. The Governor has designated TDHCA as the administrator of these funds. On December 15, 2006, TDHCA submitted the state's action plan to the U.S. Department of Housing and Urban Development. Approximately 71 percent of the funds will be used for repair, rehabilitation, and reconstruction of owner occupied and rental units across the disaster-impacted areas. Use of the funds has not been finalized and the award is not reflected in the 2006 Federal Funds amount.

Social Services Block Grant—Disaster Relief: Texas was awarded $88.0 million to provide an array of health care and social services to victims of the Gulf Coast hurricanes. Funds may also be used for repairs or reconstruction of health care facilities. According to the HHSC, $41.6 million will be provided to four COGs for distribution to local entities affected by Hurricane Rita; $36.3 million will be allocated to COGs based on the location of Hurricane Katrina evacuees; and $10.0 million will be held as a reserve for other needs (e.g., substance abuse services, HIV medications, etc.).

Workforce Investment Act National Emergency Grant: The Texas Workforce Commission was awarded $88.4 million to assist hurricane victims. Allowable uses include creating temporary employment for dislocated individuals; making payments to individuals not qualified for Disaster Unemployment Assistance or Unemployment Insurance (or to those who have exhausted those benefits); providing job training to those settling in Texas; and providing crisis and financial counseling.

FEMA Individuals and Households Program: Expenses related to Hurricane Rita, such as personal property assistance, medical and dental care, funeral expenses, and transportation can be reimbursed through this program administered by HHSC. Federal Funds are projected to total $94.3 million, and a 10 percent state match is required ($10.4 million). The HHSC projects 82,466 families will be provided payments averaging $1,072.

Medicaid: A federal waiver allows Hurricane Katrina evacuees and Texans affected by Hurricane Rita to be provided services through the Texas Medicaid program for five months at 100 percent federal reimbursement. Applications for temporary coverage were due by January 31, 2006. An uncompensated care pool was also available through January 31, 2006, for reimbursement to providers for uninsured evacuees who were ineligible for Medicaid. The number of evacuees served through the Medicaid waiver totaled 58,671, almost half of whom were children. It is anticipated that federal reimbursements for fiscal year 2006 will total $66.2 million.

Other Federal Funding Sources:

- Child Care and Development Fund: The State of Texas requested and received a waiver of the state match associated with Federal Funds used to provide child care to families affected by the Gulf Coast hurricanes. The federal government approved the use of $30.7 million in Federal Funds without a state match.
- Emergency Highway Funding: Out of a $2.75 billion appropriation to the Federal Highway Administration, the Texas Department of Transportation was awarded $15.0 million. Funds can be used for activities such as highway clean-up, rebuilding bridges and road surfaces on federally supported highways, and replacing traffic signals and highway signs.
- Food Stamps Employment and Training: The TWC received $12.9 million to provide services to Katrina

evacuees and residents affected by the hurricanes who are Food Stamp recipients.
- TANF Emergency Response: Texas was awarded $97 million to provide short-term, nonrecurring cash assistance to families affected by Hurricane Katrina. HHSC anticipates expending $11.3 million on one-time payments of $1,000 to about 12,500 families.
- Crisis Counseling: The Texas Department of State Health Services anticipates $5.1 million in Federal Funds will be used in fiscal year 2006 to provide mental health services to hurricane victims. Funds can be used for outreach, screening, diagnostic services, treatment, and training of workers to provide counseling.

UNMET LOCAL AND STATE NEEDS

Despite the state's best efforts, not all needs will be met with state and federal funding sources. Ongoing costs for providing public education and health care to Hurricane Katrina evacuees will remain. Many local entities and individuals were left with the task of finding ways to rebuild. In February 2006, the Office of the Governor identified many of these unmet needs in a report titled "Texas Rebounds." The following is a small sample of such needs:

- Hurricane Rita damaged or destroyed more than 75,000 homes. Of those damaged, more than 40,000 (53 percent) were uninsured. Although damage varied, the average cost to repair these homes will exceed $8,000 per home, FEMA or insurance will not reimburse these costs.
- Many small businesses damaged by Hurricane Rita were forced to close. The majority of these businesses have yet to reopen, leaving their owners with little or no income. FEMA referred more than 40,000 businesses to the Small Business Administration (SBA) for help. The SBA provides low-interest loans to small business owners whose properties were either underinsured or uninsured. The SBA processed less than 3,000 applications for assistance and denied more than 1,000 of those.
- At the peak of Hurricane Rita's destruction, more than 286,000 homes in southeast Texas were left without electricity. Entergy Gulf States, the energy provider of that region, repaired or replaced 12 generation units, 87 substations, 634 transmission structures, 5,000 transformers, and nearly 10,000 distribution poles at a cost of more than $369 million. Without state or federal assistance, the reconstruction costs will undoubtedly be passed on to the consumer in the form of higher energy rates.
- Some of the smaller communities damaged by Hurricane Rita face the same reconstruction costs as their larger counterparts, without the same resources. For example, many volunteer fire departments and emergency response units sustained damage to buildings, vehicles and equipment, most of which were acquired or purchased with small grants and donations. These items are not easily replaced. These communities will be left with the task of finding the resources to restore their equipment to pre-Rita condition, without compromising the safety of the communities which they serve.
- Hurricane Rita also greatly affected farmers and ranchers in southeast Texas. The United States Department of Agriculture (USDA), Texas extension agents, farmers, and ranchers have tracked agricultural losses in southeast Texas in excess of $49 million. These losses include a wide range of commodities such as rice, sugarcane, soybeans, sorghum, corn, livestock, fish, shellfish, and other stored commodities.

DISASTER-RELATED TRANSFER AUTHORITY

Texas continues to recover from the devastating effects of Hurricanes Katrina and Rita. Inevitably, new storms will form and threaten the state, and Texas' resources will once again be put to the test. During fiscal year 2006 state agencies offset hurricane costs by using Federal Funds. State agencies used their existing appropriations for hurricane-related expenditures until they received federal assistance. For most agencies this was not an issue because the hurricanes struck at the beginning of the 2006 fiscal year; however, this could be a problem if a disaster occurred at the end of the fiscal year.

Emergencies occurring between legislative sessions may be addressed through Budget Execution, a process allowing the Legislative Budget Board and the Governor to approve transfers of appropriations among state agencies, or between purposes within a state agency. Additional flexibility provided by rider could avoid a need for Budget Execution. Article IX, Section 13.13, Disaster Related Transfer Authority, in the 2006–07 General Appropriations Act currently provides agencies the authority to "transfer appropriations within the agency, without regard to any limits on transfer of appropriations between strategies, subject to the prior notification of the Legislative Budget Board and Governor." Agencies, however, do not have the authority to spend forward appropriations or transfer unexpended balances from one fiscal year to another. As a result, state agencies

responding to a disaster that occurs at the end of a fiscal year may not have the financial resources to meet funding obligations or fulfill agency responsibilities without interruption.

Recommendation 1 would amend Article IX, Section 14.04, Disaster Related Transfer Authority, in the 2008–09 General Revenue Bill to read as follows:

Disaster-related Transfer Authority.

(a) In the event of a disaster proclamation by the Governor under the Texas Disaster Act of 1975, Chapter 418, Government Code, transfers of appropriations made in this Act, if necessary to respond to the disaster and if made according to the terms of this section, are permitted. No part of this Section 14.04 shall be read to limit, modify, or abridge the authority of the Governor to proclaim martial law or exercise any other powers vested in the Governor under the constitution or laws of this state.

(b) Health and Human Services Agencies: For a health and human services agency listed in Chapter 531, Government Code, that directly responds to the disaster, the Commissioner of Health and Human Services is authorized to transfer funds from another health and human services agency listed in Chapter 531, Government Code to the responding agency, and may transfer funds between the strategies of each agency for the purpose of funding the disaster response subject to the prior notification of the Legislative Budget Board and Governor as provided by Subsection ~~(e)~~ (g).

(c) Other Agencies: An agency other than a health and human services agency listed in Chapter 531, Government Code that directly responds to a disaster may transfer appropriations within the agency, without regard to any limits on transfer of appropriations between strategies, subject to the prior notification of the Legislative Budget Board and Governor as provided by Subsection ~~(e)~~ (g).

(d) Transfers Between Agencies: In the event that a transfer involving at least one agency not listed in Chapter 531, government Code is necessary in order to respond to a disaster, the agencies involved in the transfer shall request approval from the Legislative Budget Board and the Governor for the emergency transfer of funds, pursuant to Article XVI, Section 69, Texas Constitution. Any request under this subsection should include the same information required in the recommended plan of transfer below, and a copy shall be provided to the Comptroller.

(e) Appropriation Transfers between Fiscal Years: Agencies responding to a disaster are authorized to transfer funds appropriated in fiscal year 2009 to fiscal year 2008, subject to the prior notification of the Legislative Budget Board and Governor as provided by Subsection (g).

(f) Unexpended Balances: Any unobligated balances from transfers made under subsection (e) as of August 31, 2008, are appropriated to the agency for the same purpose for the biennium beginning September 1, 2008.

~~(e)~~ (g) Notification of Recommended Plan of Transfer.

(1) Recommended Plan of Transfer: A recommended plan of transfer submitted by an agency to the Governor and Legislative Budget Board under this section must include the following information:

(A) a copy of the appropriate disaster proclamation made under Chapter 418, Government Code;

(B) the amounts to be transferred (listed by method of finance);

(C) the agency or agencies affected;

(D) the programs affected by the transfer; and

(E) any other information requested by the Legislative Budget Board.

(2) Notification~~ and Approval~~: An agency must notify the Legislative Budget Board, the Comptroller, the Governor, and any other agency involved in the transfer ~~at least 14 days~~ prior to the date of recommended transfers. ~~If neither the Legislative Budget Board nor the Governor issue a written disapproval within 14 days of receipt of the agency recommended plan of transfer, t~~The Comptroller shall transfer the funds as recommended.

FISCAL IMPACT OF THE RECOMMENDATION

Recommendation 1 has no significant fiscal impact. The introduced 2008–09 General Appropriations Bill includes an amended rider addressing this recommendation.

COMPARISON OF COST SAVINGS MEASURES OF STATE EMPLOYEE HEALTH PLANS

Many factors contribute to the high cost of healthcare in Texas. These factors include: expensive medical technology; the aging population; costly end-of-life measures; increased cost and use of pharmaceuticals; less managed care; hospital consolidation; litigation; administrative overhead; a complex insurance structure; and physicians incomes. Healthcare is a complex system of interrelated parts and as a result, the solutions to reduce healthcare costs are also complex. With the implementation of prior cost savings measures, fewer solutions remain to effectively and responsibly constrain costs. Containing healthcare costs makes healthcare cheaper for all payers without shifting cost from one payer to another.

The administrators of the state employee health plans, Employees Retirement System, Teacher Retirement System, University of Texas System, and Texas A&M University System, provide health insurance coverage to state government and higher education employees. These plans continually adjust benefits and cost sharing to control spending while maintaining comprehensive coverage for health plan participants across the state. This review examines strategies common to all the state health plans that could reduce the cost of prescription drugs, and hospital and provider services. These strategies include: increasing the use of the mail-order pharmacy program; managing the high cost of specialty drugs; negotiating with pharmacies to achieve greater volume discounts; and establishing a tiered a provider network.

FACTS AND FINDINGS

- After Medicaid, spending for employees' health is the next largest category of healthcare spending by state governments.
- In fiscal year 2006, the four state employee health plans spent an estimated $3.7 billion on health plan expenditures.
- The consumer price index for medical care increased an average of 4.3 percent a year from 1999 to 2005.
- In 2006, the state health plans paid $847 million for prescription drugs which consumed an average of 22 percent of health plan spending.
- As individuals age into their 40s and 50s, they consume more medical resources. The average age of the state health plan participant is age 46.
- Blue Cross Blue Shield of Texas estimates that only about 50 percent of the state employee health plans medical claim payments are paid to more efficient and higher performing, lower cost providers.
- All of the state employee health plans offer a mail order pharmacy program to allow participants to reduce their share of prescription drug cost, but program participation only averages 20 percent in each of the plans except the plan which covers retired teachers.

DISCUSSION

From the 1960s to the 1980s, federal and state governments pursued a regulatory strategy to control rising healthcare costs through techniques such as certificate of need, rate setting, and coordinated health planning. In the late 1980s and early 1990s, regulation was considered ineffective and efforts were redirected to other solutions. In the 1990s, policymakers turned to market-based strategies, relying on managed care and competitive purchasing to restrain costs.

Governments and employers continue to search for opportunities to decrease the current level of growth without reducing access to needed healthcare services or creating undue burdens for patients and providers. Recent efforts to influence the trend in healthcare include consumer driven care, health savings accounts, preauthorization programs, and increased cost sharing. Despite some successes, policy makers continue to face the challenge of making healthcare accessible and affordable.

The consumer price index for medical care increased an average of 4.3 percent a year from 1999 to 2005. In 2006, the medical costs have risen 0.32 percent a month, as the result of increases in medical commodities such as prescription and nonprescription drugs; medical supplies; medical services; and hospital services. Healthcare cost increases may be attributed to several interrelated factors that affect the cost and use of healthcare services. Those factors include: improved medical technology; the aging population; costly end of life measures; increased cost and use of pharmaceuticals; less managed care; hospital consolidation; litigation;

administrative overhead; a complex insurance structure; and higher provider expenses.

After Medicaid, spending for employees' health is the next largest category of healthcare spending by state governments. According to the National Association of State Budget Officers spending on healthcare consumed 8.2 percent of all states' expenditures from 2002 to 2003. Overall, state and local government employers contribute more toward employee health care than do large private sector employers. Private sector employers contribute an average of 84 percent of the total employee premium and have been steadily trending downward over the past few years while state and local governments average above 91 percent. The National Conference of State Legislatures reports that 15 states, including Texas, still cover 100 percent of the employee-only premium. Approximately, 60 percent of the cost of employee benefits in Texas is funded with General Revenue Funds.

COST SHIFTING AND COST CONTAINMENT

Generally, costs are reduced one of two ways, with "cost containment" or with "cost shifting." Cost shifting and cost containment measures are initiatives used by health plan administrators to reduce the cost of employee health benefits. Each year, fewer options remain that will easily, effectively, and responsibly constrain costs.

Cost shifting is when the cost and use of the services remain equal, but the payment is shifted from one payer to another. In the past, the state increased member copayments, coinsurance, or deductibles thus requiring the members to pay a greater share of their costs. **Figure 1** shows how much the four state employee health plans, Employees Retirement System (ERS), Teacher Retirement System (TRS), University of Texas System (UT), and Texas A&M University System (A&M), and their members paid for their portion of costs in fiscal year 2005. The members' out of pocket includes, copayments, deductibles, and coinsurance. The member's share of costs increases significantly when premium contributions are included in the amount.

Sometimes cost shifting can have positive outcomes, mainly if it reduces use. Shifting more of the cost of care to the patient may reduce unnecessary or inappropriate use of health services. The ERS increased the hospital copayment in 2003 from $50 to $100. The purpose of the increase was to discourage participants from using the emergency room for non-emergent care by making them responsible for a greater share of cost of an emergency room visit. In the first year of the $100 copayment, ERS reported approximately $4.4 million per year, All Funds savings from the increase in the emergency room copayment.

Reduced front-end costs can sometimes lead to increased long-term costs. Future costs increase when an untreated illness evolves and ultimately requires more and higher cost treatment. However, according to the *RAND Health Insurance Experiment*, a 15-year study published in 1992, cost sharing consistently reduced spending. There was no significant difference in the overall health of individuals with free healthcare versus those with health insurance that included some cost sharing. Those with health insurance sought treatment less often. Individuals who paid 25 percent of their costs incurred $193 less per year in charges than patients with free healthcare.

Cost containment is a second option to reduce health plan costs. Costs are best reduced when a benefit plan can provide healthcare more efficiently by eliminating unnecessary and wasteful systems. Cost containment occurs when:

FIGURE 1
PERCENTAGE OF MEMBER AND HEALTH PLAN COST SHARING, FISCAL YEARS 2005 AND 2006

COST SHARING	EMPLOYEES RETIREMENT SYSTEM	TEACHER RETIREMENT SYSTEM-ACTIVECARE	TEACHER RETIREMENT SYSTEM-CARE	UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M UNIVERSITY SYSTEM
Plan	78.9%	73.3%	72.9%	80.1%	80.9%
Member Out-of-Pocket	21.1%	26.7%	27.1%	19.9%	19.1%
Member Out-of-Pocket including premium	35.8%	NA*	45.6%	33.3%	36.7%

*The exact member share is unknown. The school districts contribute a portion toward members premiums, but the amount varies by school district. If members paid the total amount of the premium and school districts contributed nothing, the members' share would be 61.4 percent.
Sources: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

- the cost of services is reduced;
- the need for services is reduced;
- money is spent on a less costly service that is equally as effective as a more costly service; or
- expensive or unnecessary services are cut without creating more need in the future.

Ultimately, cost containment makes healthcare cheaper for all payers. The cost containment measures presented in this report could provide the state with cost savings in the 2008–09 biennium.

HEALTHCARE COST DRIVERS

Certain healthcare cost drivers can be responsibly managed while others cannot be controlled. The Texas state demographer predicts that 3.7 million Texans will be age 65 or over in 2020. This projection is nearly double the number of people that were in the same age group in 2000. Those age 65 or over will grow by the greatest percentage of any of the age groups. The total population of Texas is expected to increase 9.4 million from 2000 to 2020, 1.6 million of those will be age 65 or over.

Baby boomers, Americans born between 1946 and 1964, require healthcare services with increasing regularity. The average age of the state health plan participant is age 46. As individuals age into their 40s and 50s they consume more medical resources. On average, men in the 45 to 54 age group spend twice as much as their counterparts in the 35 to 44 age group. ERS attributes 1.91 percent of the increase in the cost of its health plan to two variables: (1) the increasing age of the population and (2) the changing mix of fewer active members and more retired members in the plan.

According to a 2003 article in the *Annual Review of Public Health*, 81 percent of healthcare economists believe that improved medical technology is the primary reason for growing healthcare expenditures, yet they are unable to estimate how much such technology increases costs. Improved medical technology is a component of the increased cost of prescription drugs, doctors, hospitals, and nursing homes services. Presumably, technology benefits patients and may reduce the higher cost treatment of advanced illnesses; therefore, the net effect is also unknown. Improving medical technology and the aging population are two factors driving healthcare cost that are difficult for policy makers to influence.

Patient demand for healthcare services continues to increase and the cost of those services is increasing as well. The RAND Corporation reported that in 1965, the real cost per hospital day was about $128. In 2002, the cost had risen to $1,289 per day (adjusted to constant 2002 dollars). The cost trend for a day in the hospital illustrates the steady increase in the price of healthcare services over the past four decades. The state's spending to fund the state health plans increased as well. **Figure 2** shows the amounts the state appropriated to pay for employee health insurance since 2000.

In 2006, the state's portion for all plans in **Figure 2** totaled $1.7 billion in appropriations. The plans have other sources of income including employee contributions, investment income, and funds outside the treasury that pay for the difference between the state's contribution and the total cost of claims and administration. When the state's appropriation decreases, the plans use more of the other sources of income or modify benefits to reduce the total cost of providing healthcare.

The four state employee health plans paid $3.7 billion in claims in fiscal year 2006. Those dollars are spent in one of three main categories: hospitals, medical and pharmacy. **Figure 3** shows the distribution of expenditures in all four state health plans.

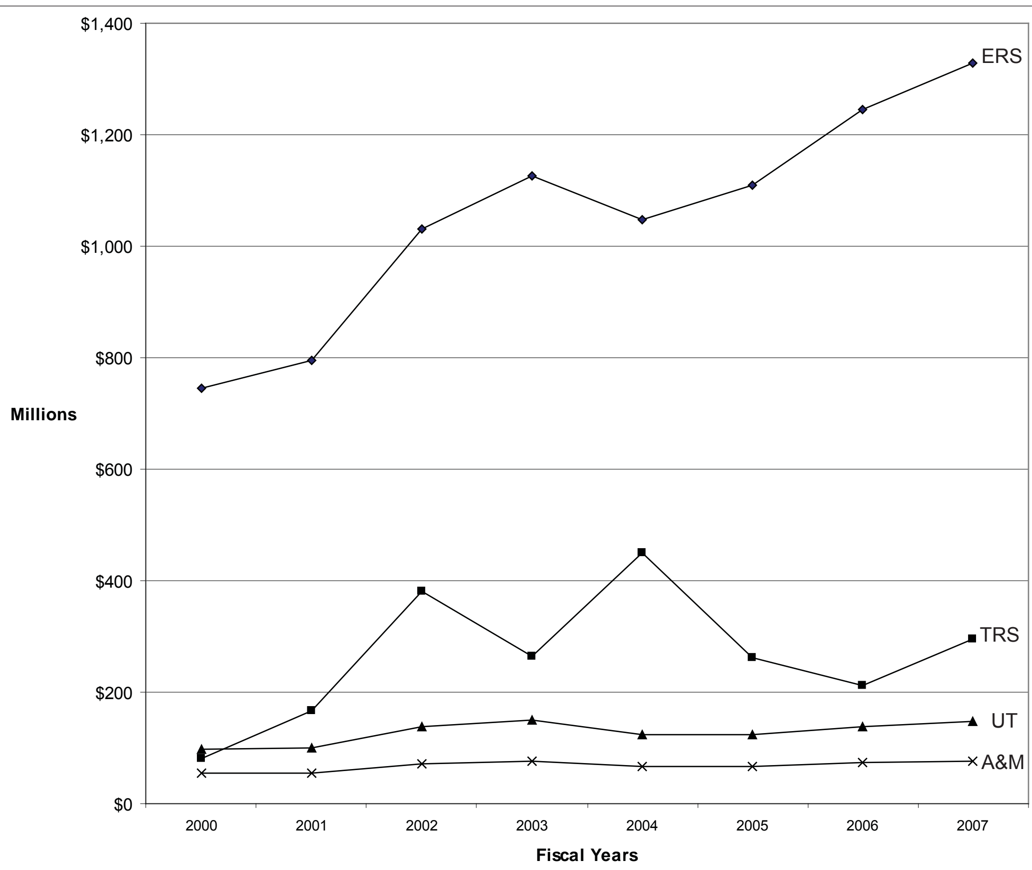
In 2005, national prescription drug spending is estimated to be $203.5 billion. In the same year, 3.6 billion prescriptions were purchased, increasing the average number of prescriptions per person from 10.6 to 12.3 from 2004 to 2005 respectively. In 1985 doctors prescribed 109 drugs for every 100 office visits, by 1999 that number increased to 146 drugs for every 100 visits.

In 2006, the state health plans spent $847 million on prescription drugs, which on average consumed 22 percent of the spending on employee health benefits. Lipitor, a drug used to control cholesterol, was the number one drug by expenditure and volume in each of the state health plans. **Figure 4** shows the amount the state and employees have spent on five of the most costly drugs prescribed to participants of the state health plans.

CURRENT STATE EMPLOYEE HEALTH PLANS

Texas funds four state health plans. Each plan covers a portion of the state's employee population and contains more than one coverage option for employees. **Figure 5** shows some detail of each plan and its covered population.

FIGURE 2
COST TO THE STATE TO FUND STATE HEALTH PLANS, FISCAL YEARS 2000 TO 2007



SOURCE: Legislative Budget Board.

FIGURE 3
FISCAL YEAR 2006 HEALTH PLAN SPENDING BY CATEGORY

DISTRIBUTION OF EXPENDITURES	EMPLOYEES RETIREMENT SYSTEM	TEACHER RETIREMENT SYSTEM-ACTIVECARE	TEACHER RETIREMENT SYSTEM-CARE	UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M UNIVERSITY SYSTEM
Hospital	41.6%	43.6%	34.5%	41.9%	37.7%
Other Medical	34.7%	33.2%	25.4%	32.1%	30.3%
Pharmacy	20.7%	16.0%	35.4%	22.0%	26.7%

SOURCES: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

FIGURE 4
DRUGS PRESCRIBED IN TEXAS STATE HEALTH PLANS WITH THE GREATEST TOTAL EXPENDITURE, FISCAL YEAR 2005

DRUG	USE	TOTAL SPENDING
Lipitor	Reducing cholesterol and triglycerides to help prevent strokes and heart attacks.	$57,934,595
Nexium	Heart burn/acid reflux	31,027,237
Zocor	Reducing cholesterol and triglycerides to help prevent strokes and heart attacks.	22,912,600
Plavix	Myocardial Reinfarction Prevention, Acute Syndrome of the Heart, Prevention of Blood Clots in the Brain	15,794,715
Enbrel	Psoriasis associated with Arthritis, Plaque Psoriasis, Rheumatoid Arthritis, Joint Inflammatory Disease in Children and Young Adults	9,169,592
	Total	**$136,838,739**

SOURCES: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

FIGURE 5
EMPLOYEE HEALTH PLAN HIGHLIGHTS

	EMPLOYEES RETIREMENT SYSTEM	TEACHER RETIREMENT SYSTEM-ACTIVECARE	TEACHER RETIREMENT SYSTEM-CARE	UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M UNIVERSITY SYSTEM
Covered Population	State Employee and other employees and retirees (see note)*	Active Teachers	Retired Teachers	UT System Employees and Retirees	A&M System Employees and Retirees
Self-Funded Plan	HealthSelect	TRS-ActiveCare	TRS-Care	UTSelect	A&M Care
2007 Projected Total Participants	514,840	300,100	197,133	163,333	54,791
2006 Total Participants	504,000	275,205	187,873	159,568	55,291
Active Participants	201,000	166,847	0	73,049	21,336
Retired Participants	69,000	0	153,681	14,013	6,299
Average age of Participants	40	35	67	47	39
Participants in Self-Funded Plan	89%	94%	100%	77%	61%
Total Expenditures in millions	$1,655	$807	$733	$432	$108
Self-funded Plan Premium Fiscal Year 2007	$358.31	446	note	346.19	398.38
Employer Share	$358.31	note	note	346.19	361.19
Full-time Employee Share	$0	note	90-310	0	37.19

*Employees and retirees of the following groups: state agencies, institutions of higher education other than UT and A&M, Public Junior Colleges, the Texas Municipal Retirement System, the Texas County and District Retirement System, and the community supervision and corrections departments.
NOTE: The Teacher Retirement System Plan premiums are funded from several sources making it difficult to quantify the exact share the employee and employer contribute.
SOURCES: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

Figure 6 shows how the costs are distributed over the entire pool of participants. Some participants cost the plan $0 in fiscal year 2005 and 2006, while other consumed a greater portion of the plans spending.

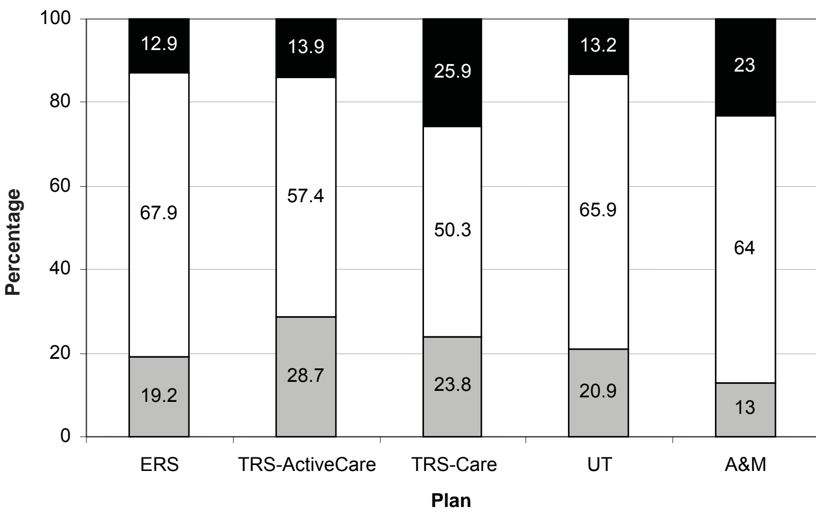
RECENT MEASURES TO CONTAIN STATE HEALTHCARE COSTS

ERS, TRS, UT and A&M have continually adjusted the health plan administration and benefit design to help control healthcare cost without compromising access to healthcare services to members across the state. These measures have been a combination of cost shifting and cost containment strategies.

The plans have used cost shifting to fund a portion of the increased spending on employee health benefits. Each of the agencies implemented most or all of the following cost shifting measures:

- a three-tiered copayment structure for prescription drugs;
- required participants to pay a $50 plan year prescription drug deductible;
- members must use a generic when available or pay an additional cost for the brand name drug;
- more expensive copayments for prescription drugs purchased at a retail pharmacy rather than mail order;

FIGURE 6
DISTRIBUTION OF MEDICAL CLAIMS FOR EACH PLAN, FISCAL YEARS 2005 AND 2006



SOURCES: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

- increased copayments for office visits for a primary care physicians and specialists; and
- increased emergency room copayment.

The state employee health plans were directed by the Texas Legislature to implement disease management in 2003 to contain costs. Disease management is a system of coordinated healthcare interventions and communications with health plan participants whose health status is at risk. Disease management is voluntary and is designed to reach plan members who have been diagnosed with a costly chronic condition, such as diabetes. Typically, patients enroll in the program, a registered nurse contacts them, and the nurse works with the patients and their doctor to ensure they are actively managing their condition. **Figure 7** shows the amount the state health plans report saving as a result of disease management, excluding TRS which had some disease management programs in place the before law mandated it.

The plans have the flexibility to initiate cost containment measures to make the benefit plan more efficient. Some past initiatives resulted in direct cost savings while others improved the program and its services.

- In 2006, A&M negotiated a new contract with their pharmacy benefit manager. The changes included a reduction in administrative fees and dispensing fees at retail and through mail order, as well as increased discounts for brand name and generic prescription drugs at retail and through mail order. The new pricing was implemented June 1, 2006 and A&M projects the changes will save the plan approximately $3.5 million in fiscal year 2007.
- In 2006 ERS awarded new contracts for the administration of the self-funded plan and the pharmacy benefit plan. ERS estimates the renegotiated agreements will save the plan $79 million in the health benefit plan

FIGURE 7
SAVINGS ASSOCIATED WITH DISEASE MANAGEMENT

	EMPLOYEES RETIREMENT SYSTEM	UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M UNIVERSITY SYSTEM
Implementation period	2004 to 2005	2004 to 2005	2004 to 2005
Savings in millions	$10.9	$5.1	$0.81

SOURCES: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

and approximately $48 million in the pharmacy benefit plan from 2007 to 2009.

- In 2002, TRS negotiated larger prescription drug discount as part of the contract that created TRS-ActiveCare. In fiscal year 2004 TRS-Care switched to a more efficient all Aetna network of providers to reduce costs. In 2006, TRS competitively bid its pharmacy benefit contract and entered into a new contract with Caremark.
- In 2001, UT created a Pharmacy Advisory Committee, which consisted of staff from the UT medical and pharmacy faculty. The Pharmacy Advisory Committee assisted the health plan to restructure the pharmacy benefits. Also, UTs prescription drug benefit plan includes a Step Therapy Program which helps ensure patients' receive a lower cost medication when an equally effective lower cost alternative is available. The program also monitors dose and drug interaction to reduce a patient's risk of negative side effects. According to Express Scripts, a pharmacy benefit manager, Step Therapy Programs typically increase generic prescription drug use by 2 percent in the first year of the program, thereby, reducing drug costs.

COST CONTAINMENT STRATEGIES

The state health insurance plans are substantially similar in benefit design and offer comparable benefits to state and higher education employees. Also, the plans have taken many of the same cost shifting and cost containment steps to control costs. In our examination of the plans, we did not identify any cost containment measures that one plan had adopted that another plan had not also evaluated and/or adopted in some form.

There are four cost containment strategies that the plans have not implemented that could be effective in reducing the cost of prescription drugs, and hospital and provider services. These cost containment strategies in some cases could reduce choice in healthcare service providers, but could achieve immediate savings without merely increasing member costs. The plans could:

1. Reduce the member's and state's cost of prescription drugs by increasing the number of participants using the mail-order pharmacy program.
2. Evaluate current activities and future opportunities for tracking and controlling the cost and use of high cost specialty prescription drugs, such as biotech drugs.
3. Negotiate with a smaller group of pharmacies to achieve greater volume discounts.
4. Create a tiered network that offers participants choice, but identifies less expensive, more effective providers and encourages participants to select those providers when they need services.

INCREASE USE OF THE MAIL ORDER PHARMACY PROGRAM

Health plans can reduce prescription drug costs by increasing participation in mail-order pharmacy programs. Plans receive volume discounts from the mail order pharmacy and pay less for prescription drug dispensing fees charged by pharmacists' when they fill a prescription. Prescription drugs such as antibiotics, that are used to treat a short-term illness, are appropriately purchased at a retail pharmacy. While other drugs like Lipitor or Nexium, which are used on a long-term basis to treat chronic symptoms, could be more appropriately purchased through the mail-order pharmacy program. Such long-term drugs, also known as maintenance drugs, could be purchased through mail order at a reduced cost.

The plans have structured prescription drug copayments to steer participants who use maintenance drugs to the mail order pharmacy program. The plans either:

- charge reduced copayments for maintenance drugs purchased through the mail-order pharmacy program, or
- charge higher copayments for maintenance drugs purchased at a retail pharmacy to offset the increased cost to the plan.

Figure 8 shows the copayment structures of each of the plans, including the rate at which members purchase prescription drugs by mail and at retail pharmacies. The plans encourage use of the mail-order pharmacy with the copayment structure.

For example, if UT health plan participants purchased a one-month supply of a preferred brand name maintenance drug at the retail pharmacy they would pay $25. If they purchased a three-month supply of the same drug through mail order, the participants would pay $50 for the three-month supply and would save $25. ERS uses another approach with a similar outcome. If ERS health plan participants purchased a one-month supply of a brand name maintenance drug at the retail pharmacy they would pay $35. If they purchased a three-month supply of the same drug through mail order, participants would pay $75. Essentially, participants pay

FIGURE 8
PRESCRIPTION DRUG COPAYMENTS, AND MAIL ORDER AND RETAIL PHARMACY ACTIVITY, FISCAL YEAR 2006

	EMPLOYEES RETIREMENT SYSTEM	TEACHER RETIREMENT SYSTEM-ACTIVECARE	TEACHER RETIREMENT SYSTEM-CARE	UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M UNIVERSITY SYSTEM
	Generic/Brand or Preferred/Non-preferred				
Retail Copayment (30-day supply)	10/25/40	10/25/40	10/25/40	10/25/40	10/25/50 30/75/150*
Retail Copayment for Maintenance Drugs (30-day supply)	15/35/55	15/35/55	none	none	none
Mail Order Copayment (90-day supply)	30/75/120	20/65.50/100	20/50/80	20/50/80	20/50/100
Percentage using retail pharmacies for maintenance drugs	48.9%	59%	66%	45.7%	52.8%
Percentage using mail order for maintenance drugs	16.0%	21.3%	55.6%	19.5%	22.3%
Additional copayments to purchase maintenance drugs at retail pharmacies	$15.2	$4.5	$0	$0	$1.5

*Texas A&M University 90-day at retail program copayments.
SOURCES: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

$105 for a three-month supply at retail and pays $75 by mail, saving $30.

A&M started offering participants the option to purchase a 90-day supply of a maintenance drug at a select group of retail pharmacies. This program feature allows member the convenience of purchasing a three-month supply at one time instead of having to fill the prescription monthly. In this scenario, the member pays three retail copayments. The plan saves money from reduced drug costs and dispensing fees.

Regardless of the copayment structure, participants are generally not taking advantage of the lower price of drugs at the mail-order pharmacy. Members regularly purchase maintenance drugs at a retail pharmacy at an extra cost. In fiscal year 2006, plan members paid an additional $21.2 million in copayments to purchase maintenance drugs at retail pharmacies.

No formal analysis has been conducted, but the plans attribute low enrollment in the mail order pharmacy program to several possible factors:

- Participants feel the mail order program is complicated.
- Participants cannot always afford to pay for three months' worth of a prescription drug at one time, so even though the annual cost is higher; the monthly cost is easier to budget for.
- Participants are concerned about prescriptions drugs arriving in the mailbox. Some drugs are temperature sensitive and may be exposed to heat or cold. Others could be stolen or lost in the mail.

On average, 54.5 percent of participants use the retail pharmacies for maintenance drugs. This number may be slightly increased by participants who purchase their first prescription at a retail pharmacy and switch to mail order after they began taking the drug regularly. The success of the mail-order program at TRS-Care indicates that participants can effectively use mail order. At TRS-Care, 55.6 percent of participants filled maintenance prescriptions through the mail-order program, while the other plans average approximately 20 percent.

Generally, when a participant purchases a medication through the mail-order pharmacy, the participant and the health plan save money. The health plans receive larger discounts from mail order pharmacies, because participants purchase drugs in bulk (a 90-day supply instead of a 30-day

supply) and the mail-order program does not charge dispensing fees.

The plans could evaluate barriers to the mail-order pharmacy program and identify opportunities to promote the mail-order program. By increasing participation in the mail-order pharmacy program, the plans would reduce the member out-of-pocket costs, and in most cases plans costs. TRS, UT and A&M report the plans could save money by increasing participation in mail-order program by 10 percent. ERSs plan costs would remain the same because participants pay an additional charge to purchase maintenance drugs at retail.

AFFECT OF HIGH COST SPECIALTY DRUGS ON STATE HEALTH PLANS

A specialty pharmacy provides specialty oral medications, self-injectables, and medications administered at the doctor's office. These medications often require special storage and handling and may not be readily available at the local drugstore. Biotech is one type of specialty drug. Biotechs are high cost drugs that are made using living materials, such as proteins and enzymes, rather than chemicals. Unlike traditional pharmaceutical pills, biotechs are often infused or injected.

According to Medco Health Solutions, spending on specialty pharmaceuticals like biotech drugs is growing twice as fast as traditional prescription drugs. Insurers project the cost of specialty pharmaceuticals will grow by between 20 percent and 50 percent annually. Employers and governments, the main payers of healthcare, will bear most of the cost of these drugs. Drug companies attribute the high cost of specialty drugs to the high cost of developing and manufacturing biotech drugs.

Enbrel is a biotech drug that is included in the state health plans' prescription drug coverage. As shown in **Figure 4**, Enbrel is one of the state's most costly prescription drugs. State health plan participants filled 8,471 prescriptions at a cost of $17.3 million to the state. That is an average of $2,046 per prescription as opposed to a traditional prescription drug like Lipitor, which cost the state $100 per prescription on average.

These drugs are not likely to get cheaper since current federal law does not allow generic versions of biotech drugs. To be good stewards of the health plans limited resources, the plans must consider when it is appropriate to use specialty drugs, because specialty drugs can vary greatly in cost and effectiveness. For example, Erbitux, a colorectal cancer drug, is about $38,000 for a four-month treatment. In clinical trials the drug extended the average patient survival by a few weeks or months. By contrast, Gleevec, a drug for a different cancer, has been shown to extend patients' lives for years, and is priced at $37,000 annually.

The state health plans are managing members' use of specialty drugs with case management, prior authorization programs, and dosage restrictions. Medco, the pharmacy benefit manager firm, works with a specialty pharmacy to ensure competitive pricing on high cost prescription drugs. However, the plans report that these drugs, which comprise less than 1 percent of the total number of prescriptions filled, averaged 11.6 percent of the total drug costs to the plans in fiscal year 2005. **Figure 9** shows each the state health plans' cost and use of specialty drug.

The state health plans could evaluate current activities and future opportunities for tracking and controlling the cost and use of specialty prescription drugs, such as biotech drugs. As costs increase, plans should identify savings realized from plan activities related to specialty prescription drugs.

FIGURE 9
STATE HEALTH PLANS' SPECIALTY DRUG COST AND USE, FISCAL YEAR 2005

SPECIALTY DRUGS	EMPLOYEES RETIREMENT SYSTEM	TEACHER RETIREMENT SYSTEM-ACTIVECARE	TEACHER RETIREMENT SYSTEM-CARE	UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M UNIVERSITY SYSTEM
Percentage of Prescriptions	0.36%	0.33%	0.32%	0.38%	0.60%
Percent of Prescription Drug Costs	11.8%	15.4%	7.3%	11.1%	12.5%
Specialty Presciption Drug Costs (in millions)	$32.2	$18.7	$19.0	$8.7	$3.6

Sources: Legislative Budget Board; Employees Retirement System; Teacher Retirement System; University of Texas System; Texas A&M University System.

OPTIMIZING THE PHARMACY NETWORK TO CONTAIN COSTS

States use a variety of use management and pricing strategies to contain pharmaceutical costs. One option states have used to contain costs in Medicaid is selective contracting. When states contract with a limited number of providers for a single good or service such as laboratory services or home health services they are able to negotiate greater price discounts. This approach could also be applied to prescription drugs. A health plan could negotiate with fewer pharmacies ensuring those pharmacies receive a larger portion of the plan business, and as a result, the plan receives a greater discount.

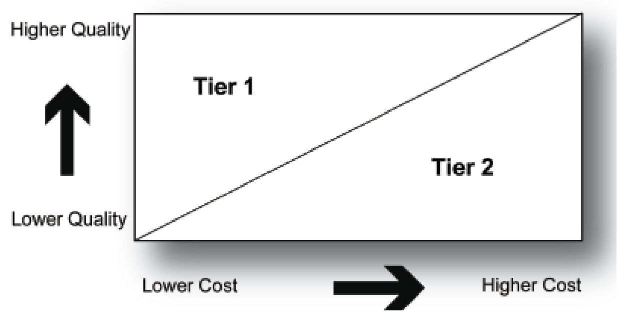
Optimizing the pharmacy network would reduce costs. However, reducing the size of the network to achieve a volume discount may also result in fewer participating pharmacies in certain areas of the state. To address this concern, the plans could provide options for rural areas that may fall outside the selected network. Conversely, the pharmacy network could include any pharmacy willing to accept the plans' reimbursement rate. By negotiating greater discounts on prescription drugs, the plans would reduce cost allowing the benefits to remain intact.

USING A TIERED NETWORK APPROACH TO CONTAIN COSTS

As a result of rising healthcare costs, insurers are creating incentives for consumers to consider cost differences when choosing among providers. **Figure 10** shows how a tiered network separates hospitals and providers into two groups (1) higher quality, lower cost; and (2) lower quality, higher cost.

A tiered network allows employees to continue to use a higher cost hospital or provider, but under a less favorable payment structure. For example, a member pays a $20 copayment when they visit a network doctor. With a tiered approach, the member might pay a $10 copayment for a tier-1 physician and a $30 copayment for a tier-2 physician. A tiered program may also operate by having the health plan pay 80 percent of the cost when a member chooses a lower cost, tier-1 provider and 70 percent if the member chooses the higher cost tier-2 provider.

FIGURE 10
EXAMPLE OF A TIERED NETWORK



SOURCE: Blue Cross Blue Shield of Texas.

Because tiered networks do not eliminate hospitals or providers from the network, they are typically more palatable to plan members than a network that eliminates the higher cost hospitals and providers. Another benefit of tiered networks is that it may encourage hospitals and providers to reduce rates to qualify for tier 1.

Insurers in California began offering plans with tiered hospital networks in 2002. PacifiCare first instituted its program in January 2002. Under the plan, members could use a Select Hospital or another hospital within PacifiCare's network. If members chose a Select Hospital, benefits were paid in full, and if members went to another hospital, they paid $100, $250, or $400 per hospitalization, depending on the hospital's cost.

The California Public Employees' Retirement System (CalPERS) established an exclusive provider network for California state employees. Instead of creating two hospitals tiers, CalPERS removed 34 high-cost hospitals from the CalPERS network beginning in 2005. CalPERS has not yet verified the savings that resulted from the exclusive provider network.

In 2007, BlueCross BlueShield of Minnesota will introduce a tiered hospital network program. Using cost and quality information, the insurer will establish a two-tiered hospital network. BlueCross BlueShield of Minnesota predicts that employers could save 6 percent to 8 percent annually by offering the two-tiered network.

Blue Cross Blue Shield of Texas (BCBS) evaluated providers and established a BlueChoice Solutions network of efficient providers based on cost and quality information. The BlueChoice Solutions provider network consists of a subset of physicians and professional providers within the health plan network. The state employee health plans have not limited or divided the network based on provider performance. BlueChoice Solutions is considered a high performance network.

A tiered provider network is similar to state employee prescription drugs coverage. The state health plans use tiered

prescription drug pricing which requires members to pay a higher out-of-pocket for non-preferred drugs ($40) and the least for generic drugs ($10). Should a participant prefer a provider in the higher cost network, the participant may seek care from them, but would pay a greater share of the cost of their care.

All current BlueChoice hospitals participate in the BlueChoice Solutions network. Only 60 of the state's 254 counties have more than one hospital. The hospitals in those 60 counties are often part of a hospital system. Those two considerations make it problematic to establish a tiered hospital network in Texas. For example, a hospital system may have a hospital in Houston that is a tier-2 hospital and another hospital in a rural county that is the only hospital available. As a result, some rural counties would be without a tier-1 hospital.

BCBS considers total costs associated with a provider when choosing providers for the BlueChoice Solutions performance network. Costs include hospital charges associated with the providers admitting hospital. This process allows BCBS to incorporate the cost of hospitals as a component of the tiered provider network. BCBS estimates that only about 50 percent of the states spending is paid to more efficient, high performing, low cost providers.

The plans could implement a tiered provider network to reduce costs. A tiered network should be based on cost and quality and should provide health plan participants with information regarding which network hospitals and network providers are preferred.

Figure 11 shows the amount BCBS estimates the state could save annually in All Funds by adding the BlueChoice Solutions provider network as a tiered network within the current state network.

FIGURE 11
ESTIMATED ANNUAL SAVINGS FROM IMPLEMENTING A TIERED NETWORK

HEALTH PLAN	SAVINGS ($ MILLIONS)
Employees Retirement System	$42.0
Teacher Retirement System	25.0
University of Texas System	12.0
Texas A&M University System	2.7
Total	**$81.7**

SOURCE: Blue Cross Blue Shield of Texas.

CREATE A COMPREHENSIVE STATE EMPLOYEE WELLNESS PROGRAM TO REDUCE STATE COSTS

By adopting a comprehensive wellness program, Texas state government could reduce healthcare costs, absenteeism, and disability claims while increasing state employee productivity. Despite efforts to contain costs, insurance premiums continue to rise. National trends indicate a 7 percent to 10 percent increase in health insurance premiums in 2008 and again in 2009.

Over the past decade, an increasing number of private- and public-sector employers implemented broad workplace health and wellness programs that reduce health related costs. A wellness program helps employees understand the negative effects of unhealthy habits and encourages them to be responsible with their health. When program participants reduce risks like smoking, overeating, and being physically inactive they prevent diseases that otherwise result in costly medical claims and increased sick days. In the first three to five years after implementing a comprehensive and coordinated wellness program, Texas state government could save a cumulative $80 million in employees' future health related costs.

CONCERNS

- ♦ Costly diseases like diabetes, congestive heart failure, and hypertension are often the result of unhealthy behaviors, such as smoking, overeating, and physical inactivity. The current Texas state employees' wellness programs do not include the components necessary to reduce health care related costs and encourage healthy behavior.
- ♦ Most state agencies lack the staff, expertise, or funds to offer a broad and effective wellness program.
- ♦ Wellness programs without participation incentives are less effective at reducing costs and encouraging responsible behavior than those with participation incentives.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code, Chapter 664, the State Employees Health Fitness and Education Act of 1983, to require that the statewide wellness program be a comprehensive program that includes the components necessary to reduce direct and indirect costs associated with preventable disease.
- ♦ **Recommendation 2:** Amend Texas Government Code, Chapter 664, to establish a statewide wellness coordinator's office within the Department of State Health Services. Require the agencies charged with oversight of the state funded health plans to provide the information necessary for Department of State Health Services to establish and manage the comprehensive statewide wellness program.
- ♦ **Recommendation 3:** Amend Texas Government Code, Chapter 664, to create a wellness surcharge. All Texas state government employees covered by a state funded health plan who choose not to take action to reduce their health risks would pay a surcharge. The cost of the wellness surcharge would be up to 1 percent of an employee's annual gross salary, not to exceed $35 per month or $420 per year. The wellness surcharge would be a participation incentive and offset health plan costs that result from an individual's unhealthy behavior.

DISCUSSION

The goal of wellness programs is to help individuals reduce health risk and prevent disease. Most Americans spend half their waking hours at work, and employers are the primary source of health insurance. Therefore, the workplace provides the best opportunity to encourage individuals to eat healthy, exercise, reduce stress, and quit smoking. Workplace wellness is a fringe benefit that appeals to current and prospective employees. Reduced medical costs save both the employee and the employer money, and improved health translates to improved productivity at work and at home. Comprehensive statewide employee wellness programs benefit state employees, reduce healthcare costs, increase productivity, and improve quality of life.

Texas Government Code, Chapter 664, the state employees health fitness and education statute, was enacted in 1983 and modified in 1989. Under current law, before implementing a wellness program, each state agency must develop a wellness plan. The agency must submit the plan to the Department of State Health Services (DSHS) for approval. If the agency expects to spend state funds on wellness, the Governor's

Office must approve the spending. Since 1989, DSHS has approved 49 agency wellness plans. Yet, few agencies regularly offer a range of wellness activities at work.

The National Governors Association recommends that states integrate comprehensive wellness programs into health benefit plans for all employees to maximize participation. Healthy employees are more productive because they require fewer sick days and avoid presenteeism (when sick employees come to work despite the public health risks and decreased productivity). On average, the medical costs of physically active individuals are 24 percent less than sedentary individuals.

The first step in motivating employees to manage their health is to educate them on the effects of health risks. Changing the culture of health is a continuous progression, requiring more than a health fair or a health screening. It is similar to previous long-term policy shifts, such as laws requiring drivers and passengers to wear seat belts and laws discouraging smoking in the workplace.

THE COST OF PREVENTABLE DISEASE

Texas spent over $3 billion in fiscal year 2005 to provide health insurance to its employees. Two factors make it difficult to identify the costs attributable to preventable disease in state employees. First, the process used to code medical claims makes it difficult to identify all treatment cost associated with a single disease. Second, specific information about an individual's health is confidential.

However, data shows that smoking and obesity are the first and second leading causes of preventable death in the United States. In Texas, 20.5 percent of adults currently smoke, and 25.8 percent of adults are obese. Obesity increases healthcare costs 36 percent, and smoking increases healthcare costs 21 percent. Like most employers, the state has limited ability to continuously fund increasing employee health insurance premiums. A wellness program would reduce costs associated with the health risk factors as shown in **Figure 1**, saving both the employee and the employer money.

TEXAS' CURRENT WELLNESS EFFORTS

A few Texas state agencies offer health promotion activities at work. However, the state does not take a comprehensive approach to wellness and does not offer wellness activities to the majority of employees. With this fragmented approach, Texas cannot ensure that the state or its employees benefit from wellness initiatives.

FIGURE 1
NATIONAL COSTS ASSOCIATED WITH CERTAIN HEALTH RISK FACTORS

HEALTH RISK FACTOR	ANNUAL HEALTHCARE COST	COST OF LOST PRODUCTIVITY
Physical inactivity	$76 billion	unknown
Smoking	$75 billion	$80 billion
Poor nutrition	$33 billion	$9 billion

SOURCE: Centers for Disease Control.

Our survey of agencies in January 2006, with DSHS-approved wellness programs indicated that only 12 agencies were offering wellness programs with some of the components of an effective wellness program. Three of those agencies had invested a small amount of state funds in employee wellness.

The fragmentation of the state wellness programs is further demonstrated by the Employee Assistance Program (EAP). The EAP provides education and counseling to assist employees with challenges on and off the job. EAP vendors sometimes offer information about health topics, and would be part of a comprehensive wellness program. Currently, EAP is not available to all state employees. In 2006, the majority of state agencies contracting for EAP were contracting with one of two vendors, but the contract rate for EAP services varied. Agencies negotiated rates from $0.92 to $1.50 per employee per month. In fiscal year 2005, the state paid $3.8 million to EAP providers. A comprehensive program with coordinated services would ensure benefits like EAP are purchased at the lowest rate and available to every employee.

In 2006, DSHS piloted an employee wellness program for its employees that consisted of components intended to help employees understand good health, eat healthier foods, increase physical activity, and manage stress. DSHS offered leave to motivate employees to visit their primary care physician. According to Blue Cross Blue Shield, the health plan administrator, DSHS employees' visited their doctors to have health screenings that detect and prevent disease at a significantly higher rate than non-DSHS employees. The program's success may be attributed to the agency's subject matter expertise, the link between wellness and DSHS mission, and management's support for the wellness program.

BENEFITS OF EMPLOYER WELLNESS PROGRAMS

The amount an employer saves by offering an employee wellness program is heavily dependent on creating a wellness program that fits the workforce. Nationally, 85 percent of employers offer at least one health promotion activity at work. **Figure 2** shows the percentage of large employers with employer-sponsored health benefits that offer employees specific wellness activities as part of their wellness programs.

FIGURE 2
WELLNESS ACTIVITY OFFERED BY LARGE EMPLOYERS

WELLNESS ACTIVITY	PERCENTAGE OF EMPLOYERS OFFERING ACTIVITY
Fitness Programs or on-site health club facilities	44 %
Smoking cessation Programs	43 %
Weight Loss program	42 %

SOURCE: Kaiser Network.

The Wellness Council of America estimates that an employer with a comprehensive workplace wellness program could realize a $3 to $6 return for each $1 invested. Several private sector companies have long standing, effective wellness programs that have successfully reduced costs. Citibank offers employees a comprehensive wellness program that focuses on risk reduction. The program began in 1994 by offering a health risk assessment. In the first year, 16,500 or 40 percent of employees completed the risk assessment, and high risk employees received personalized education programs. After subtracting program costs, Citibank saved approximately $6.6 million in reduced medical costs. A 2005 review of 27 wellness programs found an average return on investment of $5.81 for each $1 spent. **Figure 3** shows an analysis of employer workplace wellness program cost savings by area of reduction.

COMPONENTS OF AN EFFECTIVE WELLNESS PROGRAM

A comprehensive statewide employee wellness program would benefit all state employees, reduce health related costs, increase productivity, and improve quality of life. Many employers provide wellness programs, and there are a number of models used in those programs. Private-employers have been investing in employee wellness since the early 1990s; however, comprehensive public sector programs are a more recent occurrence.

FIGURE 3
SAVINGS EMPLOYERS ACHIEVE BY IMPROVING EMPLOYEE HEALTH

AREA OF REDUCTION	PERCENTAGE OF REDUCTION
Healthcare Costs	26%
Absenteeism	27%

SOURCE: The Art of Health Promotion.

The City of Fort Worth established its employee wellness program in February 2002 and is achieving positive results. The City of Fort Worth's wellness program includes an annual health risk assessment and free screenings for all eligible employees. Kept strictly confidential, survey responses and screening results are used to pinpoint health plan issues and assist the wellness coordinator to customize the risk reduction programs.

Employees qualify for incentives if they complete two consecutive annual health risk assessments and practice at least six of 13 healthy behaviors outlined by the program. The program awards up to $250 or 15 hours of wellness leave to healthy employees. In 2006, almost half of the 5,500 eligible employees qualified for an incentive, thus the city awarded $198,700 in cash and 7,944 hours of leave.

The educational and motivational programs cover the following areas.

- Weight Management
- Fitness Training
- Stress Management
- Tobacco Cessation
- Disease Management

The City of Fort Worth's wellness program budget is approximately $540,000 a year, and as a result of incorporating wellness in the benefit plan, the city's health insurance premiums did not increase in 2005. By contrast, the Employees Retirement System HealthSelect premiums increased 5 percent in 2005.

While each wellness program varies according to employees' needs, effective programs include common key components. The necessary components of effective and comprehensive wellness programs include the following.

Health Risk Assessment: A health risk assessment (HRA) is necessary to ensure that individuals are aware of behaviors that contribute to their risk for disease. An HRA is a series of questions about health and life habits, including questions about physical activity and diet, dental hygiene, use of safety

belts, and family medical history. The individual or his or her primary care physician can use this information to assess health and identify appropriate screenings. To accompany the HRA, employers may offer screenings at the workplace for common risk factors such as high blood pressure, high cholesterol, high blood sugar, and obesity.

HRA results are confidential. The Health Information Portability and Accountability Act (HIPAA) does not preclude an employer from collecting health data. Employers may collect and analyze HRA data in the same manner the health plans' use health information for disease management programs. HIPAA ensures health plan members will not be excluded from coverage, denied benefits, or charged more for coverage based on health status.

To alleviate employees concerns about the privacy of health information, program administrators educate employees on HIPAA compliance to reassure them their health information will not be misused. Other administrators have enlisted third-party contractors to administer the HRA, analyze results, and follow-up with health plan members. This strategy can effectively eliminate privacy concerns.

Classes and information: It is beneficial to offer a variety of health promotion classes and information on fitness, smoking cessation, nutrition, emotional well being, and stress management. Classes should be available during lunch and before and after work to maximize participation. The University of North Texas's wellness policy provides an extra hour off from work for an employee who participates in an employer-sponsored lunchtime fitness class or walking group.

A supportive environment: State agencies' policies and goals should make it easy for employees to integrate healthy behaviors and physical activity into their daily routines. State owned buildings should ensure snack bars and state-run cafeterias offer healthy food choices. Managers could encourage walking breaks during the day instead of smoking breaks to help reduce health risks. One state agency, DSHS, is promoting healthy living by prohibiting the use of tobacco on its state-owned land.

Appropriate program design: A wellness program must include employee participation and communication. Class offerings should be based on employee feedback and must target the healthcare claims that cost the most. In other public programs, the wellness coordinator surveys employees and analyzes health claim data to ensure the success of the wellness program. Establishing a statewide wellness coordinator's office would increase return on the state investment in wellness.

Incentives: The National Governors Association Center for Best Practices states that integrated incentives for individuals to better manage their health are essential to encourage participation in the wellness program. Wellness programs with incentives are more successful at reducing direct and indirect health-related costs than programs that do not integrate participation incentives.

Some employers provide a direct financial incentive to employees for participating in a health risk assessment, meeting with a health consultant to discuss prevention, or participating in one or two health promotion activities during the year. However, cash incentive programs can be problematic. The costs are unpredictable because it unknown how many employees will reach a set goal. Also, employees who successfully complete a wellness goal often self-report, and basing a reward on the honor system could lead to improprieties.

Since most state employees do not pay a premium or deductible for health insurance, Texas cannot tie participation in the wellness program to health insurance premiums. Without direct incentives available to Texas, a wellness surcharge could be used to encourage participation and provide resources to fund the program for participating employees. **Figure 4** shows the effects of incentives on participation in public sector wellness programs.

Recommendation 1 would amend Texas Government Code, Chapter 664, the State Employees Health Fitness and Education Act of 1983, to require that the statewide wellness program be a comprehensive program that includes (1) a health risk assessment, (2) classes, (3) a work environment that encourages wellness, and (4) a wellness program with incentives, designed to reduce costs. In other programs incentives range from a wellness surcharge, discounted premiums, or time-off for successfully completing an HRA. A statewide approach to wellness would ensure the program design addresses the state health plan costs drivers and promotes wellness activities that reduce state employee health risk factors.

The amount an employer saves by offering an employee wellness program is heavily dependent on creating a wellness program that fits the workforce. The most successful programs are supported by management and developed with employee participation, thus bringing greater benefit to employees and employers. Recommendation 2 would amend Texas

FIGURE 4
HIGHLIGHTS OF SELECTED PUBLIC-SECTOR WELLNESS PROGRAMS

EMPLOYER	INITIATIVE	INCENTIVES	APPROXIMATE PARTICIPATION RATE
City of Austin	• Health screenings • Health education and fitness programs • Discounted fitness classes • Wellness coordinator and committee	• Prize Drawings	20%
City of Fort Worth	• Health risk assessment • Healthy lifestyle criteria that must be met to qualify for incentives • Education seminars • Fitness classes, walking groups, gym discounts	• Successful wellness program participants earn up to $250 in cash or 15 hours of wellness leave	44%
MD Anderson	• Comprehensive program • An environment that encourages and supports well being • Wide range or opportunities to be active and get involved in wellness • Wellness coaches and 154 wellness champions who promote wellness to coworkers	• Time during the workday to participate in wellness training classes • Promote the value of quality of life • Wellness related give-a-ways	20–50%, varies by activity
Washoe School District, Nevada	• Annual health screening • Employees must take action to reduce health risk factors or employee pays higher premium	• $40-monthly surcharge	98%
West Virginia	• Comprehensive program • Offered statewide to all public employees • One on one consultation with a health promotion coach • Workplace wellness coordinators	• Wellness related give-a-ways, like T-shirts and pedometers	20%
Alabama	• Charge active and retired employees who smoke $20 more per month for health coverage. • A discount for employees and retirees who certify that they have not used tobacco products in the past 12 months. To qualify for the non-smoker discount, participants agree to periodic tobacco usage testing.	• Discount on health care premiums for non-smokers • Prize drawings • Cash incentive for completing weight loss program • Waived co-pays for employees follow-up on health screenings with primary care physician	Not available

Source: Legislative Budget Board.

Government Code, Chapter 664, the State Employees Health Fitness and Education Act of 1983, to establish a statewide wellness coordinator's office at DSHS. The wellness coordinator and staff would collaborate with the state health plan oversight agencies and other state agencies as necessary to design and manage the appropriate statewide wellness program.

An appropriately designed wellness program is strategically developed and implemented and includes policies and activities that target health risk behaviors and the needs of the employee. Initially, the statewide wellness coordinator should survey employees to determine need. The coordinator would also analyze insurance claims data to ensure the state provides the appropriate activities to address costs that drive state health plan expenditures. The wellness coordinator would either hire state staff to provide the activities or contract with a vendor who specializes in wellness services. The coordinator would develop a simple and clear goal for the wellness program once he or she understands the state employee culture and can determine how health promotions fits into the current work environment.

Recommendation 3 would amend Texas Government Code, Chapter 664, to create a wellness surcharge. All Texas state government employees covered by a state funded health plan who choose not to take required action to reduce their health risks would pay a surcharge. The cost of the wellness surcharge

would be up to 1 percent of an employee's annual gross salary, not to exceed $35 per month or $420 per year. The wellness surcharge would be a participation incentive and a means of funding for the program as well as an offset of health plan costs that result from an individual's unhealthy behavior. The surcharge would be paid monthly through payroll deduction in the same manner as employees pay for health insurance premiums. The surcharge would be deposited to a General Revenue–Dedicated State Employee Wellness account, created in Texas Government Code, Chapter 664, to fund the statewide wellness program activities. Any balance in the General Revenue–Dedicated account at the end of the biennium would be transferred to the state funded health plans to help pay health care claims. The 2008–09 General Appropriations Bill would appropriate $225,000 to fund the first year of the program, and appropriate 2009 revenue from the wellness surcharge to the statewide wellness coordinator's office at DSHS.

Contingent upon the passage of legislation to implement recommendations, the following rider could be included in the 2008–09 General Appropriations Bill:

State Employee Wellness Program.

a. Each state employee who elects not to participate in the statewide employee wellness program enacted by legislation shall pay up to 1 percent of their annual gross salary, not to exceed $35 per month or $420 per year as a wellness surcharge.

b. Contingent on passage of legislation creating a comprehensive state employee wellness program, by the Eightieth Legislature, Regular Session, the Department of State Health Services is appropriated $225,000 for fiscal year 2008 from General Revenue and 3.5 FTEs to implement the provisions of the legislation.

c. Contingent on passage of legislation relating to a state employee wellness surcharge, by the Eightieth Legislature, Regular Session, the Department of State Health Services is hereby appropriated an amount estimated to be $17,917,191 in fiscal year 2009 out of revenue collected in the General Revenue–Dedicated State Employee Wellness account and certified by the Comptroller of Public Accounts pursuant to the enactment of this legislation, or similar legislation, implementing a state employee wellness program. Any balance in the General Revenue-Dedicated account at the end of the biennium shall be transferred in a proportional manner to the state funded health plans' trust funds for the purpose of paying claims.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 and 2 would result in a $225,000 cost in General Revenue Funds in fiscal year 2008. These funds would pay for 3.5 additional full-time equivalents and administrative costs to establish the comprehensive statewide wellness program. This staffing level is comparable to that of other wellness programs described in this review. Recommendation 3 would generate an estimated $17.9 million in General Revenue–Dedicated Funds that would be appropriated to DSHS to fund the statewide wellness program. The revenue in 2009–2012 would pay for the activities required by recommendations 1 and 2. As an alternative to a wellness surcharge, the state could fund the program and incentives with General Revenue Funds. The cost of the wellness program and related incentives would depend on the type of program and incentives the statewide coordinator identifies as most appropriate for state employees. Based on other public programs, we estimate a comprehensive wellness program would cost a minimum of $3 per employee per month or $10.7 million annually plus the cost of selected incentives.

The fiscal impact in **Figure 5** assumes that in 2009, 35 percent of all active state employees covered by a state health plans would choose not to participate in the wellness program and would pay a surcharge of one-half of one percent of their monthly salary. In 2009, this would generate approximately $17.9 million in revenue. The wellness surcharge would be a participation incentive and a means to fund the program as well as an offset of health plan costs that result from an individual's unhealthy behavior. Participation rates typically increase as employees become more familiar with wellness benefits. We assume an increase in participation of 2 percent to 3 percent each fiscal year of the program thereby reducing the revenue. The statewide wellness coordinator in collaboration with the state health plan oversight agencies would determine the exact amount of the wellness surcharge as part of the appropriate program design. Collection and appropriation of the surcharge would begin in fiscal year 2009.

Assuming a reasonable return on investment for a wellness program of $4.50 saved for $1 invested, the state could save a cumulative $80 million in three to five years after implementing the program. The costs the state avoids occur by reducing:

- state employee premiums;
- lost productivity from absenteeism; and
- disability claims.

FIGURE 5
FIVE-YEAR FISCAL IMPACT

FISCAL YEAR	SAVINGS/(COST) TO GENERAL REVENUE FUNDS	PROBABLE REVENUE GAIN/ (LOSS) TO GENERAL REVENUE–DEDICATED FUNDS FROM WELLNESS SURCHARGE	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED FUNDS FROM WELLNESS SURCHARGE	CHANGE IN FULL-TIME EQUIVALENTS FROM FISCAL YEAR 2007
2008	($225,000)	$0	$0	3.5
2009	$0	$17,917,191	($17,917,191)	3.5
2010	$0	$16,381,432	($16,381,432)	3.5
2011	$0	$15,357,593	($15,357,593)	3.5
2012	$0	$14,333,753	($14,333,753)	3.5

Source: Legislative Budget Board.

Adopting a comprehensive and coordinated state employee wellness program would reduce healthcare related costs for all state employees in fiscal years 2010, 2011, and 2012. The return on investment would vary depending on the model used to establish a wellness program. Savings could be achieved as early as two years after implementing the program, but it could take three to five years to realize savings. The City of Fort Worth experienced zero growth in health insurance premiums in the budget cycle after it incorporated wellness in its health benefit plan. Citibank saved $6.6 million on medical claims at the end of the first year of its wellness initiative.

The introduced 2008–09 General Appropriations Bill does not address these recommendations.

ESTABLISH A RETIREE HEALTH INSURANCE TRUST FUND FOR COMPLIANCE WITH GASB 45 ACCOUNTING STANDARDS

The Governmental Accounting Standards Board (GASB) recently issued GASB Statement 45, introducing accounting standards for "Other Post Employment Benefits," which primarily concerns retiree healthcare. The standards require governmental employers to account for retiree healthcare in a manner similar to methods used for retirement annuities. They apply to state entities and local entities such as cities and counties. Employers must either contribute an annual amount (the Annually Required Contribution) into a trust fund, or book this amount as a liability. Large employers such as Texas will need to account for the Annually Required Contribution or the liabilities in fiscal year 2008, though the individual plans will need to begin reporting in fiscal year 2007. Texas retiree health plans have not released estimates, but it is likely that the annual cost of funding the Annually Required Contribution will be in the billions of dollars, and the potential liability is in the tens of billions of dollars. There are various types of responses to the new standards which can have significant impacts on the state's finances and current or future retirees.

FACTS AND FINDINGS

- The new accounting standards do not add to the long term costs of providing retiree health, they merely recognize what those costs will be as the benefits are earned.
- Texas costs for OPEBs were $629 million in Fiscal Year 2005.
- Most governmental employers are unlikely to fully fund the Annually Required Contribution immediately, but many are making plans to begin making contributions that will ramp up to the full contribution.
- Even partial contributions of the Annually Required Contribution would greatly reduce the liabilities Texas has to recognize.
- When a similar provision was applied to the private sector, the main responses were to reduce benefits or to no longer provide retiree health. Many governmental employers are likely to reduce retiree health benefits, or increase retiree premiums, but few are likely to eliminate them.

CONCERNS

- If no contributions are made, over several years the recognized liabilities could begin to affect Texas bond rating; after 10 years the liability would be greater than $50 billion.
- If no trust fund is set up, the new Governmental Accounting Standards Board standards would require the Employees Retirement System Group Benefit Program to perform more than 50 actuarial separate valuations at significant cost.

RECOMMENDATIONS

- **Recommendation 1:** Establish a qualified retiree health insurance trust fund for the Employees Retirement System Group Benefits Program.
- **Recommendation 2:** If the state makes Governmental Accounting Standards Board "Other Post Employment Benefits" contributions this biennium, establish separate qualified retiree health insurance trust funds for the Teachers Retirement System, the University of Texas System, and the Texas A&M System.

DISCUSSION

Governmental Accounting Standards Board (GASB) is an independent organization which is devoted to establishing standards of state and local governmental accounting and financial reporting. By using these standards, governments can provide useful information for users of financial reports and guide and educate the public, including issuers, auditors, and other users of those financial reports.

CALCULATION OF PRIOR SERVICE LIABILITIES AND THE ARC

There are two GASB standards that affect accounting for "Other Post Employment Benefits" (OPEBs), GASB 43 and GASB 45. GASB 43 applies to the entity that provides the healthcare plan, while GASB 45 applies to the government that finances the benefits. These standards complement each other and this report uses GASB 45 to refer to both standards. For the state of Texas, the entities that are directly affected by GASB 43 include the Employees Retirement System (ERS), the Teacher Retirement System (TRS), the University of Texas System (UT), and the Texas A&M System. Potentially,

GASB 45 only affects the state of Texas, though depending on the state's response, the standards could affect every state agency, institution of higher education, junior college, and school district.

To calculate the prior service liabilities, employers will estimate the present value of the future liability for the provision of healthcare to their employees by estimating the expected costs of health care for current and future retirees for each year in the future, and discounting back using an appropriate interest rate. The liability will be split into liability for prior service (e.g., all service for current retirees) and for future service. Every year there will be a contribution for future healthcare benefits related to service performed by active employees during that year. This is analogous to the normal cost for a retirement plan. The prior service liability as of August 30, 2007 will be calculated, but the employer is allowed to amortize/recognize this amount over 30 years. The Annually Required Contribution (ARC) will equal the yearly amortization amount added to the normal cost. For those not familiar with retirement terminology, the amortization of the prior service liability is analogous to making mortgage payments over 30 years to pay off a house loan. Though the state is allowed to amortize the prior service liability for accounting purposes, the full amount is already an obligation of the state.

CONSEQUENCES OF NOT CONTRIBUTING TO A TRUST FUND

GASB 45 makes a strong case for placing significant contributions into a trust fund, but it does not force employers to do so. However, there are consequences if contributions are not made. In such a case, the unpaid ARC shows up as a liability on the books of the employer. Over time with each year's ARC amount added to all prior years' ARC with interest, the liability will be significant. Two of the three major bond rating agencies, Standard & Poors and Fitch, have announced they will treat these liabilities the same as any other obligation, thereby affecting the bond rating of governmental employers.

The rating agencies consider not only the relative size of obligations an entity has, but also whether the entity is making progress toward funding these obligations. Few states are likely to start making contributions of the full ARC into a fund immediately. Mercer Consulting has suggested that ramping up towards making the full contribution in five years would be sufficient to minimize any impact on bond ratings. It is now too early to estimate how many states plan to fully fund the ARC over the next several years, though some may choose to not provide any funding in the very short term.

Another reason to consider making contributions to a trust fund is the way the liabilities (and thereby the ARC) are calculated. If contributions are being made, future liabilities are discounted at a rate similar to what a pension system earns in investment returns (e.g., 8 percent); if contributions are not made, future liabilities are only discounted at the rate the state treasury would earn (e.g., 4 percent). This difference is enough to roughly double the liabilities, thereby doubling the ARC if no contributions are made. If partial contributions of the ARC are made, the interest rate would be a blended rate, discounting the paid liabilities at 8 percent and the unpaid amounts at 4 percent.

This creates a strong incentive to at least fund the liabilities the state incurs for retiree health insurance payments which will be made far in the future. Using the discount rates just discussed, the cost of funding a benefit which will be paid 30 years from now will be only a third of the liability the state would incur for not funding it. Similarly, the cost of funding a benefit to be paid 50 years from now will be only one-sixth of the liability the state would incur for not funding it. An example of such a benefit is the provision of retiree healthcare at age 80 for an active employee who is now age 30.

If the state makes partial contributions of the ARC, it can reduce incurred liabilities by two or more times the value of contributions it makes. One approach of making partial contributions would be to fully fund the normal cost (identified above) for all employees under age 40, and amortize their prior service liability over the next 30 years. Other ages, such as 45 or 50, could also be considered, depending on how large a contribution the state wants to make. This approach would make it straightforward to determine which employees would be eligible to have insurance costs paid for from the trust fund, and which employees and retirees would be paid for on a pay-as-you-go basis.

There are several sources of relevant liability to the state: public school teachers (under TRS-Care), state employees (under ERS), higher-education employees under ERS, and UT and A&M employees. Several years ago, TRS estimated retiree healthcare liabilities for TRS Care, resulting in a prior service liability of around $10 billion. Medical inflation has remained higher than anticipated, and this liability would

increase at the interest rate TRS assumed (8 percent), so it has increased since then.

OPTIONS FOR GASB 45 CONTRIBUTIONS

The Texas' Comptroller of Public Account's 2005 Comprehensive Annual Financial Report shows the 2005 cost of Other Post Employment Benefits to be $629 million. Other governmental entities have estimated that the ARC to be between four and eight times the current costs. The ARC includes an amount analogous to current costs, so at a minimum Texas would need to contribute an additional amount three times greater than current contributions to meet this obligation. TRS represented approximately 40 percent of the 2005 costs, so their prior service liability would likely be approximately 40 percent of the total Texas prior service liability. The majority of the current costs are paid with General Revenue Funds, and so the majority of the costs of an ARC contribution would also be General Revenue Funds.

One important concept adopted by GASB is the notion of a substantive plan. The substantive plan refers to how the employer has traditionally funded the plan, as well as the benefit levels. Historic funding and benefits are the primary guides to retirees' and active employees' expectations, though any benefit changes that have been implemented would be taken into account. In the absence of statutory limitations, these guidelines constitute the substantive plan and shall be the basis of projecting forward retiree costs and benefits, even if they are not codified in current statutes.

One impact of the substantive plan is the effect on cost sharing—not just between retirees and the employer, but between entities like the state and community colleges, institutions of higher education, and local school districts. Generally, if an employer picks up a given percentage of the current costs, they would pick up the same percentage of the ARC. There are policy decisions to be made as far as the most appropriate allocation of liabilities, but the simplest solution would be for the state to assume all the liabilities, and at the same time ask for other entities to increase their contributions as the state does.

Another issue is that GASB has given guidance that if no appropriate trust fund is established, then each individual employer would need to have its own actuarial valuation, which would create substantial costs. Currently, establishing a relevant trust is enough to prevent this requirement, though actually funding the trust is not required. GASB has mentioned that establishing a trust without any funding only to avoid valuation costs is abusive of their intent, and they may disallow this practice in the future. This issue affects ERS in particular, since the state, community colleges, and Texas Municipal Retirement System entities are all in ERS for insurance and all have separate financial reporting. Since the TRS trust fund is for retirees only, it should be a qualified trust fund so they are not affected by this, and financial reporting for UT system components and Texas A&M components is sufficiently consolidated for them not to be affected either.

Implementing Recommendation 1 would establish a qualified trust fund for ERS, would avoid the costs associated with multiple actuarial valuations for a single plan. Note that establishing a trust fund for any of the systems would require statutory changes in the applicable Texas Government Code.

If any GASB OPEB funding is provided, then both Recommendation 1 and Recommendation 2 should be implemented (i.e., separate qualified retiree trust funds should be set up for each of the four systems described above). While this is required for ERS, UT and A&M since they also have active employees in their current insurance trust funds, there is another reason to set up a separate trust fund. If the state makes contributions for future retiree health insurance benefits, having a separate trust fund would give much greater control on how the funds are eventually used. This approach would simplify accounting if only partial contributions are made, and is advisable even if the full ARC is paid. Rules regarding who the trust would pay for, and how much it would pay for them could be established. As an example the TRS CARE trust fund currently has many sources of income, no direct way to determine when retiree premiums should be increased (or by how much), and looks to be needing supplemental payments from the state for the foreseeable future- after the 2006–07 biennium. A separate trust would give more control to the state for determining supplemental funding amounts, allow for clear guidelines for the usage of trust fund amounts, improve accountability in tracking the usage of the fund, and make it easy to determine trust fund account balances.

So at a minimum, Texas should consider establishing one or more trust funds. Other considerations include determining whether to fund the trust funds, and if so by how much, and whether to make adjustments to either retirement or retiree health to reduce liabilities and the ARC.

Figure 1 shows options regarding funding levels, and their impact on Texas liabilities.

At least 12 states have established trust funds or introduced legislation to do so. At least 12 states have calculated and disclosed prior service liabilities. New York City has contributed $2 billion to a trust fund. Clearly there is some action by governmental entities on this front. Some governmental employers will likely respond to GASB 45 by reducing the costs of retiree health insurance to lower their liabilities in the near future. However, since many governmental employees are unionized, this option may not be effective for many entities.

RETIREE HEALTH POLICY OPTIONS TO REDUCE LIABILITIES

There are three major factors to consider before changing a plan to lower the costs of retiree healthcare to minimize the GASB liabilities: (1) reducing costs which will be incurred in the near future has a much bigger effect due to the discounting of future liabilities; (2) retirees under age 65 generally cost twice as much as those over age 65 due to Medicare; and (3) some care must be taken not to violate the federal Age Discrimination Act.

Figure 2 includes potential options for reducing state liabilities that would have a significant reduction in GASB liabilities. While other changes to benefits would also reduce liabilities, they would generally have a relatively greater effect on benefits and a relatively lesser effect on long-term liabilities for the state. For some options, some grandfathering of current retirees and/or current employees near retirement would be advisable, for others it would be required under federal law.

FISCAL IMPACT OF THE RECOMMENDATIONS

Establishing any of the recommended trust funds would not have a significant fiscal impact. The fiscal impact of making contributions to the trust funds cannot be determined since the cost is dependent on the contribution policy chosen and any changes made to retirement or retiree health policies. Additionally, an accurate estimate would require the retirement plans to make official estimates, and none of them have made estimates in response to GASB 45. Finally, an argument could be made that the fiscal impact of a contribution would be a long-term savings greater than or equal to the contribution, since the state would avoid liabilities equal to two or more time the contribution.

The introduced 2008–09 General Appropriations Bill does not address the recommendations.

FIGURE 1
FUNDING OPTIONS FOR THE RETIREMENT TRUST FUND

	OPTION	CONSIDERATION
A	Make no contributions to a fund and make no changes to provision of retiree benefits.	This would likely cause the state to incur $4 billion in liabilities a year due to the lower interest rate assumption. The amount after 10 years would accumulate to more than $50 billion, a significant consideration for the bond rating agencies.
B	Place an amount equal to the ARC in a trust fund, or ramp up to this amount over several biennia.	A significant amount of funding necessary, would be difficult to afford, but would eliminate or minimize any liabilities the state would have to recognize.
C	Place some amount in a trust fund, but lower than the ARC.	A discussion of partial contribution approaches for active employees based on attained age is made above. Or the state could pay the normal cost thereby avoiding adding additional liabilities for active employees, though we would have to recognize prior service liabilities.
D	Make plan design changes to retiree health regarding eligibility and/or retiree contributions, possibly in combination with partial or full funding of the resulting ARC.	At the extreme, requiring full premiums for retiree health would end the GASB 45 liabilities, and merely providing an insurance plan that can be purchased would still be a benefit.

Source: Legislative Budget Board.

FIGURE 2
POLICY OPTIONS TO REDUCE RETIREE HEALTHCARE LIABILITIES

	OPTION	CONSIDERATION
A	Pay a graduated rate for retirees based on years of service, where those who had say 20 years of service receive the current subsidy, but those with fewer years pay a greater percentage of their costs.	Would reduce insurance costs and inspire some employees to work longer before retiring.
B	Require retirees to pay a significant portion of the cost of coverage prior to age 65.	They would still have coverage, but they would just have to pay greater rates. As a practical matter, charging more than 70% or so could increase state costs due to adverse selection.
C	Require school districts to pay for the cost of coverage above the TRS-Care retiree premiums prior to age 65	This option would make a major reduction in state liabilities and costs, and it would also diminish the incentive for districts to encourage teachers to retire early. Districts would likely need additional taxing authority.
D	Require ERS and higher-ed retirees to pay some amount for coverage prior to age 65, up to the difference in costs for pre-Medicare and post-Medicare coverage.	Would reduce insurance costs and inspire some employees to work longer before retiring.
E	Require TRS-Care premiums for coverage prior to age 65 to equal the premiums for over age 65 plus the difference in costs for pre-Medicare and post-Medicare coverage.	This would give all age groups the same subsidy.
F	Require all retirees to pay 50% of the cost of insurance and dependents 75%.	A major reduction in retiree health benefits.
G	Move to a defined benefit, where the state provides $x times the number of years of service, and retirees pick up the rest of the cost of coverage.	A significant limitation on state liability. Would greatly extend the working life of those who start working for the state later in life.
H	Only cover retirees prior to age 65, since Medicare provides the majority of coverage that state insurance plans provide.	A major reduction in retiree health benefits, though not as great with the introduction of Medicare Part D.
I	Change coordination of benefits with Medicare.	Medicare pays 80% of the costs of a procedure. With current coinsurance amounts and coordination of benefits policies, the retiree generally pays only 4% of the costs.
J	Reduce ERS coverage for both actives and retirees by increasing copays, deductibles, coinsurance, and out-of-pocket maximums.	Reduces current insurance costs as well as the costs of GASB 45 contributions.
K	Change eligibility for retirement to rule of 85, rule of 90, or minimum age 60.	Minimum age 60 would have a major impact, rule of 85 would have a small impact.

Source: Legislative Budget Board.

ELIMINATE CERTAIN APPROPRIATIONS FOR LOCAL RETIREMENT CONTRIBUTIONS TO THE TEACHER RETIREMENT SYSTEM

Texas public school districts and institutions of higher education spend monies from a variety of sources on salaries for teachers and other employees. If this salary funding is from unappropriated federal grants, then Federal Funds must be used to pay the costs of Teacher Retirement System (TRS) retirement contributions. Institutions of higher education also have access to locally held non-Education and General Funds. State law requires that these funding sources must also be used to pay the costs of employee benefit contributions associated with salaries paid from these funds.

Currently, both for unappropriated Federal Funds and for higher education non-Education and General Funds, the state appropriates General Revenue Funds for the TRS retirement contributions, and the Local Funds are sent to TRS which then reimburses the General Revenue Fund. This practice inflates General Revenue Fund appropriations and increases the cost of contribution rate increases. The state should end the practice of appropriating General Revenue Funds for these local contributions, and TRS should instead deposit the contributions directly in the TRS retirement trust fund.

CONCERNS

- TRS has estimated that at the current 6 percent retirement contribution rate, approximately $455 million will be received in the 2008–09 biennium from local school districts and institutions of higher education for salaries paid from unappropriated sources. Current practice is to appropriate a state contribution to TRS as General Revenue Funds on behalf of these salaries and for TRS to deposit the funds received for unappropriated salaries to General Revenue Funds as an offset. This inflates General Revenue Fund appropriations by $455 million, and is inconsistent with the methodology used for all other benefits, including Employees Retirement System retirement, Group Insurance, and Social Security.
- The introduced 2008–09 General Appropriations Bill includes an increase in the contribution rate for TRS to 6.4 percent. This increase, together with the current reimbursement practice, causes General Revenue Fund appropriations to increase by an additional $30 million for costs that should be borne by local sources.

RECOMMENDATION

- **Recommendation 1:** Amend Texas Government Code 825 to require that Teacher Retirement System (TRS) retirement contributions from Federal Funds and non-Educational and General Funds be deposited into the TRS retirement trust fund directly.

DISCUSSION

Current Teacher Retirement System (TRS) governing statutes (Texas Government Code 825.406) require TRS retirement contributions related to salaries paid from Federal Funds to be sent by the employer to TRS, which must then deposit these amounts into the General Revenue Fund. Similarly, Texas Government Code 825.407 requires institutions of higher education to reimburse the state for TRS retirement contributions related to salaries paid from non-Education and General Funds. In both cases, these statutes require the state to appropriate General Revenue Funds for the related retirement contributions, even though the original funding sources must supply sufficient funds to TRS to make these contributions when payroll is run.

The result is that General Revenue Fund appropriations for the TRS retirement contribution must be sufficient to cover not only retirement contributions for members paid from General Revenue Funds, but also must cover retirement contributions for members paid from unappropriated Federal Funds and non-Education and General Funds. This misrepresents the General Revenue Funds cost of funding the Teacher Retirement System, appropriates employee benefits which cannot be allocated to any appropriated programs, and overstates the overall General Revenue Funds costs of the state by a significant amount. TRS has estimated that the state will need to appropriate $455 million in General Revenue Funds in the 2008–09 biennium just to cover these locally funded costs at a 6 percent contribution rate (see **Figure 1**).

These two statutes should be amended to require TRS to deposit the received funds directly into the TRS retirement trust fund, thereby reducing the state contribution based on the portion of a member's salary paid from federal or non-Education and General Fund. The effect would be to reduce General Revenue Fund appropriations by approximately

FIGURE 1
UNAPPROPRIATED DEPOSITS TO GR BY TRS FOR RETIREMENT AT 6% RATE (IN MILLIONS)

	FEDERAL/PRIVATE GRANTS PUBLIC EDUCATION	FEDERAL/PRIVATE GRANTS HIGHER EDUCATION	NON-EDUCATION AND GENERAL FUNDS (HR ED)
2006	$111.8	$37.0	$53.0
2007	$117.4	$38.9	$55.7
2008	$123.3	$40.8	$58.4
2009	$129.4	$42.8	$61.4

Note: Dollar values in millions.
Source: Teacher Retirement System.

$485 million for the 2008–09 biennium. Typically estimated reimbursements to the General Revenue Fund would not be increased in the Comptroller's Revenue Estimate until the following biennium when the Biennial Revenue Estimate is prepared. So the recommendation would result in a reduction in estimated revenue to the General Revenue Fund of approximately $455 million, for a net savings of $30 million. This $30 million in savings would be a true savings for this biennium in the sense that the General Revenue Funds certification cost of the 2008–09 General Appropriations Act would be $30 million lower.

FISCAL IMPACT OF THE RECOMMENDATION

If the state contributes at the Legislative Budget Board recommended 6.4 percent rate, the recommendation would result in a reduction of General Revenue Funds of approximately $485 million for the 2008–09 biennium (**Figure 2**). It would also result in a reduction of estimated revenue to the General Revenue Fund of approximately $455 million (**Figure 2**), resulting in a savings of $30 million in General Revenue Funds. Whether the recommendation were implemented or not, the Biennial Revenue Estimate for the 2010–11 biennium would show the increased reimbursements at the 6.4 percent rate, so there would be no net impact in the fiscal years after 2009. At any other contribution rate greater than 6 percent, there would be savings this biennium proportional to the $30 million amount.

FIGURE 2
FIVE-YEAR FISCAL IMPACT

FISCAL YEAR	PROBABLE SAVINGS (COST) TO GENERAL REVENUE FUNDS (IN MILLIONS)	PROBABLE REVENUE GAIN (LOSS) TO GENERAL REVENUE FUNDS (IN MILLIONS)
2008	$235	($220)
2009	$250	($235)
2010	$260	($260)
2011	$275	($275)
2012	$290	($290)

Source: Legislative Budget Board.

UPDATE ON THE STREAMLINED SALES TAX REPORT

Federal courts have ruled that states may not require a firm to collect state and local sales tax on interstate sales unless the firm has a physical presence, or nexus, in the taxing state. Prior to the mid-1990s, the rulings affected primarily interstate catalog and telephone sales and some transactions between businesses conducted on proprietary computer systems. With the growth of the Internet, the potential for sales tax losses from remote sales increased dramatically.

In response to these potential revenue losses, a group of states formed the Streamlined Sales Tax Project in 2000. The goal of this project was to establish a simplified framework for collecting sales tax on remote sales either through voluntary compliance by remote sellers or through congressional action authorizing states to require vendors to collect taxes on interstate sales. The project produced the multi-state Streamlined Sales and Use Tax Agreement, which took effect in October 2005. Under the key provisions of the agreement, participating remote vendors voluntarily collect state and local sales taxes on remote sales on behalf of Streamlined Sales and Use Tax Agreement member states. Federal legislation that would ratify the agreement and mandate tax collections by remote sellers has been introduced in U.S. Congress, but has made little progress in the legislative process.

The state of Texas is not a member of the Streamlined Sales and Use Tax Agreement primarily because the agreement requires destination-based sourcing of local sales taxes while Texas has origin-based sourcing for local sales taxes. In addition to non-compliance on the sourcing issue, Texas has not aligned all sales tax definitions with Streamlined Sales and Use Tax Agreement requirements, and Texas' tax treatment of certain goods and services does not conform to guidelines of the agreement. The Texas Comptroller of Public Accounts estimates that Texas loses almost $500 million annually in uncollected taxes on remote sales.

FACTS AND FINDINGS

- The Texas Comptroller of Public Accounts estimates that the inability to require remote sellers to collect sales tax costs Texas approximately $500 million per year. If the U.S. Congress enacts legislation authorizing state to require sellers to collect taxes on remote sales, and Texas becomes a member of the Streamlined Sales and Use Tax Agreement, the state could gain $450 million to $500 million annually.
- Making the tax law changes necessary to become a member of the Streamlined Sales and Use Tax Agreement, absent congressional action mandating collection of taxes on remote sales, could result in a net revenue loss to the state.
- Changing from origin-based to destination-based sourcing of local sales tax, as required by the Streamlined Sales and Use Tax Agreement, could result in significant fiscal losses to several local taxing jurisdictions. However, a system to mitigate sales tax losses to local taxing entities could probably be designed.

DISCUSSION

Forty-five states and about 7,500 units of local government impose sales and use taxes. In the 2005 fiscal year, U.S. Census Bureau reports that states sales and gross receipts tax collections totaled $212.2 billion and accounted for one-third of all state taxes. Census Bureau numbers indicate that Texas is significantly more dependent on sales tax than the national average with sales taxes accounting for 49.9 percent of Texas state tax revenue in 2005.

In 2004, the latest year for which census data on local taxes are available, local governments collected $46.9 billion in sales taxes, 11 percent of all local taxes. In Texas, local taxing jurisdictions imposed $3.7 billion in sales taxes with sales taxes also accounting for 11 percent of local tax revenue in Texas according to Census Bureau definitions.

The Texas Comptroller of Public Accounts (CPA) uses a more restrictive definition of state tax revenue than the Census Bureau. According to comptroller definitions, the state sales tax accounted for 54.7 percent of state taxes in fiscal year 2005. The CPA reported local government sales tax allocations in Texas of $4.2 billion in 2004.

In 2006, state sales tax rates range from 2.9 percent to 7.0 percent. Tennessee, Rhode Island, and Mississippi have the highest state rate, and Colorado has the lowest. Texas, with its 6.25 percent state rate, ranks seventh highest, tied with Illinois and California.

State and local sales taxes are levied on purchases of taxable goods and services. Typically, sales tax liability is incurred when a purchaser buys a taxable good or service within the boundaries of the taxing unit and takes possession of the good or receives the service at the point of purchase. In the typical case, the seller is legally responsible for collecting the sales tax on behalf of the taxing entity.

Most jurisdictions that impose a sales tax also impose a complementary tax called a use tax. The intent of the use tax is to prevent remote vendors from having an economic advantage over local vendors. When a seller has no physical presence in the taxing unit, but a good is shipped to the taxing unit, a use tax is imposed. Unless the seller voluntarily collects the tax on behalf of the taxing unit, the purchaser is liable for payment of the use tax. In many cases, use taxes are more difficult for state and local taxing units to audit, enforce, and collect than sales taxes. The issue of taxing internet, catalog and other remote sales when the seller does not have nexus in the taxing jurisdiction is largely about collection of the use tax.

LEGAL BACKGROUND ON THE TAXATION OF INTERSTATE COMMERCE

In a series of rulings, the U.S. Supreme Court delineated the authority of states to collect taxes on interstate sales. In *National Bellas Hess, Inc. v. Department of Revenue State of Illinois, 1967*, the vendor argued that the sales tax imposed by Illinois violated both the Commerce Clause and the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution. See **Figure 1** and **Figure 2**.

Illinois attempted to collect tax from National Bellas Hess, a mail-order firm based in Missouri. All the contacts the firm had with the state were through the mail or via common carrier. The U.S. Supreme Court ruled against the state, noting the burden on interstate commerce that would be created if every state and political subdivision with their various rates and exemptions could impose a sales tax on remote sales.

FIGURE 1
COMMERCE CLAUSE

Article I, Section 8, Clause 3, United States Constitution
[The Congress shall have power]

"To regulate commerce with foreign nations, and among the several states, and with the Indian tribes;"

SOURCE: U.S. Constitution.

FIGURE 2
DUE PROCESS CLAUSE

Fourteenth Amendment, Section 1, United State Constitution

All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; **nor shall any State deprive any person of life, liberty, or property, without due process of law**; nor deny to any person within its jurisdiction the equal protection of the laws.

SOURCE: U.S. Constitution.

In *Complete Auto Transit, Inc. v. Brady, 1977*, the U.S. Supreme Court set out the following four-part test of a state's taxation of interstate commerce:

- the business must have physical presence in the taxing state;
- the tax must not discriminate against interstate commerce;
- the tax must be fairly apportioned; and
- the tax must be related to services provided by the state.

In *Quill Corp. v. North Dakota, 1992*, the U.S. Supreme Court re-affirmed that a business must have a physical presence in a state for that state to require that the business collect use tax. In doing so, the court continued the nexus requirement set out in *Bellas Hess* and *Complete Auto* as it applied to the Commerce Clause. The Court, however, explicitly separated the Commerce Clause and Due Process arguments, ruling that North Dakota had not violated the Due Process Clause. This is an important distinction for the prospect of state taxation of interstate catalog and internet sales because Congress does not have the authority to suspend the Due Process Clause. In contrast, Congress has the authority to regulate interstate commerce; therefore Congress has the power to enact legislation granting states the authority to tax remote sales.

Recent shifts in the retail Internet marketplace created a new variation of the nexus issue. Initially, many retail Internet marketers were "pure play" firms; that is, the firms operated only as remote sellers, had no traditional "brick-and-mortar" retail outlets, and were not affiliated with any brick–and-mortar retailer. Now much of retail internet commerce is conducted by firms often referred to as "click-and-mortar" or "brick-and-click" firms, Internet vendors that are to some extent affiliated with traditional retailers. For tax purposes,

many of the click-and-mortar firms claimed "entity isolation", that is, they maintained that they were entirely distinct entities, not affiliated their brick–and-mortar namesakes. Recently many of the click-and-mortar firms have agreed to collect state and local sales taxes prospectively. Some of these agreements may be related to amnesty programs of the Streamlined Sales Tax Project (SSTP) and the Multi-State Tax Compact. In Texas, many of the largest click and mortar sellers are collecting sales tax on Internet sales. The issue of whether the click-and-mortar businesses are sufficiently affiliated with their brick-and-mortar stores to create nexus has not been resolved in federal court.

STREAMLINED SALES TAX PROJECT

In response to losses and potential losses of sales and use tax revenue to remote sales, the states initiated the Streamlined Sales Tax Project (SSTP) in 2000. The purpose of the SSTP was to simplify state and local sales tax collections and provide uniformity in the application of sales tax statutes and rules. By simplifying the sales tax the SSTP hoped to address some of the legal concerns about the burden on interstate commerce set out in *Bellas* and reiterated in *Quill*. The goal was to establish a framework for the collections of sales tax on interstate mail order and Internet sales. The SSTP produced the Streamlined Sales and Use Tax Agreement. The agreement provided major elements of sales tax simplification including:

- state level administration of sales and use taxes;
- limitation of state and local governments to one tax rate except on food, vehicles and utilities;
- common state and local tax bases within each state;
- online sales and use tax registration system;
- guidelines for rate or base changes;
- uniform sourcing rules; and
- uniform product definitions.

Under the key provisions of the agreement, participating remote vendors make voluntary payments of state and local sales tax on interstate sales on behalf of Streamlined Sales and Use Tax Agreement (SSUTA) member states. These payments will be voluntary unless and until Congress enacts legislation ratifying the SSUTA.

More than 40 states participated in the SSTP at one time or another, but as of July 2006, the SSUTA had only 13 full-member states. The full-member states are states that comply with the agreement. These 13 states had a 2000 population of 55.5 million, just less than 20 percent of the population of states imposing sales tax. The agreement was to take effect when at least 10 states with 20 percent of the population of states imposing a sales tax became members of the agreement. The population of the full-member states would not have been sufficient for the agreement to have taken effect, so the SSTP created a second category, associate-members. In these states, laws and rules that would bring a state into compliance are scheduled to take effect on or before January 1, 2008, or the state is in substantial compliance with the agreement and the SSTP expects that the state will achieve compliance by January 1, 2008. There are seven-associate member states with a combined 2000 population of 25 million. Together the full-member and associate member states, as shown in **Figure 3**, had a 2000 population of 80 million, 29 percent of the 2000 population sales taxing states.

Each member state has one vote regardless of population or sales tax receipts; however, half the dues are assessed equally and half divided according to sales tax collections.

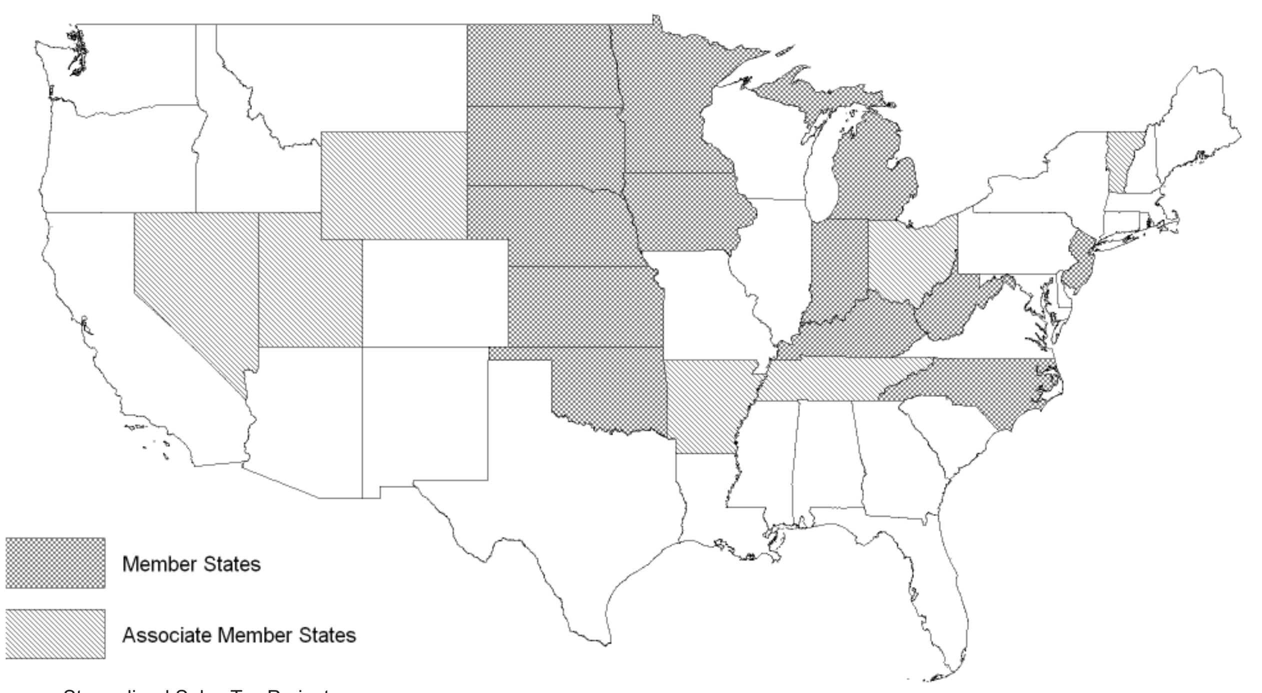
The SSUTA took effect in October 2005. More than 700 vendors have agreed to voluntarily collect sales tax on remote sales. Vendors electing to make voluntary payments can pay one of three ways:

1. The vendor may pay through a certified service provider (CSP). The CSP collection fee is 8 percent for the first $250,000 per voluntary vendor gradually decreasing to 2 percent, although temporary, lower rates have been allowed for North Dakota. CSP assessment and allocation of local taxes is currently on a zip code basis. (This scheme would present a problem if Texas were to become a SSUTA member because many local taxing entity boundaries in the state split zip codes.) As of July 2006, two CSP had been certified by the Streamlined Sales Tax Governing Board.
2. Vendors may also elect to pay by using software from a certified automated system or CAS. One had been approved as of July 2006.
3. Large, multi-state vendors may pay taxes directly using proprietary systems.

TEXAS' PARTICIPATION IN THE STREAMLINED SALES AND USE TAX AGREEMENT

In 2001, the Texas Legislature enacted legislation authorizing the state to participate in the Streamlined Sales Tax Project (SSTP) and designating the Comptroller of Public Accounts

FIGURE 3
STREAMLINED SALES AND USE TAX MEMBER STATES, DECEMBER 2006



SOURCE: Streamlined Sales Tax Project.

(CPA) as the state's representative to the SSTP. The Seventy-eighth Legislature, Regular Session, 2003, passed legislation that authorized the Comptroller to enter the state into the Streamlined Sales and Use Tax Agreement (SSUTA) if the Governor, Lt. Governor, and Speaker of the Texas House agreed. This legislation made some substantive changes to the Texas Tax Code and authorized the Comptroller to adopt rules to comply with the SSUTA requirements. The changes necessary for the state to comply with the SSUTA have not been fully implemented, and Texas is not currently a member on the SSUTA.

SOURCING RULES FOR LOCAL SALES TAXES

The primary reason why Texas is not a member of the Streamlined Sales and Use Tax Agreement (SSUTA) is that the state does not comply with the agreement's sourcing rules for local-use taxes. The SSUTA requires destination-based sourcing. For example, under destination-based sourcing, a customer purchasing a computer from Dell Computers in Round Rock and having it shipped to Amarillo would pay the Amarillo tax, and Amarillo would receive the tax revenue.

In Texas, city sales taxes, county sales taxes, and special district sales taxes are sourced to the location of the seller. Under Texas law, a buyer purchasing a computer over the Internet from a Round Rock firm and having it shipped to Amarillo pays the Round Rock sales tax, and Round Rock receives the city sales tax paid on that purchase.

In Texas, transit district sales taxes are sourced differently. Transit sales taxes are collected if the goods or services are received at the seller's place of business inside the transit area or are shipped from a business in the transit authority to a location inside that transit area.

Under some circumstances in Texas, a vendor is required to collect use tax on items shipped out of the local taxing jurisdiction or jurisdictions in which the vendor is located to another taxing jurisdiction in the state. While there are numerous exceptions, as a general rule, a vendor collects a use tax on a shipment if the vendor is doing business in the destination taxing jurisdiction, has not collected a sales tax on the transaction for the same type of taxing unit, and collecting the use tax would not make the combined local taxes greater than 2 percent.

The change to destination-based sourcing would probably result in an overall loss of revenue to local taxing units as taxes would be redistributed from urban areas that have higher tax rates to suburban and rural areas with lower tax rates. More critically, the CPA estimated that $160 million in

local tax revenue would be shifted among taxing jurisdictions under a destination-based sourcing scheme. The SSUTA sourcing rules would adversely affect certain cities in Texas that currently receive a disproportionate amount of their local sales tax on intrastate sales. Round Rock is the city with the greatest potential loss with an estimated loss of $24 million annually.

Texas is not the only state contending with the issue of destination-based sourcing. In the state of Washington, a local mitigation bill was introduced in the last legislative session, key provisions of that bill are outlined in **Figure 4**.

FIGURE 4
STATE OF WASHINGTON MITIGATION BILL

The Washington state legislature considered a bill to mitigate the local revenue losses from SSUTA in Washington. The bill would have:

- established a Streamlined Sales and Use Tax Mitigation Account;
- transferred general revenue to the account in amounts necessary to mitigate local government losses due to SSUTA sourcing requirements; and
- distributed revenue to local taxing entities to offset net revenue losses from the SSUTA sourcing rules.

The Washington legislature did not enact the bill.

SOURCE: State of Washington, Department of Revenue.

In addition to the fiscal problems created in certain taxing jurisdictions, the change to a destination-based sourcing scheme would cause additional administrative complexity for Texas vendors having to collect taxes on behalf of more than 1,400 taxing jurisdictions in the state.

At the April 2006 SSTP meeting, Utah proposed an amendment to SSUTA that would have allowed states to source intrastate sales in accordance with existing state law. This amendment would have allowed Texas to continue to source local sales tax on intrastate sales on an origins basis. The Utah amendment and a similar amendment proposed by Ohio were not adopted.

IMPACT OF DEFINITIONS, RULES, AND ENFORCEMENT

While each state may decide to tax or exempt a particular category of items, the Streamlined Sales and Use Tax Agreement (SSUTA) imposes uniform definitions of the categories. The changes in definitions would affect intrastate sales as well as remote sales. The power to include or exclude a particular item in or from a category is, in some cases, tantamount to the ability to require that an item be exempt or taxed. For example, as the Texas Comptroller of Public Accounts (CPA) interprets the SSUTA definition of candy, it is narrower than the Texas definition, in that, the SSUTA definition of candy excludes any preparation containing flour. A Hershey bar would be taxable under the SSUTA definition, a Twix bar would not. If Texas wanted to continue to tax Twix bars, the state would have to tax food. Ice is taxable under Texas statute, but would be exempt under SSUTA definitions. The CPA estimates that SSUTA definitions would cost Texas $5 to $10 million per year on intrastate sales.

The treatment of software in the SSUTA differs from the state's current tax policy. Currently, software sold in the state is taxable unless the software is shipped out of state. Under the Streamlined Sales Tax Project (SSTP) guidelines the use of the software would be taxed and the taxes would be apportioned among the states in which the software is to be used. The CPA estimates that Texas would lose about $50 million annually from the SSUTA treatment of software.

Other SSUTA provisions that could cost Texas revenue are the SSUTA small business exemption and the "relaxed good faith rule" which is less strict than current state enforcement standard. The CPA has not provided an estimate of the fiscal impact of these provisions.

Since Texas does not comply with the SSUTA, the SSTP is prohibited by confidentiality agreements from providing the state with a list of vendors voluntarily paying taxes through the SSUTA. As a result, it cannot be determined how many of the vendors participating in the SSUTA either have nexus in Texas or are already remitting sales taxes to Texas on a voluntary basis.

STATUS OF FEDERAL LEGISLATION

In 2005, two bills introduced in the 109th U.S. Congress would have ratified the Streamlined Sales and Use Tax Agreement (SSUTA) by providing congressional consent to the agreement. The bills would have authorized states to require vendors not qualifying for a small business exemption to collect sales tax on remote sales sourced to SSUTA member states. Since the bills would have granted authority only to SSUTA member states, Texas would not have gained the authority to require vendors to collect Texas state and local taxes, however, Texas merchants would have been required to collect state and local tax on behalf of member states. Both bills were referred to the Senate Committee on Finance. The bills were discussed in a hearing in July 2006 in the

Subcommittee on International Trade. No further action was taken on either bill.

ESTIMATES OF THE LOSS OF STATE AND LOCAL SALES TAXES ON REMOTE SALES

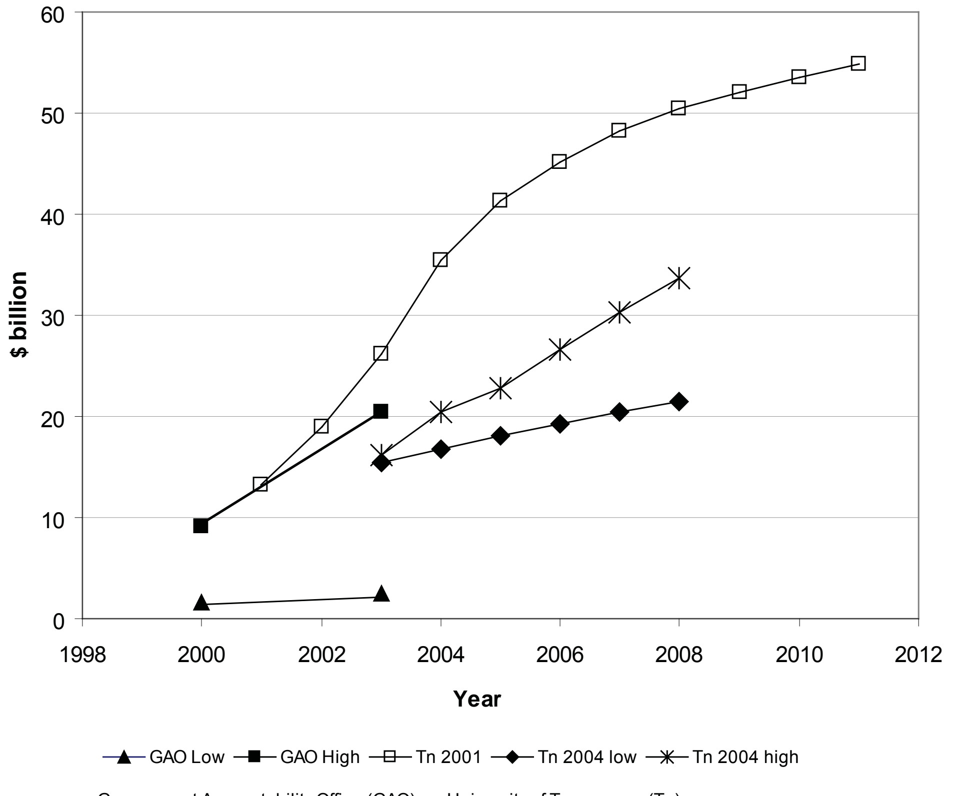
Estimates of how much e-commerce is taxable, how much tax is actually paid on e-commerce, and the amount state and local sales tax not collected on e-commerce vary significantly. The Government Accountability Office (GAO) (2000) and the University of Tennessee (2001 and 2004) produced estimates of the nationwide losses from uncollected state and local taxes on remote sales. **Figure 5** compares estimates for state and local losses of sales tax for all states on remote sales.

Neither of these sources attempted to estimate state and local government gains from voluntary collections under the SSUTA. The studies were based on existing state exemptions, definitions, and enforcement policies, thus they do not reflect revenue gains or losses from changes in state policies required under SSUTA guidelines.

Figure 6 shows a comparison of the estimates of Texas state and local sales tax losses on remote sales. The GAO study produced estimates of Texas state and local tax losses for 2003 ranging from $655 million to $2.4 billion. The 2001 Tennessee study projected Texas losses to grow from an estimated $1.2 billion in 2001 to $4.8 billion by 2011. The 2004 Tennessee revision estimated Texas state and local losses at between $1.4 billion and $1.5 billion in 2003, with approximately $1.2 billion being state revenue. The 2004 Tennessee estimate projects Texas state and local losses to reach between $2.0 billion and $3.1 billion by 2008.

In testimony before the Texas Senate Finance Committee in March 2006, representatives of the Texas Comptroller of Public Accounts (CPA) estimated that Texas loses $400 million annually in state taxes on internet and other remote sales. In subsequent discussions with staff, the CPA's office emphasized that a revenue gain of $400 million cannot be

FIGURE 5
ESTIMATES OF STATE AND LOCAL SALES TAX LOSS TO REMOTE SALES, ALL STATES, 1998 TO 2012



SOURCE: Legislative Budget Board.

FIGURE 6
ESTIMATES OF TEXAS STATE AND LOCAL SALES TAX LOSSES ON REMOTE SALES, $ BILLION

	2000	2001	-	2003	-	2006	-	2008	-	-	2011
GAO 2000			-		-		-		-	-	
Low	$0.252		-	$0.655	-		-		-	-	
High	$0.992		-	$2.466	-		-		-	-	
Tennessee 2001		$1.162	-		-	$3.957	-		-	-	$4.806
Tennessee 2004			-		-		-		-	-	
Low			-	$1.419	-		-	$1.970	-	-	
High			-	$1.479	-		-	$3.080	-	-	

SOURCE: Legislative Budget Board.

achieved by merely complying with SSUTA provisions and receiving voluntary collections through the SSUTA. Significant revenue gains would be realized only if Congress grants the states the right to require vendors to collection use taxes on remote sales. Since the March 2006 Senate Finance Committee meeting, the CPA revised the estimate of state revenue losses on remote sales in 2005 to $498 million, approximately 3 percent of Texas state sales tax collected in that fiscal year.

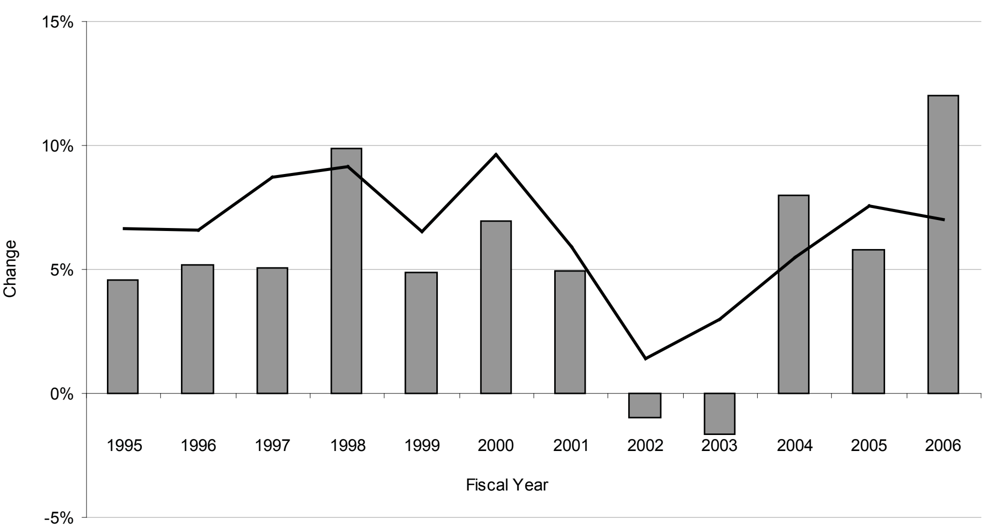
The CPA estimate and the most recent Tennessee estimates are so different because each used different assumptions about business-to-business transactions. The Tennessee estimates attribute 82 percent of 2003 revenue losses to business-to-business sales while the CPA's office estimates focus on business-to-consumer sales. The Tennessee estimates assume that 72 percent of the taxes due on taxable business-to-business sales are collected.

The CPA's estimates mail order and internet sales separately. Their estimate of catalog sales is based on data from the *Statistical Abstract of the United States*. Their estimate of internet sales is based on Census Bureau e-commerce data on retail sales, most of which are direct sales to consumers. Thus, the CPA's estimate of sales tax losses consists primarily of business-to-consumer sales and attributes little revenue loss to business-to-business sales. The CPA's reasoning is that the business-to-business sales are subject to audit because the state can audit the purchasing firm. The CPA's estimates assume that the state's power to audit the purchasing firms results in a high level of compliance.

CPA staff sees little evidence of the level of sales tax losses predicted in the most recent Tennessee study. As demonstrated in **Figure 7**, Texas sales tax receipts declined in fiscal years 2002 and 2003. This decline corresponded to a national recession; therefore it is difficult to determine if any of the decline was related to Internet expansion. Growth rates for fiscal years 2004 and 2005 returned to historical levels, and collections in fiscal year 2006 increased by 12 percent from fiscal year 2005. The sales tax growth of 2005 and 2006 would tend to support the position that losses to remote sales are not accelerating significantly.

The potential for revenue gains to the state from voluntary participation by vendors in the SSUTA are uncertain and the CPA has not estimated these gains. The CPA identified approximately $50 to $60 million in annual state revenue losses that would occur if the statutory changes necessary for Texas become a SSUTA member were enacted. Without federal action authorizing states to require vendors to collect taxes on remote sales, these revenue losses could be greater than gains from SSUTA voluntary payments.

FIGURE 7
PERCENTAGE CHANGE IN TEXAS SALES TAX COLLECTIONS AND TEXAS PERSONAL INCOME
FISCAL YEARS 1995 TO 2006



NOTES: Texas sales tax collection (bars); Texas personal income (line).
SOURCE: Comptroller of Public Accounts.

STRENGTHEN SALES TAX ENFORCEMENT RELATED TO CUSTOMS BROKERS

The U. S. Constitution prohibits states from taxing exports to foreign countries. Texas provides five methods for purchasers to receive an exemption from or refund of sales taxes paid on exported property. One of those methods, documentation by a customs broker, allows a purchaser to receive a refund while taking possession of the property in this country.

In a 2003 *e–Texas* report, the Comptroller of Public Accounts documented widespread abuse of the customs broker system and recommended repealing the customs broker provision. Rather than repeal the provision, the Texas Legislature passed legislation in 2003, which restructured the customs broker system to address some of the weaknesses in the old system. Key to the restructuring was the creation of an online system for issuing export certificates. At the same time, the 2003 legislation established a method for customs brokers to certify export without having to witness the property cross the border, thereby legalizing the most common abusive transaction under the old system.

While the new online system dealt with some of the abusive practices, the customs broker statute and related rules could be clarified to further safeguard against abuse, and the online system could be modified to reduce errors. These changes could improve administrative efficiency and provide additional state revenue through fines, export stamp sales, and the reduction of sales tax refunds.

CONCERNS

- ♦ Under Texas Tax Code, Section 151.1575 (c), the Comptroller of Public Accounts cannot fine a customs broker when the broker fails to follow statutorily required procedure. The Comptroller of Public Accounts can fine the broker only after the purchaser claims a sales tax refund, and the refund is paid. The actual refund usually occurs at a different time and place from the certification of export by the broker, making linking the refund with broker violation cumbersome and resulting in the loss of state revenue.
- ♦ Comptroller administrative rules allow a broker to issue one export certificate covering multiple receipts as long as the receipts are from the same store and the property is exported at the same place and time. This practice increases the likelihood refunds are paid on goods that are not actually exported, resulting in a loss of state and local sales tax revenue.
- ♦ Statute requires the Comptroller of Public Accounts to provide a method to prepare certificates of export when the online broker certificate system is not available. Comptroller administrative rules allow brokers to issue hardcopy certificates of export when the online computer system is down. This accommodation reintroduces opportunities for abuse and the potential for the loss of sales tax revenue.
- ♦ Under Texas Tax Code, prior to issuing a certificate of export, a customs broker must require the purchaser to produce the property that is to be exported and the receipt for that property. While the broker must affirm a general statement on the export certificate that he complied with the law, there is no specific or explicit verification that the broker has seen or inspected the property to be exported or the receipt for that property.
- ♦ The password or personal identification number issued by the Comptroller of Public Accounts to a broker or authorized employee to access the online system is not associated with any particular computer or broker location, opening up the system to possible abuse and the loss of sales tax revenue. In addition, the online customs brokers system requires a significant amount of data entry by the broker. Spelling and typographical errors limit the usefulness of the data reported to the Comptroller of Public Accounts.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Tax Code, Section 151.1575 (c) to allow the Comptroller of Public Accounts to impose a fine on a customs broker license if the customs broker or customs broker employee issues a certificate of export without following statutorily mandated procedures or administrative rules.
- ♦ **Recommendation 2:** Amend Texas Tax Code, Section 151.157(a-1), to prohibit the issuance of one certificate of export for multiple receipts.

- ♦ **Recommendation 3:** Amend Texas Tax Code, Section 151.1575, to prohibit the issuance of certificates of export other than those produced on the online system.
- ♦ **Recommendation 4:** Amend Texas Tax Code, Section 151.1575 (b), to require an entry on the certificate of export where the customs broker explicitly confirms that he has seen the property that is to be exported and a receipt for that property.
- ♦ **Recommendation 5:** The Comptroller of Public Accounts should investigate ways of limiting access to the online customs broker system to computers at approved broker locations. In addition, the Comptroller of Public Accounts should consider installing drop-down menus and internal data entry checks in the on-line system to minimize the number of data entry errors.

DISCUSSION

Article I, Section 9, of the U. S. Constitution prohibits states from imposing taxes on goods exported to a foreign country. As a result, Texas is required to grant refunds of state and local sales taxes collected on property exported from the country. Texas accepts the following five documents as proof of export:

1. A bill of lading issued by a licensed and certificated carrier of persons or property showing the seller as consignor, the buyer as consignee, and a delivery point outside the territorial limits of the United States;
2. documentation from a customs broker;
3. import documents from the country of destination;
4. an original airway, ocean, or railroad bill of lading and a forwarder's receipt if an air, ocean, or rail freight forwarder takes possession of the property; or
5. a maquiladora export certificate.

Under Texas' customs broker option, a buyer can receive a sales tax refund while taking possession of the property prior to export. The Texas provision is more extensive than the U.S. Constitutional requirement, and Texas is the only state bordering Mexico that allows a purchaser to receive an export refund when taking possession of the property in this country.

Customs brokers are licensed and regulated by both the State of Texas and the United States government. **Figure 1** shows an outline the requirements for becoming a customs broker.

FIGURE 1
CUSTOMS BROKER REQUIREMENTS

TEXAS REQUIREMENTS

In order to obtain a Texas customs broker's license a person must:

- be a U. S. customs broker licensed and regulated by U.S. Customs and Border Protection to assist importers and exporters in meeting federal requirements governing imports and exports;
- apply to the Comptroller of Public Accounts for a license;
- pay a license fee; and
- post a bond or security.

U.S. REQUIREMENTS

In order to become a U.S. customs broker an individual must:

- be a United States citizen at least 21 years old;
- not be a federal government employee;
- pass the customs broker license examination;
- submit a broker license application with appropriate fees; and
- undergo a background investigation that includes a fingerprint analysis and a review of character references, credit reports, and any arrest record. (Arrests or convictions do not necessarily preclude the issuance of a license.)

SOURCES: Comptroller of Public Accounts; U.S. Customs and Border Protection.

In 2003, the Comptroller of Public Accounts (CPA) published an *e-Texas* review that documented widespread fraud and abuse in the customs broker system. The CPA reported the following types of abuse:

- brokers certifying the export of goods without witnessing the goods leaving the country as required by CPA rule;
- brokers providing blank export certificates with stamps;
- brokers not verifying that goods existed;
- brokers selling stamps;
- brokers colluding with store employees to create fraudulent refunds;
- businesses in Mexico purchasing sales receipts from people who travel in Texas;
- receipts from store dumpsters or parking lots used to obtain refunds; and
- brokers accepting obviously fake identification cards.

The CPA recommended repealing the customs broker provision. The CPA estimated that refunds of state taxes and local taxes related to the export exemption totaled $69 million annually and that repealing the customs broker provision would result in gains of $24 million to the state

and $6 million to units of local government in fiscal year 2004.

The Seventy-eighth Legislature, Regular Session, 2003, did not repeal the customs broker provision. Instead, it enacted legislation which restructured the customs broker system. Key elements of this legislation include:

- establishing a procedure for customs brokers to certify export without having to witness the export of the property for which the certificate was issued;
- establishing of an online system for issuance of certificates of export;
- imposing a $300 broker fee for each broker location;
- imposing a $1.60 fee for each export stamp issued;
- setting new bond requirements for brokers, and
- establishing new reporting requirements for brokers.

Under the new Section 151.1575, Texas Tax Code, a customs broker or authorized employee can issue a certificate of export if the broker or authorized employee sees the property cross the border or sees the property being placed on a common carrier for delivery outside the country. In addition, the new law allows brokers to certify that the purchaser is transporting the property to a destination outside the country by doing the following:

1. examining the purchaser's;
   a. foreign identification;
   b. the property to be exported; and
   c. the receipt for the property:
2. requiring the purchaser:
   a. to state the foreign country destination of the property which must be the foreign country in which the purchaser resides;
   b. to state the date and time the property is expected to arrive in the foreign country destination;
   c. to state the date and time the property was purchased, the name and address of the place at which the property was purchased, the sales price and quantity of the property, and a description of the property;
   d. to produce the purchaser's:
      i. Form I-94, Arrival/Departure record, or its successor, as issued by the United States Immigration and Naturalization Service, for those purchasers in a county not bordering Mexico; or
      ii. air, land, or water travel documentation if the customs broker is located in a county not bordering Mexico.

The new option puts the purchaser on the honor system. If the purchaser has the proper identification and documentation, the broker accepts as verification of export the purchaser's statement that he expects to export the property. Under statutes and rules that were in place before 2004, brokers could issue export certificates only if the broker or the broker's representative witnessed export of the goods for which a certificate was issued. Allowing brokers to issue a certificate of export without witnessing export of an item, in effect, legalized the most common abusive transaction under the old system. However, customs brokers were largely ignoring the requirement to witness export under the old law, in part, because United States Customs and Border Protection would not allow them to work on the international bridges.

The implementation of fees for stamps, additional bonding requirements, the new license fee, and the establishment of the online system established under the 2003 legislation may have reduced opportunities for fraud and abuse. Brokers and their employees now use the internet-based, online system to create and issue certificates. The CPA issues each broker and authorized employee a password, and the broker or employee creates a personal identification number (pin). Only a broker or authorized employee with a pin can legally issue an export certificate, and the broker or authorized employee can legally issue the certification only from one of the licensed broker's locations. In practice, anyone who knows an active pin could issue a certificate from any location with internet access, as the pin is not linked or restricted to any particular computer or internet address.

The broker or employee enters the following items:

- the broker identification number;
- personal identification number (pin);
- outlet number;
- stamp number and expiration date;
- purchaser name and address;
- seller name and address;
- date and time of sale;
- description and price of merchandise;
- export destination;
- date and time of export; and
- total tax.

The broker prints the certificate, as shown in **Figure 2**, and affixes an export stamp. After waiting 24 hours in counties near the border or seven days in other counties, the purchaser presents the stamped certificate to the seller to receive a refund. Alternatively, the purchaser may assign the refund to the broker. The broker pays the purchaser, and the purchaser avoids the waiting period. After observing the waiting period,

FIGURE 2
SAMPLE BROKER EXPORT CERTIFICATE

Comptroller of Public Accounts FORM 00-363 (Rev. 9-03/2)

STATE OF TEXAS

LICENSED CUSTOMS BROKER EXPORT CERTIFICATION

• Please type or print all information.

Certification Identification Number: 5009999999999

Stamp number: 999999 | Expiration Date: 12/31/2003

Customs Broker name: JOHN SMITH

Texas Customs Broker license number (same as Taxpayer Number): 31234567891

Customs Broker location address (Street and number, do not use P.O. Box): 101 MAIN STREET

Outlet Number: 12

City, state, ZIP Code: AUSTIN, TEXAS 78749

Purchaser name: PABLO CRUZ

Purchaser home address (Street and number): 11111 CALLE DE MI CASA

City, state/province, ZIP code/postal code, country: GUADALAJARA, MEXICO, JALISCO 44100

Seller name: GUADALAJARA FURNITURE

Date and time of sale: 11/15/2003 11:30 AM

Seller location address (Street and number, do not use P.O. Box): 415 INTERNATIONAL

City, state, ZIP Code: WESLACO, TEXAS 78599

DESCRIPTION OF MERCHANDISE EXPORTED:

INVOICE NUMBER	QUANTITY	DESCRIPTION	SALES PRICE
999WPR11111	1	REFRIGERATOR	$ 995.87
999WPR11112	1	WASHING MACHINE	$ 326.54
999WPR11113	2	GREEN CHAIRS	$ 549.22
999WPR11144	1	MAPLE COFEE TABLE	$ 189.54

TOTAL SALES PRICE: $ 2,061.17

Foreign Country Destination: MEXICO

TOTAL TAX: $ 170.05

Export location: PROGRESO BRIDGE

Date and time of export (or when property is expected to arrive in the foreign country): 11/16/2003 11:45 AM

I, the purchaser, have provided the following information and documentation required by law: passport, laser visa identification card, or foreign voter registration picture identific
residency; produced the property and the original receipt for the property; the name and address of the place at which the property was purchased; the sales price and quantity
the property; tax paid on the property; date and time the property was purchased, the foreign country destination of the property (must be the foreign country in which the purch
the export will occur; and date and time the property is expected to arrive in the foreign country.

I understand that tangible personal property not exported is subject to taxation under this chapter and the purchaser is liable, in addition to other possible civil liabilities and crin
an amount equal to the value of the merchandise if the purchaser improperly obtained a refund of taxes. I further understand that tangible personal property that has previously
in Texas prior to export is also subject to taxation, and the purchaser is liable in the same manner as above.

I understand that providing false information to a Customs Broker is a Class B misdemeanor.

Purchaser sign here | Date

AFFIX CURRENT EXPORT CERTIFICATION STAMP HERE

INVALID WITHOUT

I declare that I am a licensed United States Customs Broker or an authorized ager
I acknowledge that I have complied with all state laws and Comptroller rules regar
an export certification.

sign here ▸ Customs Broker or authorized agent: JOHN SMITH | Date: 11/15/2003

Print Name of Customs Broker or authorized agent

YOU HAVE CERTAIN RIGHTS UNDER CH. 559, GOVERNMENT CODE, TO REQUES
INFORMATION WE HAVE ON FILE ABOUT YOU. CONTACT US AT THE ADDRES

SOURCE: Comptroller of Public Accounts.

the broker then takes the stamped certificate to the seller and receives the refund.

AFFECT OF THE ONLINE SYSTEM ON TEXAS

In 2003, there were 230 active customs brokers operating in 800 locations. Brokers issued 2.8 million stamps in 2001. While the refund value associated with the export stamps was not reported prior to January 1, 2004, in the *e-Texas* report on customs brokers, the Comptroller of Public Accounts estimated that the state and local revenue loss from the export exemption totaled $69 million.

Under the new online system, as of 2006, the number of brokers declined to 42, and the number of broker locations decreased to 161. The 42 customs brokers had about 600 employees authorized to issue certificates of export. As shown in **Figure 3**, since the online system took effect, the number of stamps issued declined from pre-2003 levels to 1.2 million in fiscal year 2006; however, the dollar amount of customs broker refunds exceeded earlier CPA estimates of the cost of the entire export exemption. In fiscal year 2006, the statewide value of refunds reported by customs brokers totaled $92.3 million. The cost of customs broker refunds is increasing rapidly, growing by 16.7 percent in fiscal year 2006.

Either the CPA under-estimated the average value of refunds per export certificate issued under the pre-2003 statute, or the 2003 legislative changes have not significantly reduced the dollar value of refunds. The CPA estimate of $69 million in export refunds in 2004, assuming 2.8 million stamps, implies a refund of about $25 per certificate. Refunds in fiscal year 2006 averaged $76 per certificate, with an average taxable value of $920 per certificate. At $76 per certificate, 2.8 million certificates would cost state and local governments over $200 million. The $1.60 per stamp fee and the ability to report multiple receipts on a single certificate may have caused the consolidation of a larger dollar amount of refunds on fewer certificates.

FIGURE 3
CUSTOMS BROKERS NUMBER STAMPS ISSUED AND REFUNDS REPORTED

FISCAL YEAR	STAMPS ISSUED UNDER HOUSE BILL 109	REFUNDS ($ MILLION)
2004 part	672,630	$ 44.2
2005	1,126,005	$ 79.1
2006	1,212,572	$ 92.3

SOURCE: Comptroller of Public Accounts.

The cities along the Rio Grande river account for about half of the state total of refunds related to customs broker certificates of export. In the cities shown in **Figure 4**, the ratio of customs broker refunds to taxable sales is significant.

While sales related to customs broker refunds are not included in taxable receipts and not all customs broker refunds are from retail sales, the ratio of customs broker refunds to taxable retail sales might provide some insight into the importance of the refunds and export sales. If the provisions of the 2003 legislation had reduced the amount of refunds by a substantial amount, the percentage of sales that were taxable might have increased noticeably in cities with significant customs broker refunds. **Figure 5** shows taxable aggregate retail sales as a percentage of gross retail sales in seven border cities—Brownsville, Del Rio, Eagle Pass, El Paso, Harlingen, Laredo, and McAllen. During the three calendar years prior to the enactment of the 2003 legislation, taxable retail sales were between 48.9 percent and 49.6 percent of gross retail sales.

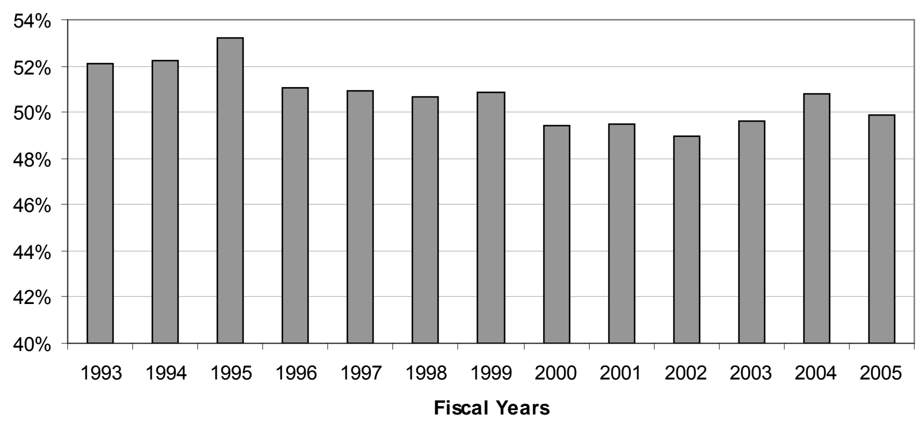
In 2004, the percentage increased by over 1 percent to 50.8 percent. The increase was short-lived. In 2005, the percentage

FIGURE 4
COMPARISON OF BROKER REFUNDS TO TAXABLE RETAIL SALES BY CITY, 2005

CITY/CITIES	VALUE OF PURCHASES SUBJECT TO CUSTOMS BROKER REFUNDS ($ MILLION)	TAXABLE RETAIL SALES ($ MILLION)	VALUE OF PURCHASES SUBJECT TO CUSTOMS BROKER REFUNDS AS A PERCENTAGE OF TAXABLE RETAIL SALES
Brownsville	$70.2	$936.9	7.5%
Del Rio	$4.1	$204.8	2.0%
Eagle Pass	$16.3	$232.5	7.0%
El Paso	$139.7	$3,422.5	4.1%
Cities of Hidalgo County	$302.4	$3,266.1	9.3%
Laredo	$388.5	$1,407.1	27.6%

SOURCE: Comptroller of Public Accounts.

FIGURE 5
TAXABLE RETAIL SALES AS A PERCENTAGE OF GROSS RETAIL SALES, FISCAL YEARS 1993 TO 2005 (BROWNSVILLE, DEL RIO, EAGLE PASS, EL PASO, HARLINGEN, LAREDO, AND MCALLEN)



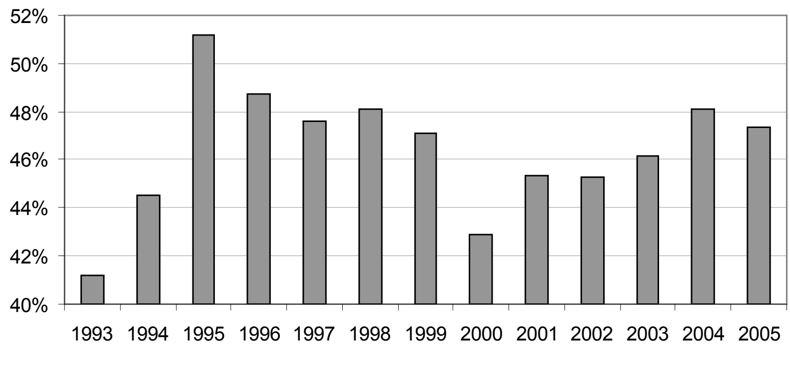
SOURCE: Comptroller of Public Accounts.

of taxable sales dropped back below 50 percent. In three of the seven cities—Del Rio, El Paso, and Harlingen—the ratio of taxable to gross retail sales was less in 2005 than in 2003. In the other four cities, the ratio increased. In Laredo, where the value of purchases for which brokers issued export certificates equaled 27.6 percent of taxable retail sales in 2005, the change in the ratio of taxable to gross sale was greater. As shown in **Figure 6**, in Laredo the percentage of retail sales that were taxable increased by almost 2 percentage points in 2004. The percentage declined to 47.4 percent in 2005, still 1.2 percentage points greater than 2003 levels. The changes in the ratio of taxable retail sales to gross retail sales provide some evidence that the new system has marginally reduced the revenue loss from the export exemption, but these savings are not close to the 2003 CPA estimate of the revenue gain from repealing the customs broker exemption.

PENALTIES FOR BROKER VIOLATIONS

Under Texas Tax Code, Section 151.1575 (c), the CPA may impose penalties for broker violations. If a broker does not comply with the statutory requirements the CPA may require the broker to pay the amount of the tax refunded and a penalty equal to the amount refunded, but not less than $500 or more than $5,000. According to the current interpretation of the penalty provision, if a CPA enforcement officer witnesses a customs broker issue an export certificate without following the statutorily required procedure the CPA cannot impose a fine or penalty. The CPA can impose a fine only after the purchaser receives the associated sales tax

FIGURE 6
TAXABLE RETAIL SALES AS A PERCENTAGE OF GROSS RETAIL SALES, LAREDO, FISCAL YEARS 1993 TO 2005



SOURCE: Comptroller of Public Accounts.

refund. The refund usually occurs at a different time and place from the certification of export, making connecting the actual refund with broker violation unnecessarily cumbersome.

The inability to cite a broker for a violation at the time a violation occurs is partly responsible for a decline in the number of cases in which the CPA imposed penalties. Between the time that the new system took effect and November 2006, the Comptroller of Public Accounts enforced 10 violations of the statute and imposed $5,619.93 in penalties. The number of CPA undercover or "sting" operations related to customs brokers also declined since the enactment of the new system. The CPA is enforcing violations at a rate of three violations per million certificates issued, and penalties are less than three-one-thousandths of 1 percent of the refunds issued. Given the widespread abuses in the system before the enactment of the new system, this is a surprisingly low rate of violations and penalties.

Recommendation 1 would simplify the penalty provision under Section 151.1575 (c), Texas Tax Code, by allowing the CPA to penalize a broker for a violation without having to associate the broker violation with the actual payment of a refund.

MULTIPLE RECEIPTS ON ONE CERTIFICATE

Texas Administrative Code, Title 34, Part 1, Chapter 3, Subchapter O, Rule 3.360, (Comptroller of Public Accounts, Sales Tax Rules) allows multiple invoices from a single seller to be listed on the same export certificate if the listed items are exported at the same place and at the same time. Prior to the enactment of the new system, the CPA had reported brokers not verifying the existence of goods for which they were issuing export certificates and issuing certificates based on receipts gathered from parking lots and dumpsters. Allowing the listing of multiple receipts on a single export certificate would seem to facilitate this abuse. Recommendation 2 would amend the Texas Tax Code to prohibit issuance of a single export certificate for multiple receipts to reduce the potential for abuse.

ISSUANCE OF CERTIFICATES OTHER THAN THROUGH THE ONLINE SYSTEM

Statute requires the Comptroller of Public Accounts to provide a method to prepare certificates of export when the online broker certificate system is not available. When the state's online customs broker website is unavailable due to technical or communications problems, the CPA allows brokers to issue hardcopy certificates of export. When the system is functioning again, the brokers must enter the export certification information on the website within 48 hours. This accommodation reintroduces hardcopy certificates into the system. Prior to 2004, the CPA reported brokers selling blank signed certificates and stamps. Recommendation 3 would amend the Texas Tax Code to prohibit the issuance of certificates of export when the online system is not available.

VERIFICATION OF THE PROPERTY FOR EXPORT

Under Texas Tax Code, Section 151.1575, prior to issuing a certificate of export, a customs broker must require the purchaser to produce the property that is to be exported and the receipt for that property. While brokers must affirm a general statement on the export certificate that they complied with the law, there is no specific or explicit verification that the brokers have seen or inspected the property to be exported or the receipt for that property. Failure of brokers to verify the existence of the export property was one of the significant problems occurring prior to the restructuring of the system. CPA enforcement officers indicate that failure of the brokers to verify the existence of property to be exported remains a problem in the current system. Recommendation 4 would amend Texas Tax Code, Section 151.1575 (b), to require that brokers affirm on the export certificate that they have seen the export property and the receipt for that property.

ISSUES WITH ONLINE SYSTEM ACCESS AND DATA ENTRY

A broker or authorized employee can legally issue a certificate of export only from one of the licensed broker's locations. In practice, anyone who knows an active pin can issue a certificate from any location with internet access, because the pin is not linked or restricted to any particular computer or internet address.

The online customs brokers system requires a significant amount of data entry by the broker. Spelling and typographical errors limit the usefulness of the data reported to the Comptroller of Public Accounts (CPA). For example, misspelling of city names makes it difficult for CPA staff to determine the sales tax loss to a particular city. The data requires a significant amount of correction of data entry errors when reports are prepared for local taxing jurisdictions. After CPA corrections, about 4 percent of customs broker refunds are not attributable to any city because of data entry errors. The agency should consider installing drop-down menus to eliminate this type of problem.

Another frequent data entry error involves a mismatch between the amount of refund and the value of the property for which the refund is authorized. The CPA should consider installing data checks to ensure the internal consistency of the brokers' data entry.

Recommendation 5 suggests that the CPA investigate limiting access to the online customs broker system to computers at approved broker locations and consider installing drop-down menus and data entry checks in the online system to address the data entry problems.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 could increase the amount of penalty revenue collected. Recommendation 2 could increase the amount of revenue from export stamp sales.

Recommendations 3 and 4 will reduce the opportunities for abuses of the system and could result in revenue gains by reducing the amount of sales tax refunds. The revenue gains from Recommendations 1 through 4 cannot be determined.

Recommendation 5 suggests that the CPA make certain modifications to the online customs broker system. The CPA should implement the modifications only if the CPA determines that they can be accomplished with existing resources and are cost effective, therefore the recommendation would have no significant cost.

The introduced 2008–09 General Appropriations Bill does not address any of the five recommendations.

POTENTIAL TEXAS MEDICAID PROGRAM REFORM OPTIONS

In 2006 Medicaid recipients in Texas totaled approximately 2.77 million. As a result of program changes, growth in the Texas Medicaid population, price of medical services and increased healthcare utilization, costs continue to rise each year. During the last decade annual Medicaid spending has accounted for 21 percent to 26 percent of the Texas state budget. In total, state spending on Medicaid totaled approximately $18.2 billion in All Funds in fiscal year 2006 or approximately 24 percent of the state budget.

Recent changes in federal law and a federally approved research and demonstration waiver in Florida provide new opportunities for Texas to investigate potential benefit and plan reforms aimed at containing the cost of Medicaid. While the Medicaid reform experience of other states is important to consider, most of the reforms have been rolled-out only recently. In addition, it will be necessary for Texas to develop a customized approach to Medicaid reform due to the size, complexity and distinctive aspects of the Medicaid program in the state. Although certain reforms may be pursued through a state plan amendment under new options included in the federal Deficit Reduction Act of 2005, the restrictions included in the law may limit Texas' ability to take advantage of these options. This review provides information on potential Medicaid benefit and plan reforms being implemented in other states under the new options provided by Deficit Reduction Act or via research and demonstration waivers.

FACTS AND FINDINGS

- ♦ The federal Deficit Reduction Act includes mandatory and optional reforms that could change the way states operate their Medicaid programs. Kentucky, West Virginia and Idaho have taken advantage of certain options to implement benefit and plan reforms through state plan amendments. The amendments were approved by the Centers for Medicare and Medicaid Services in May 2006. The Medicaid reforms Florida is now piloting were approved by Centers for Medicare and Medicaid Services under a research and demonstration waiver in October 2005. However, enrollment of Medicaid recipients began in September 2006. Therefore, it is too early for results to be available from these reform initiatives.
- ♦ The Deficit Reduction Act allows states to amend their Medicaid state plans to impose premiums and cost sharing on recipients as a condition for receiving certain medical services. However, due to exemptions for certain populations and services, the applicability of premiums in Texas is limited. Based on initial analysis, the Health and Human Service Commission estimates that fewer than 5,000 Medicaid recipients could be eligible to pay premiums with the majority of those eligible being non-mandatory children up to the age of one. However, increased cost sharing for non-preferred prescription drugs may be an area of opportunity for Texas to contain cost.
- ♦ The Deficit Reduction Act allows states to charge Medicaid recipients co-payments for non-emergent visits to hospital emergency rooms subject to certain conditions such as the availability of an alternative service network. In fiscal year 2004, 47 percent of all emergency room visits made by Medicaid recipients in selected programs were for non-emergent conditions.
- ♦ Texas has not formally evaluated the Medicaid benefit and plan reforms other states are implementing to contain costs. Reforms with potential application to Texas include the use of risk-adjusted premiums with capped benefits, tiered benefit plans, healthy behavior incentives, health opportunity accounts, Medicaid opt-out allowances, and premiums and cost sharing.

DISCUSSION

Medicaid is a federal-state funded entitlement program, created by Congress in 1965. The program provides basic healthcare for low-income citizens and people with chronic or long-term care needs. Medicaid is administered by the Health and Human Services Commission (HHSC) in Texas. Because Medicaid is an entitlement program, the state cannot limit the number of eligible people who can enroll or the mandatory benefits unless the state obtains a waiver from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program. Initially, Medicaid was intended to provide healthcare to low-income persons eligible for welfare. However, over the years Medicaid has been expanded to cover different populations with complex eligibility rules.

While Medicaid in Texas serves various client groups and covers many different medical and long-term care services, there are three general categories of persons eligible for Medicaid:

- Families and Children: Eligibility for this group is based on different income levels, depending on age or pregnancy. This group includes non-disabled children which make up 68 percent of the state's Medicaid recipients.
- Cash Assistance Recipients: Eligibility for this group is based on receipt of Temporary Assistance for Needy Families (TANF) benefits or Supplemental Security Income (SSI).
- Aged and Disabled: Eligibility for this group is based on income level, age, and physical or mental disabilities.

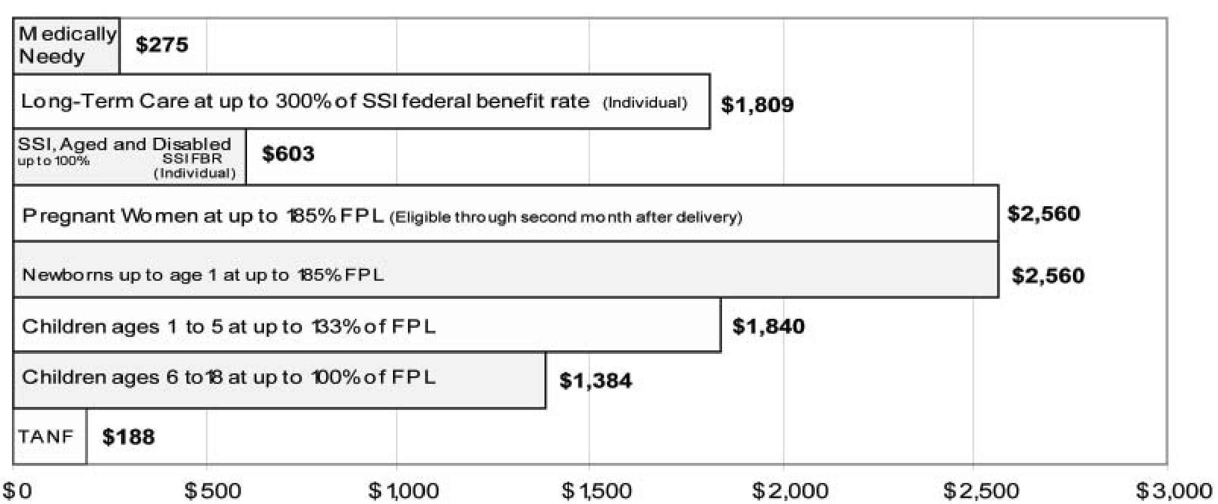
Figure 1 shows the maximum monthly countable income limits for a family of three to be eligible for Medicaid in Texas based on client group.

In 2006, Texas Medicaid recipients totaled 2.77 million. As a result of program expansions and growth in the Texas Medicaid population, costs have increased significantly. During the last decade Medicaid annual spending accounted for 21 to 26 percent of the Texas state budget. Combined federal and state spending on Texas Medicaid totaled approximately $18.2 billion in fiscal year 2006 compared to the late 1980s when total cost was less than $2 billion.

In 2006, Texas' federal matching rate for Medicaid was 60.66 percent, as a result, Texas matched 39.34 percent of most Medicaid costs. Generally, non-disabled children are the least expensive to serve while the aged and disabled are generally the most expensive. In fiscal year 2005 the aged and disabled comprised only 21 percent of recipients served, however, they accounted for approximately 61 percent of Medicaid expenditures.

To address increasing healthcare costs and improved access and quality of care, the Texas Legislature established a Medicaid managed care pilot program in 1991. Managed care is distinct from a traditional fee-for-service health financing arrangement. Managed care is a network of providers that agree to coordinate and provide healthcare to a population for a specific payment per person, or capitation rate. Texas Medicaid uses two managed care strategies: (1) Health Maintenance Organizations (HMO), under a capitated model, and (2) Primary Care Case Management (PCCM), a non-capitated model, where each participant is assigned a physician that authorizes most services.

FIGURE 1
MEDICAID ELIGIBILITY IN TEXAS
MAXIMUM MONTHLY COUNTABLE INCOME* LIMIT (FAMILY OF THREE), 2006



*"Countable income" is gross income adjusted for allowable deductions, typically work-related. Note: SSI does not certify families of three. SSI certifies only individuals and couples. SSI is not tied to the Federal Poverty Level, but is based on the FBR, as indicated above.
NOTE: Foster children under the age of 21 are also eligible for Medicaid.
SOURCE: Health and Human Service Commission.

Other cost containment initiatives implemented recently in the Texas Medicaid program include changes in the eligibility determination and enrollment process, further expansion of managed care selective contracting for hospitals and the use of a preferred drug list for Medicaid pharmacy benefits.

POTENTIAL MEDICAID REFORM OPTIONS

Benefit and plan reforms (i.e., changes to health plan structures and benefit packages) in the Medicaid program may be initiated via research and demonstration waivers (waivers) or state plan amendments under the federal Deficit Reduction Act of 2005 (DRA).

DRA, which was enacted in February 2006, includes mandatory and optional reforms that change the way states operate their Medicaid programs. For example, DRA changes some of the rules allowing states more flexibility with respect to statewide uniformity and comparability of benefits for certain groups of recipients. Kentucky, West Virginia and Idaho have taken advantage of certain options in DRA to implement benefit and plan reforms through state plan amendments.

The new options provided by DRA for states to change their Medicaid programs are estimated to achieve $11.5 billion in gross federal savings and $4.9 billion in net savings over a five-year period. Over a ten-year period the reductions in federal Medicaid spending are estimated at $28.3 billion. Although there are multiple provisions affecting Medicaid in DRA, this report focuses in part on the optional Medicaid benefit and plan reforms contained in DRA including:

- Tiered benefit structures allowing states increased flexibility in terms of eligibility and program benefits;
- Healthy behavior incentives increasing consumer accountability over their own health through measures aimed at fostering beneficiary personal responsibility;
- Health Opportunity Accounts (HOAs) increasing consumer choice in the type of care they obtain; and
- Premiums and cost sharing for certain services including non-preferred prescription drugs and non-emergent emergency room usage.

Waivers allow states to change their Medicaid programs in ways that differ from federal standards. Over the last decade, some states relied on waivers to cover populations that they could not cover under regular Medicaid or to require recipients to enroll in managed care. With the onset of state fiscal pressures, waiver activity focused more on increasing beneficiary cost sharing and, in some cases, reducing benefits or capping enrollment. In addition, waivers typically change the federal and state financial relationship by imposing caps on federal funding as part of the federal government's policy to assure that waivers do not result in new federal costs.

The reforms Florida is now piloting were approved under a waiver in October 2005. As a result of concerns in the legislature about Florida's reforms, the changes are being implemented through pilots in two counties—Broward (Ft. Lauderdale) and Duval (Jacksonville) over two years. At the end of the two years, the legislature must vote to implement the changes statewide.

Florida's Medicaid program is the fourth largest in the country, covering 2.2 million recipients. The following groups are required to participate in the pilot:

- Disabled adults and children, non-institutionalized elderly and disabled individuals receiving Social Security Insurance;
- Families with incomes below 23 percent federal poverty level (FPL) or about $3,701 annually for a family of three; and
- Children age 0 to 1 under 200 percent of the FPL ($32,180 annually for a family of three), age 1 to 6 under 133 percent of FPL ($21,400 annually for a family of three), and age 6 to 21 under 100 percent of FPL ($16,090 annually for a family of three).

The following individuals eligible under the above groups are excluded from mandatory participation during the initial phase of the pilot program:

- Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21;
- Children with special healthcare needs who participate in Florida's Early Steps program;
- Foster care children;
- Individuals diagnosed with developmental disabilities;
- Individuals eligible under a hospice-related eligibility group;
- Pregnant women with incomes above 100 percent of FPL ($16,090 annually for a family of three); and
- Individuals with Medicare coverage.

Florida's reform efforts are aimed at improving the predictability of Medicaid spending and reducing the rate of spending growth. Florida's reforms rest on the following key elements:

1. Risk-adjusted premiums with capped benefits—Premiums have been developed for enrollees in the Medicaid reform pilot areas. The premium has two components, comprehensive care and catastrophic care. All Medicaid reform enrollees have access to the full premium when choosing a managed care organization (MCO). All enrollees are subject to managed care. Florida will reimburse most MCOs on a capitated basis. Before the waiver, Florida paid for covered benefits for fee-for-service recipients and made capitated payments to MCOs. Thus, state spending levels were driven by enrollment, utilization of care, and the cost of services. The waiver gives Florida more control over its spending since it will consist of risk-adjusted premiums for each beneficiary. Thus, state spending is driven primarily by enrollment and the premium amounts. Once expenditures reach the benefit cap of $550,000 per beneficiary per state fiscal year, neither the state nor the MCOs are responsible for further costs. The cost will become uncompensated care which will be subsidized by the new hospital financing pool discussed below. Because the limits will enable the state to control maximum expenditures for each adult, it will influence the amounts of the risk-adjusted premiums allotted to recipients. Pregnant women and children are exempt from most of the limits.

2. Tiered benefits plans—Before the waiver, Florida established a benefit package and then negotiated a capitated rate with MCOs to provide covered benefits. Under the waiver, the MCOs determine the benefits they will offer for the state established risk-adjusted premiums, subject to state approval. Because MCOs will have increased ability to determine benefits, the available benefit packages for adults may vary. Pregnant women and children also receive risk-adjusted premiums and choose among MCO benefit plans. However, the MCOs are still required to provide all medically necessary care to pregnant women and children under the Early Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit.

3. Enhanced benefit accounts—These accounts have been established to provide incentives to Medicaid reform enrollees to encourage healthier behaviors. For instance, people with diabetes, asthma or heart disease who participate in disease management programs could earn the incentive. Upon successful completion of approved wellness activities such as disease management programs, the state may deposit funds into the enrollee's Enhanced Benefit Account up to a $125 per year.

4. Medicaid Opt-Out—This option provides individuals with the opportunity to use their premiums to "opt out" of Medicaid and to purchase insurance through the workplace.

5. Hospital Financing Pool—The state has established a pool to provide direct payments and distributions to safety net providers that offer coverage to the uninsured. Funds will be distributed to safety net providers, such as hospitals meeting certain state and federal requirements and replaces other hospital financing arrangements. The waiver authorizes a pool that is capped at $1 billion each year and financed with state and federal matching funds.

6. Changes in Federal and State financing—The federal government caps Federal Funds under approved waivers to ensure that federal costs do not exceed what federal costs would have been without the waiver. The Florida waiver establishes per capita caps that limit the amount of Federal Funds the state can receive per beneficiary for the groups covered by the waiver. These costs can change based on inflation and enrollment. These caps apply on a statewide basis even though the waiver will be implemented in only two counties initially.

The reforms in Florida and efforts in Kentucky, West Virginia and Idaho provide an opportunity for Texas to evaluate various cost containment reforms in its Medicaid program. The next section of this report identifies Medicaid benefit and plan reforms being demonstrated in these states:

- Risk-adjusted premiums with capped benefits
- Tiered benefit plans
- Healthy behavior incentives such as enhanced benefit accounts
- Health opportunity accounts
- Medicaid opt-out
- Premiums and cost sharing

While certain reforms could be implemented via a state plan amendment under DRA, DRA's restrictions generally limit

their applicability to Texas. As a result, any significant Medicaid reform initiative in Texas would likely require the submittal of a waiver request to CMS for approval.

RISK-ADJUSTED PREMIUMS WITH CAPPED BENEFITS

To control costs, improve management and increase recipient choice and responsibility, Florida developed a comprehensive Medicaid reform strategy. A key element of Florida's reform strategy is the risk-adjusted premium structure. In a traditional capitated environment, a health plan receives one premium for managing financial risk and coordinating all care for an enrollee. This includes managing the financial risk of serving both the vast majority of cases and those relatively few individuals who experience very high medical expenditures. Florida's risk-adjusted premium structure differs from traditional capitation in that it divides the Medicaid risk into two components namely comprehensive and catastrophic care, caps maximum annual benefits and provides risk-adjusted premiums for each Medicaid recipient to shop for coverage from pre-approved MCOs.

According to the Florida Medicaid reform waiver application, the comprehensive care component includes the Medicaid services that the majority of Medicaid enrollees need and should represent approximately 90 percent of historical medical expenditures. The catastrophic care component serves the needs of the limited number of Medicaid enrollees who have unusually high costs in any particular year. All Managed Care Organizations (MCO) must assume the comprehensive risk for their enrollees. For each target population served, plans may choose whether to assume the catastrophic risk as well.

While developing its benefits plan, Florida recognized the need for safeguards to ensure appropriate and adequate care for enrollees moving from comprehensive to catastrophic care. Therefore it requires MCOs to coordinate and manage all care regardless of whether the entity assumed financial risk for the catastrophic component.

From the enrollee's perspective there is only one benefit package. Under this model, the combination of the comprehensive and catastrophic components is subject to the overall limits of the benefit package. The comprehensive premium covers 100 percent of the cost of an enrollee's care, less any required enrollee cost sharing, until that care reaches pre-established thresholds. At that time, the expenses for care become subject to the catastrophic component. Through a plan cost sharing mechanism, a small portion of the expenses over the threshold are retained within the comprehensive component to ensure that plans not bearing catastrophic risk have financial motivation to continue to manage care efficiently.

Comprehensive care premiums are based on eligibility groups, age, and gender for a specified geographic area and then risk-adjusted for individual health status based on a Medicaid prescription risk-adjustment model. This model is used during the initial stages of Medicaid reform to risk-adjusted premiums paid to MCOs participating in Florida's reform areas. The Medicaid prescription model was created by a team from the University of California San Diego to use historical pharmacy utilization data as a predictor of future healthcare costs. By combining this model with an MCOs historical pharmacy utilization, the state and the MCO can determine its members' predicted future physical, mental, and pharmacy healthcare costs with a greater degree of accuracy than with the current age- and gender-based methodology, according to the Florida waiver application.

The catastrophic premium component covers the bulk of an individual's medical expenses, less any required plan cost sharing, after those expenses exceed a pre-established catastrophic threshold. The state established criteria to offer some MCOs a financial choice for managing high cost cases to either accept the premium and self-insure, or reject the premium and have the state act as reinsurer. The option to accept the catastrophic component will be limited to areas where there are no HMOs. According to the Florida Medicaid reform waiver application, for plans choosing not to cover the catastrophic component, the state will retain the catastrophic premium as a method to fund catastrophic coverage and maintain budget neutrality.

An individual's medical expenses becomes subject to catastrophic component funding when either of two defined thresholds is reached including a dollar threshold and an inpatient day threshold. For the dollar threshold, all healthcare expenditures for each individual are accumulated throughout the plan year and compared to a pre-established dollar threshold. If an individual's expenses exceed that threshold, the remainder of the expenses, excluding any required plan cost sharing, for that individual are provided through the catastrophic premium component, up to a maximum per-year benefit limit of $550,000 per state fiscal year (with the exception of pregnant women and children under age 21). Once this maximum benefit level is reached, further care for that individual becomes uncompensated care.

For the inpatient day threshold, the Medicaid state plan limits coverage of inpatient hospital days to 45 days per state fiscal year for individuals over age 21. It is possible that a customized benefit plan may include fewer covered inpatient hospital days, yet still meet the sufficiency test for certain target populations. The state will provide up to 45 days of inpatient coverage regardless of the nominal limit established by the MCO and those excess days are to be funded through the catastrophic premium component.

Texas uses a capitated rate structure in its Medicaid managed care program that is similar to Florida's risk-based premium structure. The key difference is that MCOs under Florida's Medicaid reform initiative have the ability to limit certain benefits including a maximum per-year benefit limit of $550,000. Another important difference in Florida is that MCOs have significant flexibility to customize their benefits packages providing recipients increased choice in selecting from different packages according to their needs. For instance receipts in Broward County, Florida can choose among 12 different benefit packages offered by MCOs.

TIERED BENEFIT PLANS

Unless a specific waiver exists, Texas Medicaid is now required to provide the same benefits in terms of scope, duration, state uniformity and comparability to all recipients. New options contained in DRA and options available to Texas via a potential waiver would allow the state to tailor benefit packages to meet individual population needs. In 2006, Kentucky, Idaho, West Virginia and Florida established different types of tiered benefit structures within their Medicaid programs. Tiered benefit plans assign recipients deemed to be part of a healthier group to a more limited benefit package and provides those who are expected to have more extensive medical needs additional coverage. This coverage might be the same as what was available before the tiered approach was adopted, or it could include benefit enhancements. Some movement across groups and benefit package assignments may be permitted, but predictability in spending is predicated on the assumption that at least a considerable portion of people will stay within their benefit package assignment for some period, regardless of their actual medical needs. Kentucky, West Virginia and Idaho have each received approval under the DRA to divide Medicaid enrollees into groups and provide different benefit packages to each group.

According to the Kentucky Cabinet for Health and Family Services who developed the KyHealth Choices reform, the design is aimed at improving the health status of enrollees, ensuring a continuum of care and ensuring the solvency of the Medicaid program. The Kentucky design creates four benefit packages including:

- Global Choices: A benchmark plan for the general Medicaid population
- Optimum Choices: The benchmark plan plus intermediate care facility level of care
- Comprehensive Choices: The benchmark plan plus nursing facility level of care and services previously covered by the Home- and Community-Based Care and Acquired Brain Injury waivers
- Family Choices: The plan for children currently covered by KCHIP and traditional Medicaid

Through its changes, Idaho is seeking to redesign its program so it provides vital services, while promoting prevention and personal responsibility for Idaho participants. The Idaho reform provides for a separate benefits category for low-income adults and children who receive SCHIP-like benefits with personal health accounts. No benefit changes are planned for disabled individuals or those with special health needs.

West Virginia also has an approved DRA state plan amendment that tiers benefits for children and parents. Its stated goals are to emphasize personal empowerment and responsibility and to ensure that participants receive the right care at the right time by the right provider through care coordination. Unlike Kentucky and Idaho, West Virginia's system is not based on anticipated health needs of recipients but rather on their behavior. These member agreements are discussed in more detail in the Healthy Behavior Incentives section of this report. Under the West Virginia plan, children and parents will be enrolled in an "Enhanced" plan if they sign a member agreement and comply with its requirements. People who do not sign the agreement or who the state determines have failed to meet the requirements of the agreement will be enrolled in a more limited "Basic" plan, which excludes coverage for certain care such as diabetes care and mental health services. The West Virginia state plan amendment states that children may be enrolled in the "Basic" plan, but includes coverage for medical care services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) as a wrap-around benefit. Children account for three quarters of those who are subject to the new system.

Florida also uses tiered benefits although implements it differently via its waiver. Instead of being assigned to a benefit package, under Florida's Medicaid reform, recipients choose from benefit packages based on available offerings from participating MCOs, with each MCO offering different benefit packages that focus on the needs of different populations. According to the Florida waiver application, the reform benefit packages are different from traditional Medicaid in several ways. To provide additional or special services to the targeted population, tiered benefit packages may vary the amount, duration and scope of some services, and may contain service-specific coverage limits, such as the number of visits or dollar cost. All packages must cover mandatory Medicaid services, including medically necessary services for pregnant women and EPSDT services for children under age 21. MCOs may also develop tiered benefit packages that cover optional services. In addition, MCOs may also cover services not currently offered, such as adult dental care.

The state approves all benefit packages and the packages must be at least actuarially equivalent to the services provided to the target population currently. In addition to being actuarially equivalent to the value of traditional Medicaid services, each MCOs benefit package must pass a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population. While one of the major principles the state seeks to test is the variation of amount, duration and scope, MCOs are not required to change benefit packages and may choose to offer a benefit package that mirrors current coverage levels. Actual benefit packages will depend on market innovation and the population the provider seeks to serve and will be reviewed annually by the state. Currently, Broward County has 12 MCOs including 3 Personal Service Networks (PSN) signed-up while Duval County signed-up 5 MCOs including 2 PSNs. **Figure 2** shows a benefit package comparison chart for the Children and Families eligibility group in Duval County, Florida.

According to HHSC, DRA prohibits the applicability of tiered benefits to certain groups including the blind or disabled, women who are pregnant, or recipients who are eligible for both Medicare and Medicaid. In addition, individuals who are in institutional care, are medically frail or have special needs and are receiving long-term care services or are eligible for the federal TANF are also exempt. Children under age 19 can be included in a tiered benefit plan but only if they also receive additional medically necessary services meeting EPSDT requirements. In Texas, only a small group of Medicaid eligible individuals could be provided a tiered benefit package including foster children with incomes between 200 percent to 400 percent of FPL ($32,180 to $64,360 annually for a family of three) and pregnant women with incomes between 133 percent to 185 percent of FPL ($21,400 to $29,767 annually for a family of three). Therefore, the potential benefits to the Texas Medicaid program of implementing tiered benefit plan reforms via a state plan amendment under new options contained in DRA are likely to be limited. As a result, Texas would likely only consider implementing this reform if it were cost effective and feasible via a waiver.

HEALTHY BEHAVIOR INCENTIVES

A common objective among the various Medicaid reform initiatives is the promotion of healthy behaviors among Medicaid enrollees. However, how states seek to encourage healthier lifestyles among Medicaid enrollees varies in scope and structure. Most Medicaid reform states provide enrollees access to enhanced benefits for successfully participating in certain healthy activities. West Virginia, in contrast, directly links enhanced benefits to Medicaid enrollees adherence to agreed upon behaviors documented in a signed member agreement.

To improve the health of its Medicaid recipients and contain costs, Kentucky offers targeted disease management programs for enrollees diagnosed with diabetes, chronic obstructive pulmonary disease, adult asthma, pediatric obesity, cardiac-heart failure, and pediatric asthma. Upon successful participation in a disease management initiative and completion of recommended screening, enrollees may select from various enhanced benefits in the Get Healthy Benefits program. These enhanced benefits include:

- Allowances for dental services up to $50
- Allowances for vision hardware services up to $50
- Services from a nutritionist or registered dietician for meal planning and counseling
- Access to smoking cessation programs through local health departments, and nicotine replacement therapy.

Once selected, enrollees must access the enhanced benefit they select within six months. Access to the enhanced benefit terminates upon a person losing Medicaid eligibility.

West Virginia coupled the promotion of healthy behaviors with increased personal responsibility by offering Medicaid enrollees different benefit packages. West Virginia places

FIGURE 2
HEALTHPLAN OFFERINGS FOR CHILDREN AND DISABLED
DUVAL COUNTY, 2006

DUVAL - CHILDREN AND FAMILIES

DUVAL - CHILDREN AND FAMILIES

HOW TO USE THIS CHART:

✔ FIND THE HEALTH PLANS MADE FOR YOU:
If you are in the Children and Families group, look here. If you are in the Aged or Disabled group, look below.
If you need help, call a *Choice Counselor*: 1-866-454-3959; TDD 1-866-467-4970.

✔ FIND THE SERVICES THAT YOU AND YOUR FAMILY NEED:
Look at each health plan to see what it covers and how much you may have to pay for services.

COPAYS AND PLAN LIMITS DO NOT APPLY TO CHILDREN AND PREGNANT WOMEN

Rev. 10/06

HEALTH PLANS	Staywell		UnitedHealthcare		First Coast Advantage		Access Health Solutions		HealthEase	
CONTACT INFORMATION	866-613-9067		800-910-3224		866-270-2422		866-291-6171		866-613-9078	
BENEFITS	You Pay*	Plan Limit	You Pay*	Plan Limit	You Pay*	Plan Limit	You Pay*	Plan Limit	You Pay*	Plan Limit
Hospital Inpatient / Behavioral Health	$0	45 days combined^	$3 / admit	45 days combined^	$0	45 days combined^	$3 / admit	45 days combined^	$0	45 days combined^
Hospital Inpatient / Physical Health			$0							
Transplant Services		No limit^		No limit^		No limit^	$0	No limit^		No limit^
Hospital Outpatient / Surgery							$3 / visit			
Lab / X-ray							$1 / day			
Hospital Outpatient Services (non-emergency)		$1,500 / yr combined		$200 / yr		$1,500 / yr combined	$3 / visit	$1,500 / yr combined		$1,500 / yr combined
Outpatient Therapy (physical / respiratory)				$100 / yr						
Emergency Room		No limit^		No limit^		No limit^	$0	No limit^		No limit^
Ambulatory Surgery										
Dialysis Services										
Chemotherapy Services										
Primary Care Physician / ARNP/PA		1 visit / day		1 visit / day		1 visit / day	$2 / visit	1 visit / day		1 visit / day
Specialty Physician										
Clinic (FQHC, RHC)							$3 / visit			
Maternity / Family Planning Services		No limit^		No limit^		No limit^	$0	No limit^		No limit^
Home Health Services		24 visits / yr		15 visits / yr		24 visits / yr	$2 / visit	60 visits / lifetime*****		24 visits / yr
Chiropractor		24 visits / yr	$1 / visit	24 visits / yr		24 visits / yr	$1 / visit	24 visits / yr		24 visits / yr
Podiatrist			$2 / visit	12 visits / yr			$2 / visit			
Dental Services		dentures / emergency	$0	dentures / emergency		dentures / emergency	5% co-insurance	dentures / emergency		dentures / emergency
Vision Services		2 pair glasses^		2 pair glasses^		2 pair glasses^	$2 / visit	2 pair glasses^		2 pair glasses^
Hearing Services		1 device / 1 evaluation per 3 yrs		1 device / 1 evaluation per 3 yrs		1 device / 1 evaluation per 3 yrs	$0	1 device / 1 evaluation per 3 yrs		1 device / 1 evaluation per 3 yrs
Outpatient / Mental Health		**SAME	$2 / visit	**SAME		**SAME	$2 / visit	**SAME		**SAME
Outpatient / Pharmacy***		9 scripts / month	$0	$5,400 / yr		No limit^	$0	No limit^		No limit^
Non-emergency Transportation		No limit^		No limit^			$1 / trip			
Ambulance							$0			
Durable Medical Equipment****				$100 / yr						
EXTRA SERVICES Contact the plan for more details	**Over the Counter Pharmacy** - $25 per household per month **Adult Dental** - Exam / X-rays / Deep Cleanings / Unlimited Fillings / Extractions **Circumcision** - Routine for babies under one year		**Over the Counter Pharmacy** - $25 per household per month **Adult Dental** - Exams / Cleanings / Fillings / Extractions / X-rays **Circumcision** - Routine for babies under twelve weeks		**Circumcision – Newborns**				**Over the Counter Pharmacy** - $25 per household per month **Adult Dental** - Exam / X-rays / Deep Cleanings / Unlimited Fillings / Extractions **Circumcision** - Routine for babies under one year	

ENROLL – **Call** or **Visit** a *Choice Counselor* **or Mail-In** a Medicaid Reform enrollment form

^ PRIOR AUTHORIZATION, OTHER LIMITS, OR EXCEPTIONS MAY APPLY. YOUR PLAN WILL GIVE YOU DETAILS ONCE YOU ARE ENROLLED.
* COPAYS AND PLAN LIMITS DO NOT APPLY TO CHILDREN AND PREGNANT WOMEN
** SAME = SAME LIMITS AS WITH MEDICAID FEE FOR SERVICE PROGRAM
*** LIMITS DO NOT APPLY TO CHEMOTHERAPY OR HIV/AIDS DRUGS
**** LIMITS DO NOT APPLY TO ORTHOTICS AND PROSTHETICS OVER $3,000 AND MOTORIZED WHEELCHAIRS
***** IF ADDITIONAL SERVICES ARE NEEDED THEY MUST BE PRIOR AUTHORIZED

To get help, call the toll-free Helpline: 1-866-454-3959; TDD 1-866-467-4970.

Beneficiaries with disabilities can receive additional services from the Choice Counselor upon request at no charge. These services include, but are not limited to, real-time captioning, sign language interpreters, Braille, large print, CD-ROMs, and audiotapes. To receive these services, call 1-866-454-3959, TDD 1-866-467-4970; e-mail checkitout@acs-inc.com; fax at 1-850-942-1089; or mail Florida Medicaid, P.O.Box 5197, Tallahassee, Florida 32314-5197

SOURCE: Florida Agency for Health Care Administration.

recipients in various tiers based on member behavior and compliance with a member agreement. Medicaid enrollees participating in West Virginia's redesigned program will have access to a basic benefit plan through which the state will provide all mandatory services. However, recipients signing a member agreement detailing certain enrollee responsibilities (including children with parents that sign on their behalf) will have access to an enhanced benefit plan offering additional medical services. As shown in **Figure 3**, enrollees seeking access to enhanced benefits would agree to certain responsibilities that are aimed at improving beneficiary health outcomes, while potentially ensuring more efficient use of state Medicaid resources. For instance, the agreement to utilize hospital emergency rooms only for emergencies seeks to reduce the inappropriate use of hospital emergency room services.

Enrollee compliance with their member agreement will be monitored by the MCO and the respective medical provider serving a beneficiary. The state will place enrollees failing to meet the terms of their agreement in the basic benefit plan after providing advanced notification and an appeals process. These enrollees will be required to remain on the basic benefit plan for 12 months or until re-determination before they are re-enrolled in the enhanced benefit plan. However, the state is still required to continue providing EPSDT to children who transition from the enhanced to the basic benefit plan.

West Virginia's approach towards encouraging healthy behaviors among enrollees generated significant concern. There is concern that the new role providers will have in monitoring and reporting compliance with member agreements could negatively affect communication between patients and their healthcare providers. This may place providers in a position of being responsible for a member's loss of coverage, and may increase provider liability and raise concerns over patient privacy. **Figure 4** shows the different benefits provided under each plan for adults.

Through its approved Medicaid reform waiver, Florida is implementing a new approach towards incentivizing healthy behaviors among Medicaid enrollees.

Enrollees participating in state-defined healthy activities will be eligible to receive enhanced benefit credits which can be applied towards obtaining uncovered health services or paying the costs of private insurance if Medicaid eligibility is lost. Through its waiver authority, the state will establish an Enhanced Benefits Account for eligible enrollees participating in the State's Medicaid reform program. Upon successful completion of an approved wellness activity, the State will deposit funds into the enrollee's Enhanced Benefit Account up to a $125 credit limit per year. State financing of the enhanced benefit credits will come from savings obtained through the Medicaid waiver reforms, and are eligible for federal matching payments.

FIGURE 3
WEST VIRGINIA MEDICAID MEMBER AGREEMENT, 2006

- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my healthcare provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know where there has been a change in my address or phone number for myself or my children.
- I will use the hospital emergency room only for emergencies.

Source: West Virginia Bureau of Medical Services.

FIGURE 4
WEST VIRGINIA BASIC AND ENHANCED BENEFIT PLAN FOR ADULTS, 2006

BASIC PLAN	ENHANCED PLAN
• Home Health (limited to 25 visits per year)	• Home Health services (not limited)
• DME (limited to $1,000 per year with prior authorization if exceeded)	• Durable medical equipment (not limited)
• Non-emergency Medical Transportation (limited 5 trips per year)	• Non-emergency Medical Transportation (not limited)
• Prescriptions (limited to 4 per month)	• Prescriptions (not limited)
• Ambulance (emergency only)	• Ambulance (not limited)
	• Cardiac Rehabilitation
	• Dental (Emergent treatment)
	• Chiropractic Services
	• Tobacco Cessation
	• Nutritional Education
	• Diabetes Care
	• Chemical Dependency/Mental Health Services (Inpatient 30 days per year; Outpatient 20 visits per year)

SOURCE: West Virginia Bureau of Medical Services.

While designing its Medicaid reform waiver proposal, Florida identified a group of proposed wellness activities and behaviors enrollees could undertake in order to earn deposits into their Enhanced Benefit Account. The state's intention was to select activities that would encourage participation in the enhanced benefit plan while reducing administrative complexity. The state asserts that these activities and behaviors could be documented without an overly complex monitoring system. A list of wellness activities and behaviors is shown in **Figure 5**.

Eligible uses of the Enhanced Benefit funds include qualified health-related expenditures, over-the-counter pharmaceuticals, smoking cessation activities, weight reduction programs and other healthcare services not covered under the Medicaid reform. Moreover, Florida envisions allowing enrollees to accumulate funds in their Enhanced Benefit Accounts for purchases of larger services including health-related home modifications. However, there is a strict prohibition against providing enrollees any funds in their Enhanced Benefit Account in the form of cash.

Under this initiative, enrollees retain the ability to use accumulated funds in their Enhanced Benefit Accounts up to three years after the loss of their Medicaid coverage or subsidized employer sponsored insurance coverage. However, only enrollees whose incomes remain below 200 percent of FPL ($32,180 annually for a family of three) are eligible for this continued benefit.

HEALTH OPPORTUNITY ACCOUNTS

Congress included $64 million over 5 years in grant funding to establish Health Opportunity Accounts (HOAs) in 10 states in DRA. With the creation of HOAs, Congress sought to introduce the concept of Health Savings Accounts used in the private insurance market to the Medicaid population. States implementing HOAs are authorized to limit certain Medicaid services based upon payment of a deductible or co-insurance.

Starting in January 2007, DRA allows the Secretary of the U.S. Department of Health and Human Services (HHS) to approve demonstration programs for HOAs in 10 states. If approved, states may implement HOAs through a state plan amendment, without regard to statewide uniformity or comparability. States can contract with a third-party administrator to administer this benefit. At a minimum, an approved demonstration proposal would have to:

- Create patient awareness of the high cost of medical care;
- Provide incentives to patients to seek preventive care services;
- Reduce inappropriate use of healthcare services;

FIGURE 5
FLORIDA ENHANCED BENEFIT ACTIVITIES, 2006

1. On a yearly basis, the custodial parent takes her child to the primary care provider for all screenings and immunizations at the age appropriate time.
2. Parents with children between the ages of 4 to 18 make and keep appointments for an annual dental exam for their children.
3. Parents with children between the ages of 3 to 6 make and keep an appoints for a vision-screening exam.
4. Parents with children between the ages of 3 to 18 make and keep an appointment for a yearly comprehensive well child-visit.
5. The member maintains active participation in a disease management program relevant to a current or potential health problem, e.g. diabetes, heart, obesity.
6. The member completes a smoking cessation program.
7. The member completes a weight loss program.
8. The member completes and signs a living will or advance directives regarding their wishes in the event of a catastrophic illness.
9. The member plays sports in an organized entity that can be documented.
10. For the elderly and disabled, the member participates in an appropriate exercise program.
11. The member enrolls her child in an organized sport.
12. Members, when recommended by their physician, get a yearly flu shot.
13. Members with an on-going drug regimen fill and refill their prescriptions timely.
14. For members with an alcohol and/or drug issue, the member enrolls and is an active participant in an appropriate treatment program.
15. Adult members schedule and keep appointments for age appropriate screenings.

SOURCE: Florida Agency for Health and Administration.

- Enable patients to take responsibility for health outcomes;
- Provide enrollment counselors and ongoing education activities; and
- Provide transactions involving HOAs to be conducted electronically and without cash.

After the initial five-year demonstration period, a state may choose to extend its demonstration program unless HHS determined it be unsuccessful based on cost-effectiveness and quality of care outcomes. Other states may also implement HOA programs after the initial period unless HHS finds that all original 10 programs were unsuccessful in terms of cost-effectiveness and quality of care outcomes.

Recipient participation in a state's demonstration program is voluntary and generally limited to healthy children and parents. During the demonstration period, persons 65 and older, disabled individuals, pregnant women, and persons who have been on Medicaid for less than 3 continuous months are ineligible to participate. The following groups are also ineligible from participating:

- Blind or disabled individuals;
- Medicare-Medicaid recipients;
- Terminally ill hospice patients;
- Individuals eligible on the basis of institutionalization;
- The medically frail or individual with special medical needs;
- Recipients qualifying for long-term care services;
- Children in foster care receiving child welfare assistance;
- TANF parents; and
- Women in breast or cervical cancer programs.

Recipients enrolled in Medicaid managed care face additional barriers to participating in HOA programs under DRA. DRA limits the number of eligible recipients to 5 percent of a Medicaid managed care organization's population. Additionally, the proportion of the managed-care enrollees participating in the program cannot be significantly disproportionate to the proportion of enrollees from other managed care organizations. Furthermore, the state is required to adjust its per capita payment to the Medicaid managed care organizations to reflect the likely differences in utilization of health services between enrollees participating in the demonstration program and those not participating.

Under the DRA, states can limit annual contributions to HOAs, in addition to limiting HOA contributions once a set balance is met. The DRA initially caps annual state government contributions to HOAs to a maximum limit of $2,500 per adult and $1,000 per child, but provides for

subsequent annual increases based on the yearly percentage rise in the medical care component of the Consumer Price Index for urban consumers. States may contribute to a HOA beyond the maximum limits if they assure the federal government that contributions made to other individuals will be reduced in order to ensure budget neutrality. However, state contributions in excess of the maximum contribution limit are not eligible for a federal match. Moreover, although the DRA allows contributions to HOAs by charitable organizations, these amounts would not be eligible for a federal match. HOA balance or contributions are not counted as income or assets when determining eligibility.

Under the terms of DRA, the annual deductible must be at least 100 percent of a state's annual contribution to a HOA. However, the state may opt to increase the deductible to a maximum 110 percent of its annual contribution. States have the option of adjusting the annual deductible and the maximum out-of-pocket cost sharing based on family income as long as adjustments do not favor families with higher incomes. Once an enrollee meets the annual deductible, they may be responsible for additional cost sharing requirements.

States must ensure participating fee-for-service enrollees access to services from Medicaid providers at the same payment rates in effect if the deductible was not applicable. For services rendered by non-Medicaid providers, the payment rate is capped at 125 percent of the Medicaid rate. Medicaid managed care enrollees may obtain services from any provider at a maximum 125 percent of Medicaid rates. The DRA specifies that payment rates will be computed without regard to any cost sharing that could be applied through the Medicaid program.

Although no additional contributions will be made to the HOA recipients losing their Medicaid eligibility because of income or assets restrictions, these individuals will retain access to 75 percent (and all contributions made by charitable organizations) of their account balances for three-years. During this period, these individuals may use their remaining funds to purchase health insurance coverage, or make other expenditures such as job training and tuition expenses as specified by the State. Moreover, persons losing eligibility are not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

HOAs raised a concern that the increased cost sharing from HOAs and Medicaid deductibles may limit access to medically necessary care. Once the deductible is met, recipients may be required to meet other applicable cost sharing obligations, such as co-payments. Consequently, recipients forgoing necessary acute and preventive care could increase state Medicaid expenditures in the long run. For instance, a state electing to contribute the maximum to an HOA for a family of three (single parent and two children) would deposit a total $4,500 into the account. If the state set the deductible at the maximum level allowed under the DRA, the deductible would be $4,950. Under this scenario, the family would be responsible for the $450 difference between the state contribution and the HOA deductible in order to obtain standard Medicaid coverage. Moreover, family members would also have to meet any applicable cost sharing requirements, such as co-payments, after the payment of the deductible.

There is also the possibility that certain incentives built into HOAs could result in higher Medicaid expenditures. For instance, the DRA allows participating recipients to retain access to 75 percent of the funds in their HOA to use in certain approved expenditures, after losing their Medicaid eligibility. Moreover, recipients may also make payments to non-Medicaid providers at rates higher than their state Medicaid program. The Congressional Budget Office estimated that the HOA provision in DRA would increase federal spending by $60 million over 5 years.

HHSC is now determining the number of individuals who could potentially participate in a HOA demonstration. HHSC's ability to arrive at an estimate is hampered because CMS has not issued guidelines. HHSC is also assessing the Medicaid managed-care restriction outlined in DRA regarding participation in HOA demonstrations. This could prove to be a significant issue since a large portion (approximately 55 percent) of Texas' Medicaid population is or soon will be enrolled in managed care.

Irrespective of the number of potential eligible persons, Texas should consider the cost implications of the substantial changes needed to implement HOAs. Specifically, implementation of HOAs may require the following changes:

- An expanded provider network: Because HOA participants will be allowed to obtain services from non-Medicaid providers, HHSC may, at a minimum, incur costs associated with certifying non-Medicaid providers, developing and monitoring assurance measures, new provider information systems (estimated at $500,000) to enroll non-Medicaid providers in the Texas Medicaid & Healthcare Partnership (TMHP), and any modifications needed for provider

reimbursement. Moreover, because the DRA allows for higher reimbursement to non-Medicaid providers participating in the HOA demonstration (125 percent Medicaid rate), there is the possibility that current Medicaid providers will leave the system to become non-Medicaid providers in order to obtain higher reimbursement.

- Assurances related to quality-of-care: At a minimum, HHSC may incur costs associated with the development of systems to monitor the quality of care provided afforded to HOA participants and meet any reporting requirements, in addition to increased staffing needs.
- Processing of Electronic Claims: HHSC may incur additional costs for the development of a new electronic debiting system allowing for electronic withdrawals from HOAs, a new claims' processing system, and the creation and management of individual HOA accounts, deposits and associated accounting needs.
- Other Administrative and Systems Changes: HHSC may incur additional costs associated with the modification of existing eligibility systems and additional staff needs, tracking third-party contributions to HOAs and pharmacy payments, and any auditing and account maintenance.

MEDICAID OPT-OUT

A key feature of Florida's Medicaid reform is that it allows recipients to opt out of Medicaid and obtain coverage through their employer-sponsored insurance (ESI) plan or through a private plan if the individual is self-employed.

Unlike Florida, Texas operates a Health Insurance Premium Payment (HIPP) program in which Medicaid recipients with access to private health insurance enroll in ESI if it is cost effective to the state. HIPP programs require that the state continue to cover Medicaid services not available under the ESI plan, pay all premiums and all cost sharing amounts greater than requirements under Medicaid. Texas would discontinue the HIPP program if an opt-out program were implemented. **Figure 6** shows a comparison of Florida's opt-out program and Texas' HIPP program.

Under Florida's opt-out program, counselors assist individuals in making a choice about opt-out by highlighting information the individual will need to consider to make an informed choice. The counselor collects information on whether the individual has access to health insurance and encourages the individual to seek information on the health insurance available at work, when the individual can enroll, review of cost sharing by the plan, information about preexisting condition clauses and whether individual or family coverage is available. The counselor then refers the individual to the state's administrator, which assists the individual in the opt-out process. Specifically, the administrator contacts the employer and verifies available health insurance. Individuals are informed of their premium share to be used as a subsidy to pay the employee share of the ESI plan.

Payments are made directly to the employer of record whenever possible. When an enrollee is self-insured and has private coverage, payment is made directly to the insurer of record. Maximum payment is the Medicaid premium. The state may limit payment for supplemental policies to ensure efficient use of premium dollars. The availability of supplemental policies may provide access to services not currently covered by Medicaid such as adult dental coverage.

FIGURE 6
TEXAS HEALTH INSURANCE PREMUIM PAYMENT AND FLORIDA OPT-OUT PROGRAMS

TEXAS HIPP	FLORIDA OPT-OUT
• Wrap-around services are provided	• Not covered
• Medicaid pays all cost sharing requirements	• No cost sharing assistance
• Cost-effectiveness test must be met	• No cost-effectiveness test
• Participants get reimbursed premium amounts paid	• Enrollee is required to pay premium amounts in excess of the Medicaid premium
• N/A	• If the employee ESI contribution is less than the Medicaid premium, the enrollee may use the remainder to additional coverage offered by the employer
• ESI coverage must meet minimum standards of the HIPP program	• May be more restrictive than Medicaid coverage

Source: Legislative Budget Board.

To ensure budget neutrality, the total amount of all premiums, including any supplemental policies, is limited to the Medicaid premium.

The benefit package under the ESI plan must meet minimum state licensure standards, but may be more restrictive than Medicaid coverage. However, because participation is voluntary, and enrollees may switch to a Medicaid plan during the open enrollment period, the state does not provide wrap-around benefits. Enrollees electing to opt-out are responsible for paying the cost sharing requirements of the ESI plan, including deductibles, co-insurance and co-payments. ESI cost sharing requirements may be higher than the cost sharing requirements under Medicaid.

PREMIUMS AND COST SHARING

The Medicaid premium and cost sharing provisions in DRA have limited applicability in Texas due primarily to Texas' restrictive eligibility criteria for Medicaid. Cost sharing may include co-payments, co-insurance or deductibles. Under the new options contained in DRA, states may require non-exempt individuals to pay Medicaid premiums and/or cost sharing for any non-exempt services. **Figure 7** provides a summary of exempt individuals and exempt services for which no cost sharing is permitted under DRA.

Family income is determined according to methodologies established by the state. For cost sharing determinations, states may use gross income. In addition, the state must describe how it will ensure that the aggregate premium and/or cost sharing amounts do not exceed 5 percent of a family's income for the monthly or quarterly period.

DRA allows states to enforce the payment of premiums and cost sharing for certain Medicaid recipients. States may condition Medicaid eligibility upon prepayment of a

FIGURE 7

PREMIUM AND COST SHARING EXEMPTIONS IN THE DEFICIT REDUCTION ACT, 2006

Non-Exempt Individuals with Family Income above 100 Percent But at or Below 150 Percent of the Federal Poverty Level (FPL):

- Premium Rules - States may not impose premiums
- Cost Sharing Rules - Cost sharing may not exceed 10 percent of the cost of the item or service
- Aggregate Cap - Total cost sharing, including cost sharing for prescription drugs and non-emergency use of emergency rooms, may not exceed 5 percent of the family income on a monthly or quarterly basis

Non-Exempt Individuals with Family Income Above 150 Percent of the FPL:

- Premium Rules - States may impose premiums
- Cost Sharing Rules - Cost sharing may not exceed 20 percent of the cost of the item or service
- Aggregate Caps - Total premiums and cost sharing, including cost sharing for prescription drugs and non-emergency use of emergency rooms, may not exceed 5 percent of the family income on a monthly or quarterly basis

Populations Exempt from Premiums:

- Mandatory children under 18 years of age
- Children of any age obtaining foster care or adoption assistance
- Pregnant women
- Terminally ill persons obtaining hospice care
- Persons in hospitals, nursing facilities, Intermediate Care Facilities for Mental Retardation (ICF-MR) if as a condition of receiving services the individual is required by the State plan to spend for costs of medical care all but a minimum amount of their income for personal needs
- Women obtaining Medicaid based on breast or cervical cancer eligibility

Populations and Services Exempt from Cost Sharing:

- Services to mandatory children under 18 years of age
- Services to children irrespective of age receiving adoption or foster care services
- Preventive services for children under 18 irrespective of family income
- Services provided to terminally ill persons receiving hospice care
- Services to persons in hospitals, nursing facilities, ICF-MRs if as a condition of receiving services the individual is required by the State plan to spent for costs of medical care all but a minimum amount of their income for personal needs
- Services to women obtaining Medicaid based on breast or cervical cancer eligibility
- Emergency Services
- Family planning services and supplies

SOURCE: Centers for Medicare and Medicaid Services.

premium and may terminate eligibility because of failure to pay the premium. However, termination cannot occur until the failure to pay the premium continues for at least 60 days. States may also waive payment of a premium in any case where it determines that requiring the payment would create an undue hardship. In terms of cost sharing, states may permit a provider to require the individual to pay the cost sharing amount as a condition for the provision of covered care, items, or services. However, providers may reduce or waive cost sharing on a case-by-case basis.

Other states including Kentucky and Idaho used the new options in DRA to impose premiums and cost sharing requirements. Kentucky's Medicaid program assigns recipients to one of four different benefit plans. Under each plan, eligible recipients are responsible for meeting cost sharing requirements on pharmacy and non-pharmacy related services. Depending on the benefit plan, enrollees may be subject to cost sharing ranging from $1 to $3 per prescription. However, Kentucky implemented higher cost sharing on acute inpatient hospital services ($10 to $50), non-preferred brand prescription drugs (5 percent coinsurance), non-emergent emergency room visits (5 percent coinsurance), and durable medical equipment (3 percent coinsurance not to exceed $15 per month). The state also exempts enrollees from further cost sharing once they reach the maximum out-of-pocket threshold of $225 per individual per year for pharmacy services, and $225 per individual per year for the remaining medical services. Idaho integrated premiums in its reformed Medicaid program. Beginning in October 2006, the state began requiring parents whose children are enrolled in the Medicaid Basic Plan to pay monthly premiums ranging from $10 to $15 per child per month, depending on the family's income.

Due to the various constraints contained in DRA the applicability of premiums in Texas is limited. HHSC estimates that less than 5,000 Medicaid recipients could be eligible to pay premiums. According to HHSC, the majority of these individuals are non-mandatory children up to age one who have incomes between 133 percent and 185 percent of FPL. While cost sharing for non-exempt medical services requirements would also apply to a limited number of recipients, cost sharing for non-preferred drugs may provide some potential cost containment benefits to the state.

A general concern about cost sharing initiatives is that they may affect access to medical services for persons with lower incomes and high rates of health problems. Because the Medicaid population generally experiences higher incidences of chronic conditions, cost sharing initiatives could directly impact access to needed medications. Cost sharing may also result in reduced utilization of essential medications and increased hospitalizations and nursing home admissions.

There are also multiple implementation issues that should be weighed against the benefits from premiums and cost sharing in Texas. HHSC estimates significant costs associated with needed information system changes, increased workload associated with eligibility determination, provider and client education and general administration to implement premiums and cost sharing.

COST SHARING FOR NON-PREFERRED PRESCRIPTION DRUGS

DRA allows states to impose increased cost sharing on non-preferred prescription drugs. Preferred drugs are prescription drugs that are defined as the least costly effective prescription drug within a class of drugs.

States can impose increased cost sharing for non-preferred drugs within a drug class, or choose to waive or reduce any cost sharing applicable to a preferred drug within the class. DRA prevents states from imposing any cost sharing on preferred drugs for the same population exempted from premiums (see **Figure 7**). Additional limitations include:

- Recipients with income less than 150 percent of FPL, cost sharing on non-preferred drugs may not exceed the nominal cost sharing amounts;
- For recipients with incomes in excess of 150 percent of FPL, cost sharing may not exceed 20 percent of the cost of the drug (i.e., the Medicaid payment amount);
- For recipients not subject to cost sharing non-preferred drug cost sharing cannot exceed nominal amount; and
- Any cost sharing applied to a recipient for prescription drugs would be subject to the 5 percent aggregate cap of family income as discussed previously under premiums and cost sharing requirements.

The DRA also provides states with additional flexibility to include/exclude specified drugs or drug classes. If a physician determines that the preferred drug for treatment of a condition is not as effective or could have adverse effects for an individual versus a non-referred drug, cost sharing on the non-preferred drug must be the same as those applicable to preferred drugs. The physician override must comply with prior authorization criteria set by the state. Once approved,

the non-preferred drug would receive the preferred drug cost sharing.

States may permit pharmacists to make their services contingent upon the payment of the cost sharing amount. DRA also requires that state payments to providers must be reduced by the amount of the recipient cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

Texas has had previous experience with prescription drug cost sharing. The Seventy-seventh Legislature, Regular Session, 2001, directed the Health and Human Services Commission (HHSC) to establish cost sharing in the Medicaid program as one of multiple cost-containment mechanisms outlined in Article II, Section 33 of the General Appropriation's Act of 2001. In anticipation of associated savings, the legislature reduced HHSC's appropriations by $3 million in General Revenue Funds.

In late 2002, HHSC implemented cost sharing policies on non-emergent services provided in an emergency department, and generic and brand name medications. Approximately 550,000 adult Medicaid enrollees ages 19 and older, irrespective of income level were to be subject to cost sharing of $3 for non-emergency services provided in the ER, $0.50 for generic medications, and $3 for brand name medications. The state capped the cost sharing at $8 per month per individual. Although cost sharing was mandatory, providers were not allowed to refuse service based on an individual's inability to pay. The state exempted an estimated 2 million Medicaid enrollees from cost sharing, including pregnant women, children under the age of 19, individuals residing in institutions, individuals receiving hospice services, American Indians and Alaska Natives.

The state also anticipated that pharmacists would collect and retain cost sharing payments, which would have allowed the state to reduce related reimbursements by 50 percent of the value of the cost sharing payment. In addition to reimbursement reductions, HHSC predicted additional savings as cost sharing requirements could encourage enrollees to switch from name brand drugs to generics or therapeutic alternatives. In all, HHSC estimated approximately $17.2 million in General Revenue Fund savings in fiscal years 2003, 2004 and 2005 from the implementation of cost sharing.

However in December 2002, HHSC notified pharmacists that the state was suspending implementation of the Medicaid cost sharing program and associated decreases in pharmacy reimbursements. This suspension was based on a State District Court decision granting a petition by the Texas Pharmacy Association and Texas pharmacists for a temporary restraining order to prevent implementation. A key concern was that pharmacy reimbursements were reduced based on the expectation that co-payments would be collected. However, pharmacists could not deny services for non-receipt of co-payments, resulting in a loss for pharmacists. As a result, Medicaid recipients were no longer required to meet cost sharing obligations until the matter was resolved and amounts already paid were to be reimbursed. HHSC subsequently withdrew the State Plan Amendment authorizing this type of cost sharing.

EMERGENCY ROOM COST SHARING

In addition to other provisions that allow for cost sharing, DRA provides states the authority to impose cost sharing for Medicaid recipients for non-emergent visits to hospital emergency rooms (ER). Section 6043 of the DRA defines non-emergent services as "care or services furnished in an emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital". Research indicates that non-emergent conditions are those conditions that do not require treatment within 24 hours and could be most efficiently provided in alternative settings.

Historically, it was believed that individuals without health insurance were mostly to blame for extensive use of the ERs for non-emergent conditions. However, research done in different states showed that Medicaid recipients also commonly use ERs for treatment of non-emergent conditions. As stated in the Partnership for Medicaid, a report produced by various medical associations and academies, Medicaid recipients' visits to the ER represent 20 percent of all ER visits nationally, compared to 12 percent of all ER visits that were made by uninsured individuals. Furthermore, one-third of visits are for non-urgent health issues. According to a study published in Academic Emergency Medicine in 2003, Medicaid children received more non-emergent services than privately insured children, and about the same amount of services as uninsured children.

Texas is like the rest of the nation in this area. According to data from HHSC , there were approximately 600,000 visits to the ER because of non-emergent conditions among TANF and TANF-related Medicaid recipients between December 2002 and November 2003. These visits cost the state $115.9 million. If these services had been provided in alternative

settings, the Medicaid program could have reduced its costs by approximately $82 million All Funds. Even though it is believed that MCOs have better outcomes in reducing the number of visits to the ERs, data suggests that recipients receiving services under MCOs also had high utilization of the ERs for non-emergent conditions.

There are several reasons for high ER utilization in non-emergent situations. One primary issue is a lack of access to primary care providers, however, lack of knowledge about what constitutes a true emergency, and the convenience of getting all care in one place may contribute to the problem.

By law, hospitals cannot refuse care to anyone who comes to the ER. The federal Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to provide medical screening and treatment for individuals with emergent conditions, regardless of their ability to pay.

DRA does not relieve hospitals from providing appropriate medical screening, but gives them different options with regard to treating a patient with a non-emergent condition. Before providing non-emergent services, hospitals may require the patient to pay a portion of the costs based on cost sharing provisions set by the state's Medicaid program. In addition, the hospital staff must inform an individual about alternative non-emergency services providers where an individual can receive treatment without having to pay a portion of the costs. The law defines an alternative service provider as a physician's office, healthcare clinic, community health center, hospital outpatient department, community health center or similar healthcare provider that can provide an assessment and treatment of the medical condition.

DRA allows states to charge cost sharing amounts for individuals in different eligibility categories, and sets upper limits for allowable charges. **Figure 8** shows the Medicaid groups that could be subject to ER cost sharing for non-emergent services and the upper limit amounts that states can charge Medicaid recipients.

In the past, CMS has not allowed cost sharing requirements to be imposed on individuals with income below 100 percent of FPL. DRA appears to allow states to impose nominal cost sharing requirements on non-emergent ER visits from individuals with income below 100 percent of the FPL and who are exempt from other cost sharing provisions under DRA. **Figure 8** provides more information on these populations. The nominal amount could also be imposed on pregnant women and adults with income above 100 percent of FPL who are otherwise exempt from cost sharing requirements.

As of December 2006, CMS had not issued its guidance to the states regarding ER cost sharing requirements. Until the states receive this guidance, final interpretation of the cost sharing rules for non-emergent ER visits cannot be made.

DRA requires hospitals to identify alternative providers in the area and the availability of those providers. To meet this objective, hospitals would need to develop an inventory of available alternative providers and know their capacity and hours of operation. The state would also need to have this information prior to requiring cost sharing for non-emergent ER visits.

Texas Medicaid recipients use ERs for emergent and non-emergent conditions. **Figure 9** shows costs and number of visits for these two categories of ER visits.

In fiscal year 2004, there were 1.7 million visits to the ERs made by individuals in Primary Care Case Management (PCCM) and Fee-For-Service (FFS) models (excluding capitated managed care). HHSC estimated 786,291 (47 percent) of these visits were for non-emergent conditions and cost Medicaid $117.8 million. Assuming a co-payment of

FIGURE 8
DEFICIT REDUCTION ACT AND COST SHARING APPLICABILITY FOR NON-EMERGENT SERVICES AT THE EMERGENCY DEPARTMENTS, 2006

GROUPS	COST SHARING AMOUNT	LIMITS ON COST SHARING
Individuals who are exempt from cost sharing obligations under various DRA options (See **Figure 7** for description)	Cost sharing not to exceed a nominal amount (up to $3) as long as alternative provider does not require a cost sharing	Total amount of cost sharing cannot exceed five percent of the family's income. Cost sharing imposed for non-emergent services shall be instead of other cost sharing that maybe imposed for such services.
Families with income between 100 percent and 150 percent of the FPL	Cost sharing may not exceed two times the nominal amount – up to $6	
Families with income above 150 percent of FPL	There is no upper limit on charges	

Sources: Legislative Budget Board; Health and Human Services Commission.

FIGURE 9
EMERGENCY ROOM VISITS AND COSTS IN TEXAS, FISCAL YEAR 2004

ENROLLMENT GROUP	EMERGENT VISITS	COSTS OF EMERGENT VISITS	NON-EMERGENT VISITS	COSTS OF NON-EMERGENT VISITS	TOTAL VISITS	TOTAL COSTS
Children under age 21	444,188	$90,620,336	356,866	$51,772,442	801,054	$142,392,778
Adults age 21 and older	69,771	21,415,501	69,051	14,612,444	138,822	36,027,945
Pregnant women	47,774	13,303,045	45,690	9,000,896	93,464	22,303,942
Blind and disabled	203,488	44,243,709	203,778	33,670,629	407,266	77,914,338
Aged	116,278	9,487,231	101,887	7,845,554	218,165	17,332,785
Missing enrollment data	10,612	1,167,917	9,019	861,541	19,631	2,029,458
Total, All Funds	**892,111**	**$180,237,740**	**786,291**	**$117,763,507**	**1,678,402**	**$298,001,247**

Note: Fee-for-service and primary care case management programs.
Source: Health and Human Services Commission.

$3, HHSC could reduce its reimbursement to hospitals by $2.4 million in the event that Medicaid recipients would continue receiving treatment for non-emergent condition at at the ER.

Not all Medicaid recipients visit ER departments. According to HHSC data, about 26 percent of Medicaid recipients visited ER with emergent and non-emergent conditions in fiscal year 2004. **Figure 10** provides additional information about number of Medicaid recipients and corresponding visits to the ER departments.

In the absence of CMS guidance with regard to ER cost sharing for Medicaid recipients, HHSC started to assess the possibility of applying the DRA options to Texas and identified the following issues:

- The Texas Medicaid program would need to have adequate information about availability of the alternative provider networks in the state. Even though it will be the hospitals' responsibility to inform a Medicaid beneficiary about alternative locations, the state's Medicaid program needs to assess the availability of alternative providers prior to making changes related to cost sharing. Currently, there is limited information available regarding the number and characteristics of outpatient hospital clinics.
- Without guidance from the federal government, it is unclear how the state would reimburse hospitals for

FIGURE 10
ER VISITS BASED ON THE MEDICAID ENROLLMENT GROUPS FISCAL YEAR 2004

ENROLLMENT GROUP	ENROLLED RECIPIENTS	ENROLLED RECIPIENTS WITH ALL TYPES OF ER VISITS	PERCENTAGE OF RECIPIENTS WITH ER VISITS	AVERAGE NUMBER OF VISITS PER RECIPIENT WITH A HISTORY OF ER USE
Children under age 21	2,144,189	482,439	22.5%	1.7
Adults age 21 or older	263,442	68,233	25.9	2.0
Pregnant women	203,175	56,901	28.0	1.6
Blind and disabled	380,218	144,004	37.9	2.8
Aged	348,258	105,369	30.3	2.1
Missing enrollment data	0	24,914		0.8
Total	**3,339,282**	**881,860**	**26.4%**	**1.9**

Source: Health and Human Services Commission.

the initial screening, and what rates the state would pay alternative providers for the actual treatment. It is important to assess whether the reimbursement for providing services at two different locations is higher than the reimbursement to the hospital for all care that an individual would have received there.

- If the state decides to establish different levels of co-payments based on FPL as allowed by DRA, a decision will have to be made about how to inform providers about cost sharing amounts individuals are required to pay.
- There will be administrative costs associated with policy and system changes.

The state must address these issues if it plans to charge Medicaid recipients for non-emergent ER visits. As discussed previously, amounts generated by cost sharing obligations are not likely to be a significant fiscal relief for the Medicaid program but rather a method to change recipients' behavior.

Inappropriate use of ER is not a new issue; states have been assessing ways to address high costs for non-emergent ER visits. Before passage of the DRA, Idaho proposed cost sharing for individuals above 133 percent of FPL, and Washington has involved communities in addressing the problem.

Texas is also addressing this issue. As a result of the recommendations from the Legislative Budget Board's Staff Performance Report submitted to the Seventy-ninth Legislature, Regular Session, 2005, in the *Reduce the Need for Emergency Room Utilization in the Medicaid Program*, the Legislature included rider language in the 2006–07 General Appropriations Act requiring HHSC to conduct a Medicaid quality initiative pilot project that would address non-emergent use of ER. Senate Bill 1188, Seventy-ninth Legislature, Regular Session, 2005, also required HHSC to implement a comprehensive plan to reduce the use of hospital emergency rooms.

In response to these requirements, in January 2007, HHSC is launching a pilot program in McLennan County which will include approximately 100 Medicaid recipients. In addition to the required public awareness efforts aimed at educating Medicaid recipients about appropriate use of ER, the agency selected a case management program as a method to target recipients who use ER for non-emergent conditions. Since HHSC does not expect to complete the pilot until the fall of 2007, an evaluation of its results will not be available by February 15, 2007, as required by rider 55.

If this pilot determines that case management is an effective tool for changing Medicaid recipients' behavior with regard to ER use, Texas could consider this method as an alternative to assessing co-payments for ER.

DRA has also provided grant funds for the establishment of alternative non-emergency services providers in the amount of $50 million for the four-year period beginning in 2006. The law specifies that preference should be given to the states that establish or provide for alternative providers in rural or underserved areas where recipients have limited access to primary care services, and for providers that are in partnership with local community hospitals. Interested states will be required to submit an application in the form prescribed by CMS. This provision could be beneficial for Texas. According to the Health Resource and Services Administration, there are 342 designated medically underserved areas in Texas, which can be a county, or a portion of a county, in which residents have a shortage of personal health services. The state should explore an opportunity to address the shortage of the healthcare providers in these areas with the help of Federal Funds.

Without federal guidance, it is not clear what the application process would be and what role HHSC should have in identifying areas where access to non-emergency providers is limited.

USING STATE AND LOCAL FUNDS TO EXPAND HEALTHCARE COVERAGE

Most Texas hospitals provide health services free of charge (i.e., charity care) to individuals who meet certain financial criteria. Uncompensated care (including charity care and bad debt) provided by 498 non-state-owned hospitals in 2005 totaled approximately $4.3 billion. Some portion of this uncompensated care is spent on services provided to persons who could potentially be covered through a Medicaid expansion. A possible source of matching funds for a Medicaid expansion is local healthcare dollars, including county indigent healthcare funds, local tax dollars devoted to public hospitals, and hospital district tax revenue.

FACTS AND FINDINGS

- ♦ Of 498 non-state owned hospitals in Texas, 134 hospitals owned by city, county or hospital districts accounted for more than half ($1.5 billion) of charity care spending reported in 2005. Most of the charity care (90 percent) provided by local public hospitals was attributable to 6 hospital districts—Bexar, Dallas, El Paso, Harris, Tarrant, and Travis.
- ♦ Local public hospitals that account for a significant amount of uncompensated care spending, report that 88 percent of patients receiving some form of charity care were non-elderly adults.
- ♦ With certain exceptions, federal law allows states to use intergovernmental transfers and certified public expenditures to obtain allowable funds from public hospitals for use as the non-federal share for Medicaid services.
- ♦ States can access Federal Funds to expand health coverage in several ways, but the most appropriate vehicle in Texas, if using local funds, may be a Section 1115 Medicaid waiver.
- ♦ The most recent federal waivers approved by the Centers for Medicare and Medicaid Services permit the restructuring of Medicaid hospital financing systems. However, these states have negotiated conditions that Texas might want to avoid such as making funds contingent on meeting milestones related to reforming the Medicaid program or allowing Centers for Medicare and Medicaid Services approval for all sources of the non-federal share of Medicaid costs.

CONCERNS

- ♦ Texas might have matched local healthcare dollars with Medicaid Federal Funds if previous initiatives in Texas to to expand Medicaid coverage had been implemented.
- ♦ Prior to expanding coverage, the state would need to determine how much of the $1.5 billion in charity care provided by local hospitals could be used to leverage Federal Funds and expand Medicaid coverage.

RECOMMENDATION

- ♦ **Recommendation 1:** Amend the Task Force on Local Health Care Initiatives statute (Texas Government Code, Chapter 534) to extend through fiscal year 2011 those provisions authorizing demonstration projects financed by local entities that would implement Section 1115 Medicaid waivers to expand Medicaid eligibility to certain low-income families with children.

DISCUSSION

Medicaid is a joint federal-state partnership for providing medical care to low-income individuals. The federal government has always encouraged states to explore the flexibility provided by Section 1115 of the Social Security Act to implement demonstration projects. These demonstration projects are granted waivers to select federal requirements to experiment innovative strategies to support providing healthcare to low-income individuals. Most recently, four states have received approval for waivers that modify their hospital finance systems to create uncompensated care pools to either expand Medicaid coverage to uninsured adults or to pool sources of funding for the uninsured population. In light of these federal developments, Texas could potentially expand Medicaid coverage to uninsured parents of Medicaid children by using Local Funds as the non-federal share.

LOCAL PUBLIC INDIGENT HEALTH CARE DELIVERY SYSTEM

The Indigent Health Care and Treatment Act of 1985, Chapter 61 of the Texas Health and Safety Code, requires counties to offer a state-mandated set of basic healthcare services to indigent residents as the payor of last resort. Residents who have private insurance, Medicaid, or another form of health insurance are not eligible. The income

eligibility level is 21 percent of the federal poverty level (FPL) with certain restrictions on asset values. Counties can choose to serve this population through the creation of a hospital district, administration of a public hospital, or participation in a county indigent health care program (CIHCP). Currently, 114 counties operate only CIHCPs, and the remaining counties meet the state requirement through a hospital district, public hospital, or a hybrid of the three methods.

CIHCPs are funded with local tax money. Counties become eligible to apply for state assistance after they spend a set amount of their budget on approved indigent healthcare expenditures. Once a county spends 8 percent of its general revenue tax levy on approved services to individuals with income up to 50 percent of the FPL, the county can access State Assistance Funds through the Texas Department of State Health Services (DSHS). The state pays 90 percent of all costs (up to appropriated amounts) and the county pays 10 percent. State rules require that a county's maximum annual allocation be based on such factors as spending history, population, and the number of residents living below the FPL. In addition, the amount of funds that may be distributed to a single county is limited. For the 2004–05 biennium, the Texas Legislature ensured through an appropriations rider that no more than 35 percent of the appropriations be distributed to any single county. The limit was lowered to 20 percent for the 2006–07 biennium. The rider was also amended to have any unexpended funds returned to the state treasury instead of directing the funds to the Primary Health Care Program at DSHS.

In state fiscal year 2006, 14 counties received state funds, 95 counties reported indigent spending below the threshold, and 10 counties reported no expenditures on the indigent population.. DSHS made available $5.2 million in State Assistance Funds in state fiscal year 2006. A total of $4.1 million was distributed to qualifying counties. Two counties, Cameron County and Hidalgo County, received more than half of the available state matching funds distributed in state fiscal year 2006 (see **Figure 1**).

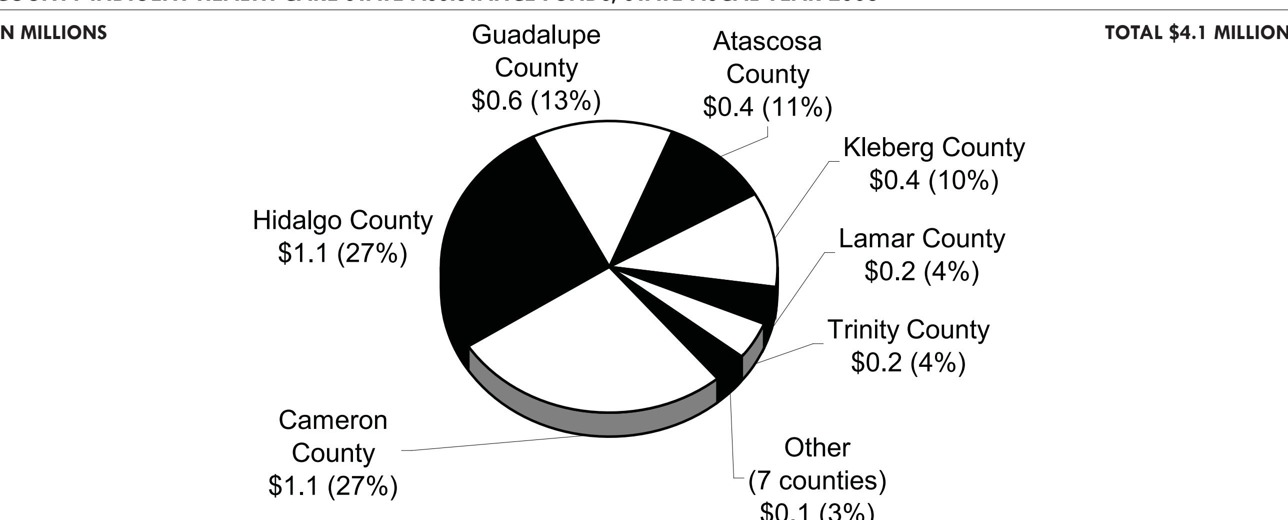
Counties reported spending about $60.0 million on healthcare provided to indigent residents during state fiscal year 2004 (basis for fiscal year 2006 distribution). **Figure 2** shows the amount of counties' indigent expenditures by dollar ranges for state fiscal year 2004 (the data used to allocate state matching funds in state fiscal year 2005). A significant number of counties (88) reported spending less than $0.5 million on indigent healthcare. These county expenditures are not being leveraged as state match for federal funds.

Hospital districts are special taxing districts created for providing healthcare to indigent people within the boundaries of the district. The hospital district has the authority to impose annual property taxes within its boundaries. Hospital district taxes account for about 25 percent of their operating revenue. The other three-quarters of revenue comes from out-of-pocket payers, private insurance, public insurance, and government programs.

Public hospitals are hospitals owned, operated, or leased by a county or municipality. Public hospital funding comes from

FIGURE 1
COUNTY INDIGENT HEALTH CARE STATE ASSISTANCE FUNDS, STATE FISCAL YEAR 2006

IN MILLIONS | TOTAL $4.1 MILLION



Source: Texas Department of State Health Services.

FIGURE 2
COUNTY INDIGENT HEALTH CARE SPENDING FOR STATE FISCAL YEAR 2004

SPENDING RANGE	SPENDING REPORTED	COUNTIES
$0	$0	10
Up to $100,000	1,791,082	42
$100,001 to $500,000	8,292,651	36
$500,001 to $1,000,000	10,789,972	15
$1,000,001 to $1,500,000	9,609,492	8
$1,500,001to $2,500,000	8,815,715	4
$2,500,001 to $3,000,000	2,922,178	1
$3,000,001 or greater	17,749,279	3
Total	**$59,970,368**	**119**

NOTE: Twenty-five counties included reported indigent spending for a year between 1998 and 2003.
SOURCE: Texas Department of State Health Services.

the same sources as hospital districts; however, local tax support is not always dedicated to indigent healthcare and may compete with other county or municipal needs.

In addition to local tax support, hospital districts, counties and municipalities owning and maintaining a public hospital and/or CIHCPs are designated to receive a portion of the tobacco settlement proceeds. These funds may be used by local governmental entities to offset dollars they have dedicated to indigent healthcare. Payments are based on the amount of unreimbursed healthcare expenditures the local entity reports to DSHS. Qualified entities received $450.0 million in a series of lump-sum payments from 1999 through 2001. Another approximately $1.8 billion was deposited in a Permanent Trust Account whereby entities receive earnings from investment of the trust. The income earned through investment of the Permanent Trust Account was distributed for the first time in April 2001, and is distributed in April of each succeeding year. The amount of the annual distribution depends on the size of the corpus during the preceding year and the income resulting from investment of the fund. The corpus of the fund remains in the Permanent Trust Account and only the earnings are distributed. In 2006, $72.1 million in earnings was distributed to qualified entities.

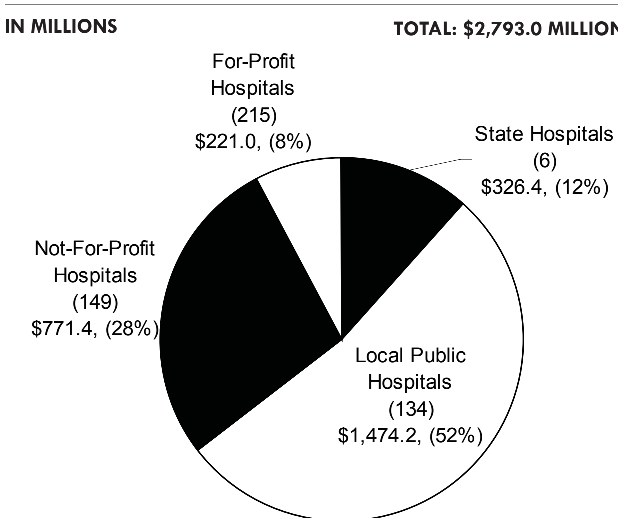
There are 23 states that use local revenue as the non-federal share to match federal funding for Medicaid programs and services. These states may require all or some counties to share in the cost of providing services for a variety of Medicaid services, from hospital inpatient services to case management services.

AMOUNT OF CHARITY CARE IN TEXAS

State law requires DSHS to collect aggregate financial, utilization, and other data from all licensed hospitals. Through the 2005 Annual Survey of Hospitals, 504 acute-care hospitals reported providing about $5.7 billion in charity care. Non-state owned hospitals provided $5.1 billion (90 percent of total charity care reported). Charity care refers to health services that are never expected to result in cash payments. State-owned hospitals reported providing $0.5 billion in charity care. A hospital's policy to provide healthcare services free of charge to individuals who meet certain financial criteria determines the extent of its charity care. Charity care charges are usually adjusted to reflect the difference between what hospitals commonly charge and what they receive in negotiated or discounted payments. When adjusted for the ratio of cost-to-charges, the amount of uncompensated care reported by non-state operated hospitals is reduced to about $2.5 billion (see **Figure 3**).

FIGURE 3
CHARITY CHARGES BY TYPE OF HOSPITAL FISCAL YEAR 2005

IN MILLIONS **TOTAL: $2,793.0 MILLION**



NOTE: Charity charges are adjusted by the ratio of cost-to-charges for each individual hospital. Local Public Hospitals include hospitals owned by cities, counties, hospital districts, hospital authorities and hospitals leased to not-for-profit organizations.
SOURCES: Legislative Budget Board; 2005 Annual Survey of Hospitals; Texas Department of State Health Services.

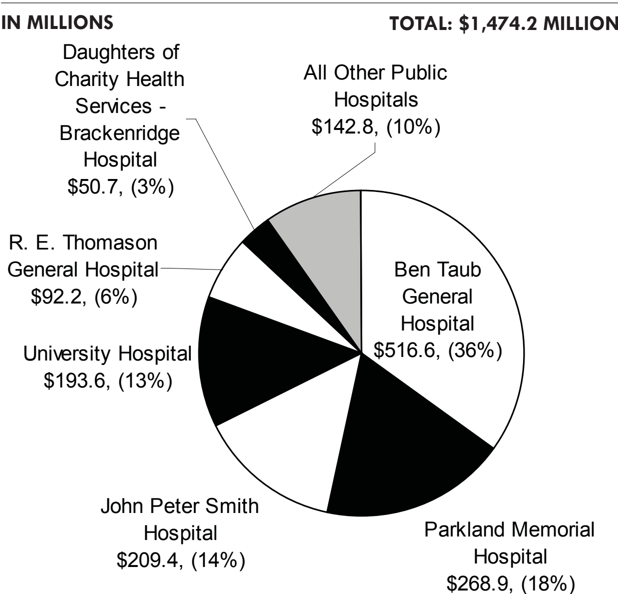
Out of the 504 reporting hospitals, 134 hospitals are owned by city, county, or hospital districts/authorities. There are also six state-owned acute care hospitals. The 134 local public hospitals reported $2.3 billion in charity care in fiscal year 2005, reduced to $1.5 billion when adjusted by the ratio of

cost-to-charges. **Figure 3** shows that local public hospitals, which represent about one quarter of the reporting hospitals, accounted for more than half of the total charity charges in fiscal year 2005.

Most of the $1.5 billion in charity care (90 percent) reported by local public hospitals is attributed to six hospital districts—Bexar, Dallas, El Paso, Harris, Tarrant, and Travis (see **Figure 4**).

FIGURE 4
CHARITY CARE REPORTED BY LOCAL PUBLIC HOSPITALS FISCAL YEAR 2005

IN MILLIONS **TOTAL: $1,474.2 MILLION**



NOTE: Charity charges are adjusted by the ratio of cost-to-charges for each individual hospital.
SOURCES: Legislative Budget Board; 2005 Annual Survey of Hospitals; Texas Department of State Health Services.

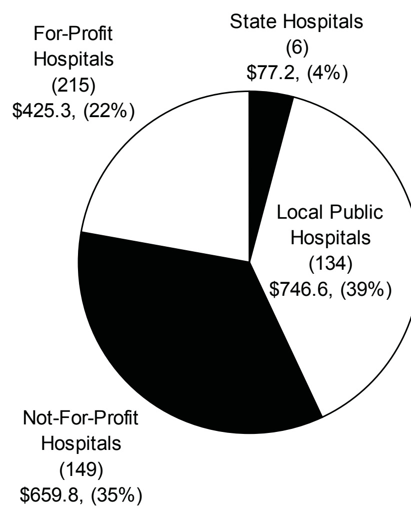
In addition to charity care, the 498 non-state operated hospitals reported nearly $4.4 billion in bad debt. When this amount is adjusted for the ratio of cost-to-charges, the figure is about $1.8 billion (see **Figure 5**). Bad debt charges are un-collectible hospital charges that result from the extension of credit. Therefore, total uncompensated care, which combines charity care and bad debt, for these hospitals was reported to be about $4.3 billion when adjusted for the ratio of cost-to-charges. Not-for-Profit and local public hospitals accounted for more than two-thirds of the bad debt reported.

RECIPIENTS OF CHARITY CARE IN TEXAS

Information on the recipients of charity care is not readily available. DSHS' annual hospital survey does not request demographic information from hospitals on charity care patients. However, to assess the population served and services delivered to charity care patients in 2005, data was collected from the six large hospital districts (Bexar, Dallas, El Paso, Harris, Tarrant, and Travis). Most charity programs provide healthcare services to indigent residents up to 200 percent level of the FPL at no cost, or require co-pays and/or premiums based on income levels. **Figures 6 and 7** show the average select characteristics in 2005 for four hospitals reporting the number of charity and self-pay patients. From demographic data collected from four of the six public hospitals that account for a significant amount of local charity care spending, it was determined that 88 percent of the patients receiving some form of charity care were nonelderly adults (between the ages of 19 and 64).

FIGURE 5
BAD DEBT CHARGES BY TYPE OF HOSPITALS FISCAL YEAR 2005

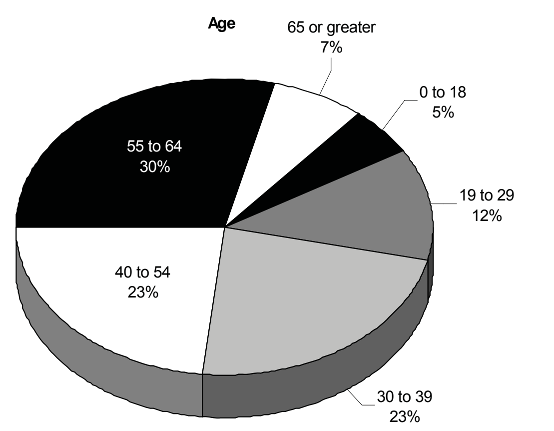
IN MILLIONS **TOTAL: $1,908.9 MILLION**



NOTE: Bad debt charges are adjusted by the ratio of cost-to-charges for each individual hospital. Local Public Hospitals include hospitals owned by cities, counties, hospital districts, hospital authorities and hospitals leased to not-for-profit organizations.
SOURCE: Legislative Budget Board; 2005 Annual Survey of Hospitals; Texas Department of State Health Services.

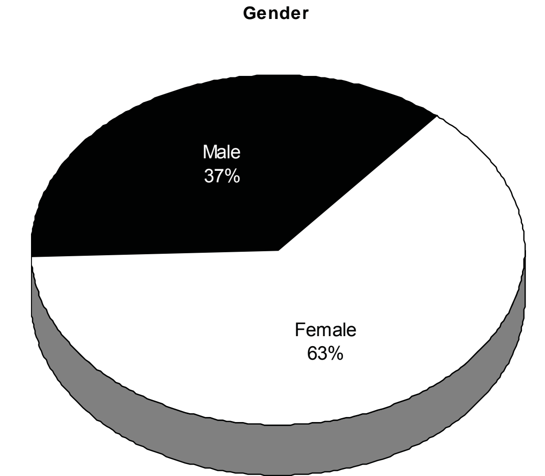
Two hospitals submitted demographic data based on encounters (i.e., inpatient, outpatient, and emergency visits). These two hospitals had a total of 2.9 million encounters in 2005. A significant amount of encounters (2.1 million or 72 percent) are attributed to patients who are between the ages of 19 and 64. During this same period, female patients made the majority of the encounters (2.0 million or 68 percent).

FIGURE 6
AGE DISTRIBUTION OF CHARITY CARE PATIENTS
FISCAL YEAR 2005



NOTE: Average of four public hospitals.
SOURCE: Legislative Budget Board.

FIGURE 7
GENDER DISTRIBUTION OF CHARITY CARE PATIENTS
FISCAL YEAR 2005



NOTE: Average of four public hospitals.
SOURCE: Legislative Budget Board.

Bexar County Hospital District: University Health System (which includes University Hospital, the public hospital for Bexar County) serves a portion of its indigent residents through a membership program. Bexar County residents who do not have health insurance and are not eligible for other programs such as Medicare, Medicaid or Children's Health Insurance Program (CHIP), have the opportunity to become members of University Health System's Care*Link*. Patients with income up to 75 percent of the FPL receive free care and those with income above 75 percent of the FPL pay a sliding scale premium based on income and family size. In 2005, the average number of enrollees in Care*Link* was 55,176. Although these members account for only 15 percent of the uninsured in Bexar County, this data may serve as indicators of who receives charity care. The enrollment in Care*Link* is capped due to budget constraints. Through Care*Link*, members have access to primary care and specialty care through a network of providers contracted with University Health System.

Dallas County Hospital District: Parkland Health and Hospital System (Parkland) provides healthcare to indigent and/or medically needy residents of Dallas County. Dallas County indigent patients with family income up to 200 percent of the FPL and no third-party health insurance coverage have access to several levels of patient care with an increasing schedule of co-payments and monthly payment requirements (HEALTHplus). For fiscal year 2005, 60,571 patients received care through Parkland HEALTHplus. Parkland's healthcare services to indigent patients are provided in various settings such as hospitals, Community Oriented Primary Care clinics, specialty care clinics and emergency rooms.

The uncompensated care provided by Parkland is not limited to the HEALTHplus program. Parkland also provides services to patients who are Dallas County residents and have income that exceeds the limit for tax-supported care, or income that cannot be determined. Uninsured patients that do not qualify for tax-supported care are classified as self-pay. Some may have limited financial resources available to pay for the services received.

El Paso County Hospital District: El Paso County Hospital District provides healthcare to indigent and uninsured county residents through its public hospital, R.E. Thomason Hospital, and primary care community care clinics (Thomason C.A.R.E.S.). More than 65 percent of patients served at Thomason Hospital are uninsured. Health care services are provided at no charge to indigent patients with incomes below 50 percent of the FPL, and patients with income up to 200 percent of the FPL contribute to some portion of their healthcare costs. During fiscal year 2005, 73,099 patients received charity care at Thomason Hospital.

Harris County Hospital District: Indigent residents of Harris County may access healthcare services through Harris County Hospital Districts' (HCHD) three public hospitals, Ben Taub Hospital, LBJ Hospital, and Quentin Mease Community Hospital. In addition, indigent residents have access to primary care services through its Community

Health Center Program. HCHD provides indigent patients financial assistance through its Gold Card program. Free healthcare services (minimal co-pays are required for prescription drugs) are provided to patients whose income falls below 100 percent of the FPL. Gold Card program participants whose incomes fall below 200 percent of the FPL must make co-pays for healthcare services.

Tarrant County Hospital District: Tarrant County indigent residents participate in a medical program, JPS Connection, to receive healthcare services. Indigent residents with income up to 200 percent of the FPL or medically indigent residents qualify for care at no charge or pay for co-pays based on household size and gross monthly income. These patients are served throughout the JPS Health Network, which includes John Peter Smith Hospital and a network of community-based health centers. The JPS Health network provided charity care to 45,359 patients in fiscal year 2005.

Travis County Hospital District: The Travis County Hospital District ensures access to healthcare services for indigent residents by contracting with Seton Healthcare Network, a non-profit health system. Seton Healthcare Network operates the only public hospital, Brackenridge Hospital, in Travis County. Patients with income levels up to 250 percent of the FPL participate in a managed care program (Seton Care Plus). Participants in Seton Care Plus program make minimal co-payments based on a sliding fee scale.

INTERGOVERNMENTAL TRANSFERS AS A FINACING MECHANISM

Matching Federal Funds for a Medicaid expansion could be financed through intergovernmental transfers (IGTs) to the state. IGTs involve fund exchanges between different levels of government institutions. States can obtain up to 60 percent of the state match for Medicaid from local sources other than state funds. Federal regulations clarify the conditions in which IGTs can be used to match Medicaid Federal Funds. Funds derived from IGTs must be appropriated directly to the state Medicaid agency, transferred from other public agencies to the state Medicaid agency, or be certified by the contributing unit of government as representing expenditures eligible for matching Medicaid federal funds. In addition, funds derived from IGTs may not be Federal Funds or Federal Funds authorized to match other Federal Funds.

Disproportionate Share Hospital Program: Both the state and the non-state Disproportionate Share Hospital programs use IGTs to supply the non-federal share of Medicaid funding. Appropriations made to state-owned hospitals are counted as match for the DSH program. These include The University of Texas Medical Branch (UTMB), The University of Texas M.D. Anderson Cancer Center, The University of Texas Health Center at Tyler (UTHSC-Tyler) and nine mental health facilities.

A second group of nine large-volume Medicaid public hospitals transfer Local Funds to draw down the remaining federal DSH funds. This group includes hospitals in nine counties: Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis. This is a voluntary arrangement, which is negotiated between the Health and Human Services Commission (HHSC) and these hospitals that make up the Texas Coalition of Transferring Hospitals. Although the state matching funds are provided by these local hospitals, about 165 local hospitals receive a DSH payment through this program. In state fiscal year 2005, the transferring hospitals received net payments totaling $182.1 million (see **Figure 8**).

Use of Upper Payment Limits: Another source of IGTs in the Texas Medicaid program is derived from public hospitals (including state-owned teaching hospitals). Federal Medicaid law offers states flexibility regarding reimbursement rates to healthcare providers. However, Medicaid payments can be no higher than the amount Medicare would pay for the same service (referred to as the upper payment limit, or UPL, for Medicaid). Texas uses upper payment limits as the basis for making supplemental payments to high-volume Medicaid providers. IGTs from public hospitals are used as match (rather than state expenditures) to make supplemental payments for both inpatient and outpatient care to various hospitals.

The first supplemental payments were made to non-state owned public hospitals in fiscal year 2002. According to HHSC, 11 non-state owned public hospitals will transfer $259.4 million and draw down an estimated $400 million in Federal Funds for fiscal year 2006. Rural, non-state-owned public hospitals receive similar supplemental payments. Although only 24 hospitals provide IGTs to draw Federal Funds, supplemental payments are distributed to an additional 94 rural, non-state-owned public rural hospitals throughout Texas. Additional supplemental payments made under federal UPL provisions are provided to select state-owned teaching hospitals, private hospitals, and physicians employed by public hospitals (see **Figure 9**). An estimated $2 billion in Federal Funds will be distributed in supplemental

FIGURE 8
DISPROPORTIONATE SHARE HOSPITAL PROGRAM (DSH)
STATE FISCAL YEAR 2005 (IN MILLIONS)

HOSPITAL	COUNTY	DSH TOTAL PAYMENT	INTERGOVERNMENTAL TRANSFER	NET PAYMENT
University Health System	Bexar	$58.9	$41.3	$17.6
Parkland Memorial Hospital	Dallas	139.3	96.9	42.4
Medical Center Hospital	Ector	14.2	4.7	9.5
R.E. Thomason General Hospital	El Paso	32.7	18.5	14.2
Ben Taub Hospital	Harris	150.0	97.5	52.5
University Medical Center	Lubbock	18.8	8.0	10.8
Christus Memorial Hospital	Nueces	30.3	20.4	9.9
John Peter Smith Hospital	Tarrant	47.0	32.7	14.3
Brackenridge Hospital	Travis	36.1	25.2	10.9
Total		**$527.3**	**$345.2**	**$182.1**

Source: Health and Human Services Commission.

FIGURE 9
OVERVIEW OF THE UPPER PAYMENT LIMIT PAYMENTS TO TEXAS

TYPE OF PROVIDERS	FEDERAL FUNDS 2006-07 BIENNIUM (IN MILLIONS)	SOURCE OF STATE SHARE	COMMENTS
Public – Urban Hospitals	$800.8	Intergovernmental Transfers	UPL payments are made to 11 hospitals.
Public – Rural Hospitals	91.2	Intergovernmental Transfers	UPL payments are made to 118 hospitals.
Public – State Teaching Hospitals	78.4	Intergovernmental Transfers	UPL payments are made to three teaching hospitals (The University of Texas Medical Branch at Galveston, MD Anderson, and The University of Texas Health Science Center at Tyler).
Private – High Volume Hospitals	38.8	General Revenue	The General Revenue for these UPL payments was only available for fiscal year 2005, but were made to hospitals in fiscal year 2006.
Private – Regional Hospitals	274.3	Intergovernmental Transfers	UPL payments are made to private hospitals located in Bexar, Montgomery, Webb, Hidalgo, Potter, Maverick, Travis, Randall, and Midland counties.
Private – Hospitals	402.0	Intergovernmental Transfers	UPL payments are made to Private hospitals statewide.
Children's Hospitals	38.7	General Revenue	Federal approval pending
Public – State Academic Health Systems Physicians	231.9	Intergovernmental Transfers	UPL payments are made to physicians employed by hospitals that are part of The University of Texas, Texas Tech University, and The University of North Texas Systems.
Public – Tarrant County Physicians	6.7	Intergovernmental Transfers	UPL payments are made to physicians employed by Tarrant County.
Total	**$1,962.1**		

Sources: Legislative Budget Board; Health and Human Services Commission.

payments to Medicaid providers during the 2006–07 biennium.

USE OF CERTIFIED PUBLIC EXPENDITURES

States have the option to use certified public expenditures (CPEs) to finance the non-federal share of Medicaid expansion. CPEs allows public agencies (including hospitals

that are owned or operated by public entities) to use expenditures as the source for the non-federal share to draw Medicaid Federal Funds. Unlike IGTs, CPEs do not include a transfer of funding to the state Medicaid agency. Instead, the federal government recognizes the public expenditure as an allowable Medicaid expenditure and provides the federal share. Texas' School Health and Related Services program (SHARS) relies on CPEs by local school districts to provide Medicaid payments to services provided to special education students. Local school districts participating in the SHARS program certified an estimated $13.6 million in allowable expenditures and received $20.5 million in Federal Funds for fiscal year 2005.

FEDERAL MEDICAID REFORMS

In the past few years, the Centers for Medicare and Medicaid Services (CMS) brought the use of IGTs to the attention of states. CMS termed IGTs that reduce the state share of Medicaid payments, while increasing the federal share of Medicaid costs "recycling of funds." The President's Budget for each of the fiscal years 2006 and 2007 included proposals by CMS to restrict the use of IGTs. CMS also proposed to limit the amount of Medicaid reimbursement to no more than the cost of providing services. Current federal law allows states to make Medicaid payments above actual costs. Although Congress has not passed legislation to implement these proposals, CMS entered into discussions with states to limit or eliminate their use of IGTs through an approval process for amending state Medicaid plans. CMS reported in June 2005, that 26 states had revised their Medicaid financing arrangements to address inappropriate use of IGTs. Texas was among the states with IGTs deemed appropriate. However, proposed state plan amendment modifying Medicaid institutional and physician reimbursement must now contain assurances by the state that providers will keep all payments and no payments are returned to the state.

ACCESSING FEDERAL FUNDS FOR A MEDICAID EXPANSION

States can access Federal Funds to expand Medicaid coverage through state plan amendments. Section 1931 of the Social Security Act allows states to expand Medicaid coverage to certain low-income individuals through a state plan amendment. Most states use the flexibility of Section 1931 to adjust income and resource standards and/or to use income and asset disregards in order to expand Medicaid eligibility to certain low-income families with children. Disregards refer to income or resources that are not included in determining eligibility (such as child support payments or the value of an automobile).

Waivers are another strategy for expanding health coverage. Section 1115 of the Social Security Act gives the federal government broad authority to waive statutory and regulatory provisions for Medicaid. Federal policy requires all Section 1115 waivers to be budget neutral to the federal government. Over the customary five-year waiver period, federal expenditures must not exceed what the federal government would have spent in the absence of the waiver.

Section 1115 Medicaid Waivers: States may use Section 1115 Medicaid waivers to expand Medicaid coverage to optional populations (e.g., low-income parents) and/or expansion populations (e.g., childless adults) who would otherwise not qualify for the program. States that use waivers to expand coverage must create offsetting savings or redirect existing Federal Funds to finance the expansion. Methods for achieving budget neutrality under traditional Section 1115 Medicaid waivers have included the use of managed care savings, redirecting federal DSH funds for the non-federal share, and/or limits on optional services. Some states have achieved budget neutrality by including the costs for a population the state could have hypothetically covered as a Medicaid optional group in the "without waiver" portion of the budget neutrality calculation.

Health Insurance Flexibility and Accountability Initiative: In 2001, the federal government released a new type of Section 1115 waiver known as the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative that gives states enhanced flexibility over their Medicaid programs. HIFA initiatives, which must be implemented statewide, are designed to expand health insurance to adults under 200 percent of the FPL and promote employer-sponsored insurance as a coverage vehicle. HIFA includes language that explicitly gives states the authority to make the following changes in their Medicaid program:

1. Impose enrollment limits on either an expenditure or enrollment basis;
2. Modify benefit packages offered to optional and expansion populations;
3. Impose greater cost-sharing limits on optional and expansion populations; and
4. Expand Medicaid to childless adults.

Similar to original Section 1115 waivers, HIFA initiatives that expand Medicaid coverage must demonstrate budget neutrality. In addition to reducing benefits and/or imposing cost sharing on existing optional populations, states may also use traditional methods to achieve budget neutrality, such as redirecting DSH funds.

HHSC develops waivers that CMS regional office reviews and forwards to the national CMS office in Baltimore for final approval. States may present a concept paper and get feedback from CMS before preparing and submitting a formal proposal for discussion and review. CMS usually develops terms and conditions which outline the operation of the proposed waiver. Each waiver is unique so there is no specified period in which CMS must approve or deny a waiver. However, CMS tries to follow a general guideline of 90 days, similar to the state plan amendment process, once the state submits a formal proposal.

EFFORTS TO EXPAND MEDICAID COVERAGE IN TEXAS

In 1997, the Seventy-fourth Legislature, Regular Session, required HHSC to restructure the Medicaid delivery system. The legislation that was enacted included provisions to use existing local resources and funds spent on charity care to draw federal Medicaid matching funds. The proposed system would have expanded Medicaid eligibility to the following groups:

- Parents of children with income up to 45 percent of the FPL
- Children age 6 and older with family income below 133 percent of the FPL
- Single adults without children with income up to 45 percent of the FPL
- Childless couples with family income up to 45 percent of the FPL.

Local funding entities would have been given the option to create a nonprofit entity called an intergovernmental initiative (IGI) to design and administer the healthcare delivery system in their geographic area (subject to state oversight and standards). System design would vary depending on the area served. The state would have been required to implement a healthcare delivery system in areas where the funding entities chose not to create an IGI. IGIs would be required, to the extent possible, to use managed care delivery systems.

Certain local public entities would have been required to make available the public funds spent on charity care in order for the state to draw down federal Medicaid matching funds for the expansion populations. Participating public entities would have included hospital districts, hospital authorities, city or county hospitals, state medical schools, the Baylor College of Medicine, the Baylor College of Dentistry, UT system teaching hospitals, government entities that provide funds to a public hospital for charity care, and Travis County. Counties operating the CIHCP would have been given the option of making resources available for matching. Local funding entities were guaranteed to receive an amount at least equal to the amount they made available for match for use in providing services under the new program. State and federal funding for current Medicaid eligibles included in the waiver would be included in the healthcare delivery system.

To finance the adult expansion and achieve federal budget neutrality, the proposed system would have redirected Federal Funds from DSH into regular Medicaid program funds. Budget neutrality would also have been achieved through anticipated savings from moving existing populations into managed care.

The HHSC was required to apply for a federal waiver to implement the provisions of the bill no later than August 31, 1995. HHSC submitted an 1115 Medicaid waiver to CMS (formerly the Health Care Financing Administration) on August 31, 1995, to implement SB 10. After reviewing the application, CMS formally submitted written questions to HHSC regarding the waiver. In November 1996, HHSC submitted an amendment that scaled back the waiver to focus only on expanded healthcare to children. Ultimately, CMS did not approve either waiver application. Provisions to restructure the delivery system expired September 1, 2001.

The federal government's primary concern about the waiver application was the proposal to mandate the enrollment of an expansion population in a particular region into a single local government-sponsored health plan. This provision was deemed necessary to ensure that the contributing entities retained control over the funds they raised through local taxation. Medicaid's regulations on freedom of choice of provider require that clients be allowed to go to any Medicaid healthcare provider who meets program standards. Although states can seek permission to waive this requirement, the federal government typically requires that waiver recipients have a choice of at least two health plans. During the negotiation process, the federal government insisted that Texas offer the expansion population a choice of at least two different plans. The issue was never formally resolved. Other

issues that were raised during the waiver development process include:

- Under the CIHCP, counties become eligible to apply for state assistance after they spend a set amount of their budget on approved indigent healthcare expenditures. State law prohibited Local Funds used as match for the Medicaid program to be included in the amount counties have to spend in order to obtain state assistance funds for their CIHCP. As a result, there was a disincentive for counties to contribute funds for Medicaid match.
- Hospital districts were reluctant to enter into agreements with HHSC because the hospitals would lose their DSH funds, leaving them vulnerable if there ultimately were insufficient funds to treat low-income patients. HHSC attempted to secure local funds from 10 large hospital districts to finance the expansion for fiscal year 1997. Only the Tarrant County Hospital District signed an agreement acceptable to HHSC.
- The same entities would have governed the IGIs, provided the matching funds, and competed for Medicaid contracts under the waiver. As a result, there were concerns related to whether use of IGIs, which are both providers of care and program administrators, would have created a conflict of interest situation.
- Questions were also raised regarding whether IGIs should have control over the entire Medicaid system in their geographic area or only the expansion populations they fund.

LOCAL INITIATIVES

Large public hospitals in three counties offered to finance the non-federal share of a coverage expansion to parents of Medicaid and/or CHIP children. These hospitals provided a combined $336.5 million in charity care in fiscal year 2005, representing 23 percent of the $1.5 billion in charity care provided by the 134 local public hospitals.

In September 2002, HHSC submitted three 1115 waiver concept papers to CMS for the three counties. **Figure 10** shows a summary of the three local initiative proposals. The three counties proposed to utilize CPEs to provide the state share to draw Medicaid payments for these new covered groups.

CMS asked initial clarifying questions and the three counties responded in coordination with HHSC. The questions and concerns CMS raised were related to freedom of choice of providers, budget neutrality, sources of local match, and certified public expenditures. The three counties proposed to achieve budget neutrality by comparing the Medicaid costs of the waiver (e.g. Medicaid coverage of Temporary Assistance for Needy Families program adults up from 17 percent to 100 percent of the FPL in the three counties) to the costs of providing Medicaid coverage to this group statewide.

According to HHSC, CMS provided guidance indicating that the three local counties should proceed with the submission of waivers. HHSC staff reported that these counties have not submitted a waiver to expand Medicaid coverage. HHSC will submit a waiver if a local county will commit resources to designing the expansion program that will demonstrate budget neutrality. According to HHSC staff, because these waivers are dependent on managed care

FIGURE 10
SUMMARY OF THREE LOCAL INITIATIVE WAIVER PROPOSALS

PROPOSAL	POPULATION	ENROLLEES	SERVICES
Austin/Travis County 1115	Parents of children on Medicaid with income from 17 to 100% of FPL.	Enrollment capped at 700 in year 1,800 in year 2,900 in year 3, 1,000 in year 4, and 1,100 in year 5.	Physician, hospital, outpatient, x-ray and lab, home health, emergency, prescription drugs, emergency transportation, durable medical equipment and, dental. Will not cover maternity or family planning services.
El Paso County Hospital District	Parents of children on Medicaid or CHIP children with income from 17 to 200% of FPL. Option to cover childless adults, in year 3 of demonstration.	Enrollment capped at 12,000 in each year.	Same acute care package as Medicaid. Will provide prescription drugs with formulary, but no limit on the number of prescriptions. Will not cover EPSDT, dentures, inpatient psychology or maternity services.
Bexar County Hospital District: University Health System	Parents of children on Medicaid with income from 17 to 100% of FPL.	Enrollment capped at 5,000 in year 5. Projected enrollment of 2,500 in year 1.	Similar acute care services as Medicaid. Will provide prescription drugs with formulary and certain diagnostic services not covered by Medicaid. Will not cover maternity services.

SOURCE: Legislative Budget Board.

savings to prove budget neutrality, the counties have to consider the negative impact of capitated rates on hospital UPL payments. Federal regulations prohibit UPL payments in managed care environments.

TASK FORCE ON LOCAL HEALTHCARE INITIATIVES

Legislation enacted by the Seventy-eighth Legislature in 2003, required HHSC to implement a Task Force on Local Health Care Initiatives. This legislation authorized the Task Force to jointly develop and implement with HHSC one or both of the following locally based demonstration projects:

- This legislation authorized the Task Force to jointly develop and implement with HHSC one or both of the following locally based demonstration projects:
- Healthcare coverage to uninsured low-income parents of children receiving Medicaid benefits, with income up to 100 percent of the FPL, and who are not covered by health insurance.
- Healthcare coverage to uninsured low-income working parents of children receiving Medicaid or CHIP benefits with income up to 200 percent of the FPL. Local entities would partner with employers to offer health benefits coverage to employees.

Both demonstration projects would require participation by local governments. Financing of the projects would be through revenue made available by participating local governmental entities and others to HHSC as match for the Medicaid program. The legislation requires HHSC, with assistance from the Task Force, to report to the Texas Legislature and the Governor about the progress of demonstration projects, as well as operation and cost-effectiveness. Reports must include:

- A detailed description of the affect, if any, on the number of uninsured individuals in the state;
- The amount of cost-savings generated by local governments;
- Information on the overall effectiveness and efficiency of the project, including the identification of any barriers to achieving efficient operation;
- A description of the project's impact on the small business community, including the employers participating in the project; and
- Identification of any issues that may have affected the determination for approval or disapproval of the demonstration projects.

HHSC was required to select representatives from the stakeholder communities and healthcare industry to make up the Task Force. Currently, the Task Force includes representatives from urban local government (7), rural local government (3), health care providers (2), physicians (2), small business (1), and the public (1).

The Task Force held a total of seven meetings since June 2003. In February 2005, a status report on the Task Force's activities was provided to the Executive Commissioner of HHSC. The Task Force worked on addressing the demonstration projects' eligibility criteria, benefit package, delivery structure, and financing issues and determined that demonstration projects should have the option to pursue covering both populations. Also, the benefit package for parents of Medicaid children with income below 100 percent of the FPL should focus on preventive/primary care services and catastrophic services, such as the following:

- Primary care with a required primary care provider (PCP);
- Limited specialty care with a PCP referral;
- A closed prescription drug formulary with mandatory generics;
- Basic radiology and lab services;
- Limited inpatient and outpatient behavioral health services; and
- Variable co-pays from $2 to $10 based on income and $100 deductible for inpatient behavioral health services.

Parents of Medicaid and CHIP children whose income is up to 200 percent of the FPL would receive the same benefits as above, but with a higher deductible for inpatient behavioral health services, limited inpatient hospital services, and catastrophic coverage for healthcare costs above a certain dollar threshold. The Task Force explained that a Medicaid Section 1115 waiver would be the appropriate method to expand coverage to these parents. The status report describes the Task Force's concerns related to demonstrating budget neutrality to the federal government. Before developing a waiver for the demonstration projects, the Task Force decided to wait to learn CMS' decision on the budget neutrality of the three local initiatives mentioned in the previous section.

A formal recommendation by the Task Force to HHSC was included in the status report. The three local waiver applications to expand Medicaid coverage should be supported by HHSC, the Governor, and the Legislature and be submitted to CMS. The Task Force concluded that CMS' response to the local waiver applications would assist them in developing either or both of the demonstration projects. The provisions authorizing the demonstration projects will expire September 1, 2009. Recommendation 1 would amend the Task Force on Local Health Care Initiatives statute (Texas Government Code, Chapter 534) to extend through fiscal year 2011 those provisions authorizing demonstration projects financed by local entities that would implement Section 1115 Medicaid waivers to expand Medicaid eligibility to certain low-income families with children.

OTHER STATES' EFFORTS TO EXPAND MEDICAID COVERAGE

In the past, states have primarily funded Medicaid expansions by relying on managed care savings or unspent DSH funds. An additional number of states have expanded Medicaid coverage to parents of Medicaid and CHIP children by using their CHIP allotment and/or re-allotment funds. A waiver has not been submitted to CMS that would only propose to expand Medicaid coverage to parents of Medicaid/CHIP children and/or childless adults with unmatched Local Funds. However, four states (California, Florida, Iowa, and Massachusetts) received approval in 2005 from CMS to restructure hospital financing. Florida, California, and Massachusetts submitted waivers in response to CMS' opposition to current financing mechanisms that it considers as improper or recycling. According to a study by the National Association of Public Hospitals and Health Systems, CMS used the opportunity to restrict certain state financing practices by undertaking individualized reviews and engaged in state-by-state negotiations to resolve issues. Although Florida was not utilizing IGTs that were considered improper, the state sought to modify its hospital financing structure to protect UPL payments to hospitals under a proposed managed care system. Although these four waivers do not represent an increase in funding for healthcare services, the negotiations involving hospital financing may be relevant to Texas.

In the past year, Iowa submitted a Section 1115 waiver to implement the IowaCare program, which included Medicaid coverage to expansion populations funded with CPEs. IowaCare is a five-year demonstration project, authorized through an 1115 Medicaid waiver, and approved by CMS in July 2005. State and county revenue expenditures serve as match. IowaCare expanded Medicaid coverage to the uninsured population (adults and parents of Medicaid and CHIP children) and includes the following components:

- The expansion group includes persons between the ages of 19 and 64 with incomes up to 200 percent of the FPL and women with income up to 300 percent of the FPL who may be eligible for obstetrical and newborn care. Enrollment may be capped. The expansion group receives a limited Medicaid benefit package.
- Enrolled persons pay monthly premiums based on their income level. A person's premium may be reduced based upon the member's increased wellness activities such as smoking cessation or compliance with the personal health improvement plan. The expansion population will pay the same co-payments required of other adults in the Medicaid program.
- The benefit package is limited to inpatient hospital care, outpatient hospital care, physician office visits, care by advanced registered nurse practitioners, dental care, pharmacy benefits, medical equipment and supplies, and transportation services to the extent they are covered in Iowa's Medicaid state plan. The provider network serving the expansion population includes government-operated acute care teaching hospitals and the University of Iowa hospitals and clinics.
- The DSH program that provided payments to the University of Iowa hospitals and clinics and generated revenue to the state will be eliminated, and a new DSH program will be developed to allocate payments to cover a portion of the cost of new enrollees.

The waiver program met "federal budget neutrality guidelines" in several ways: (1) limiting the expansion population to an expenditure cap with an annual growth rate of 7 percent; and (2) eliminating IGTs; and (3) refraining from the implementation of any new provider taxes for the duration of the waiver. IowaCare has not been fully implemented, so evaluation of the expansion program is not available.

Florida, California, and Massachusetts waivers create safety net care pools (SNCPs) or low-income pools (LIPs) to replace existing methods for providing financial support to hospitals. Unique to the other states, Florida was able to negotiate with CMS to include supplemental UPL payments into the calculations of its LIP cap. Florida's LIP will have an annual allotment of $1.0 billion in state and federal expenditures for

healthcare services provided to the uninsured. **Figure 11** shows a comparison of the four waivers discussed above.

USING LOCAL FUNDS TO EXPAND MEDICAID COVERAGE TO LOW-INCOME FAMILIES WITH CHILDREN

A significant amount of unmatched local public dollars is spent on populations that could potentially be covered through a Medicaid expansion. With certain exceptions, federal law allows states to use certified public expenditures and intergovernmental transfers to obtain allowable public funds for use as state match in the Medicaid program. Texas could apply for a Section 1115 Medicaid waiver to expand Medicaid coverage to certain low-income families with children financed with Local Funds.

Recommendation 1 would amend the Task Force on Local Health Care Initiatives statute (Texas Government Code, Chapter 534) to extend through fiscal year 2011 those provisions authorizing demonstration projects financed by local entities that would implement Section 1115 Medicaid waivers to expand Medicaid eligibility to certain low-income families with children.. The recommendation is for Texas to apply for a traditional Section 1115 waiver, not a Section 1115 HIFA waiver. HIFA waivers must be implemented statewide and geographic implementation would depend on which public hospitals transfer Local Funds for use as state match for Medicaid. Also, the proposed expansion is limited to certain low-income families with children. An expansion to childless adults would potentially require modifications to benefit packages and/or cost-sharing limits more easily obtained under a Section 1115 HIFA waiver to achieve budget neutrality.

FIGURE 11
OVERVIEW OF MEDICAID WAIVERS RESTRUCTURING HOSPITAL FINANCING

	CALIFORNIA	FLORIDA	IOWA	MASSACHUSETTS
Summary of Major Waiver Actions	Revises financing for Medicaid hospital care costs; extends selective hospital contracting program; revises state DSH program; establishes a level-funded Safety Net Care Pool (SNCP); phases out some existing IGTs and allows use of CPEs as non-federal share; prohibits any new hospital, outpatient, or physician taxes during term of demonstration.	Converts Medicaid from defined benefit to defined contribution program; creates a Low-Income Pool (LIP); terminates supplemental inpatient hospital payment program (UPL).	Extends limited coverage to various population of low-income adults ages 19 to 64, low-income pregnant women, and seriously emotionally disturbed children; restricts expansion population to receive services from only two major public hospital provider systems; eliminates certain Medicaid payments for inpatient UPL, supplemental DSH, GME, nursing facilities UPL, and physicians; limits hospital and nursing facility reimbursement to costs.	Extends coverage to various populations of low-income adults ages 19 to 64 for an additional three years; converts DSH allotment and certain supplemental payments into a level funded Safety Net Care Pool (SNCP); and phases out all existing IGTs and allows use of CPEs as non-federal share.
Uncompensated Care Pool Conditions	Makes a portion of the SNCP subject to the state's meeting of certain milestones related to transitioning elderly and disabled beneficiaries into Medicaid managed care, and another portion designated to develop initiatives to serve uninsured. Permits CPEs to be used for the non-federal share in order to access SNCP funds. Requires that CMS approve any alternate sources.	Makes a portion of its LIP contingent on meeting milestones related to evaluation and improvement of the state's Medicaid reform and serving the uninsured. Requires that CMS approve the non-federal share of LIP funds.	No SNCP or LIP. Redirects DSH and UPL payments to expand coverage to uninsured adults. Requires that all sources of the non-federal share of funding and the distribution of these funds be approved by CMS.	Requires that the state may only access federal funds in the SNCP if the source of the state share of funds has received prior approval from CMS.

Sources: Legislative Budget Board; California Healthcare Foundation.

Hospitals owned by units of local government spend approximately $1.5 billion annually in charity care when adjusted by the ratio of cost-to-charges. Some portion of these funds may already be used to draw down federal DSH funds and UPL hospital supplemental payments. HHSC would need to determine how much of this $1.5 billion could potentially be used to leverage Federal Funds and expand Medicaid coverage. Another option would be to have these hospitals certify the non-federal share to draw Medicaid funds for services provided to the expansion group.

Under a waiver, the state may be able to limit the expansion to areas of the state that contribute funds, cap enrollment on either an expenditure or enrollment basis as budget changes necessitate, and limit freedom of choice of providers. To achieve federal budget neutrality the state could compare waiver costs with what would have been incurred if this optional population (i.e., low-income families with children) were covered under the traditional Medicaid program. The U.S. Department of Health and Human Services allowed states to include in their baseline (i.e., costs without the waiver), the costs associated with covering optional populations that could have been covered by the state prior to the waiver, but never were. The state would have to maintain expenditures within a growth rate agreed upon at the outset of the waiver or be fully at risk if expenditures grow beyond the agreed upon rate.

The state and federal government would need to address the following issues during waiver development:

- Limited freedom of choice: The federal government may have a concern with proposals that limit enrollment options. Section 1115 Medicaid waivers allow the state to waive the freedom of choice provision that permits clients to go to any Medicaid healthcare provider who meets program standards. When waiving the freedom of choice provision, the federal government typically still requires that recipients be offered a choice of at least two health plans. The state may not be able to design a program that ensures local entities retain control over the funds they contribute without mandating enrollment in a particular region into a single health plan. Recently, however, CMS approved at least one Section 1115 waiver that permits mandatory enrollment into a single plan (i.e., Iowa).

- Variability in coverage levels and benefits: Another issue of concern to the federal government is coverage levels and benefit packages that vary from one locality to another. The state may need to develop common eligibility and benefit packages or at least require minimum coverage levels and benefits.

FISCAL IMPACT OF THE RECOMMENDATION

There is no significant fiscal impact from Recommendation 1. It is assumed that HHSC would be able to prepare and submit waivers using presently available resources, including local hospital resources. The introduced 2008–09 General Appropriations Bill does not address this recommendation.

MAXIMIZE FEDERAL MEDICAID REIMBURSEMENT FOR TEXAS HOSPITALS

Inpatient hospital payments made under the Medicaid program in Texas totaled an estimated $3.5 billion in state and federal funds in fiscal year 2005. Hospitals in Texas received Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments that totaled about $1.4 billion in Federal Funds for fiscal year 2005. The amount of intergovernmental transfers from public non-state-owned hospitals increased from $494.5 million in fiscal year 2002 to an estimated $1.0 billion in fiscal year 2007. Select state-owned teaching hospitals also now provide intergovernmental transfers to draw down UPL supplemental payments. Outside the Medicaid program, an additional $46.0 million in Federal Funds was provided to Texas hospitals to cover costs of emergency services to undocumented immigrants. A total of $45.9 million (General Revenue–Dedicated Funds) was distributed to eligible hospitals from the Designated Trauma Facility and Emergency Medical Services Account in fiscal year 2005.

The expansion of managed care throughout the state and any changes to hospital Medicaid reimbursement resulting from a legislatively mandated workgroup will affect these funding streams. The federal government permits each state to develop its own hospital reimbursement methodology, subject to federal approval. The following review examines recent changes to Medicaid hospital reimbursement and proposes strategies to draw approximately $79.4 million in additional Medicaid reimbursement for state-owned hospitals.

CONCERNS

- The federal provision that allowed states through the Disproportionate Share Hospital program the option to claim up to 175 percent of each qualifying state-owned public hospital's cost of uncompensated care was limited to only state fiscal years 2004 and 2005.
- The Texas Department of State Health Services' Texas Center for Infectious Disease did not meet the required Medicaid utilization rate in state fiscal years 2003 and 2004 resulting in the loss of $21 million in federal Disproportionate Share Hospital funds for state-owned hospitals in state fiscal years 2004 and 2005.
- Texas is not drawing potential Federal Disproportionate Share Hospital funds for The University of Texas Southwestern Medical Center's newly acquired hospitals.

RECOMMENDATIONS

- **Recommendation 1:** Petition the U.S. Congress to extend the federal provision that allows California to claim up to 175 percent of each public hospital's cost of uncompensated care to all states to generate additional Disproportionate Share Hospital funds for state-owned hospitals.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill that directs the Texas Health and Human Services Commission to analyze strategies for improving Medicaid reimbursement at the Texas Center for Infectious Disease and to explore including The University of Texas Southwestern Medical Center's recently acquired hospitals in the Disproportionate Share Hospital program.

DISCUSSION

Medicaid is a joint federal-state partnership for providing medical care to cash assistance recipients (Temporary Assistance for Needy Families), children, pregnant women, the elderly, and disabled persons. Inpatient hospital services are mandated Medicaid benefits (i.e., must be provided to all Medicaid-eligible clients). There are 448 general, acute care and rehabilitation hospitals, 9 children's hospitals, 29 non-state-owned psychiatric hospitals and 10 state-owned hospitals participating in the Texas Medicaid program. On average, there are about 700,000 admissions of Medicaid patients to these hospitals every year in Texas. Medicaid reimbursement for inpatient services is limited to $200,000 per client, per year (except for children).

PAYMENT METHODOLOGY FOR HOSPITALS

Since 1987, Texas has reimbursed general, acute care hospitals for inpatient hospital services provided to clients not served through managed care through a prospective payment system. A prospective payment system bases payments for inpatient services on a patient's diagnosis before the provision of services. Calculating a hospital payment involves three elements: (1) the Diagnosis Related Group (DRG), (2) the DRG relative weight, and (3) the standard dollar amount

(SDA). The product of the appropriate DRG relative weight and the SDA for the hospital is the method used to calculate the hospital's payment. **Figure 1** shows how Medicaid payments are calculated for the different types of hospitals.

Before fiscal year 2007, psychiatric hospitals that participated in the LoneSTAR II Selective Contracting program were reimbursed on a per diem basis. The LoneSTAR Select II program allowed Health and Human Services Commission (HHSC) to selectively contract with mental health facilities to provide non-emergency inpatient psychiatric services for Medicaid recipients under age 21. The LoneSTAR II program was authorized under a Medicaid 1915(b) waiver and has since expired.

OUTPATIENT HOSPITAL REIMBURSEMENT

Outpatient hospital services covered for Medicaid recipients (about 4 million encounters per year at approximately 500 provider locations) consist of diagnostic, therapeutic, or rehabilitative services delivered in a licensed hospital setting. Rates for outpatient hospital reimbursement for providers operating outside of managed care are determined by using the Tax Equity and Fiscal Responsibility Act (TEFRA) reimbursement process. An interim payment rate is used, subject to cost settlement at year's-end. The final rate is 80.3 percent of allowable costs. Outpatient hospital rates for high-volume Medicaid hospitals are paid 84.5 percent of cost.

OUTLIER PAYMENT PERCENTAGE

Medicaid limits coverage to 30 days of hospital care per spell of illness, excluding clients under the age of 21. Outlier payments are made to hospitals for inpatient services that are exceptionally high cost or exceptionally long lengths of stay for patients less than 21 years of age. According to the Centers for Medicare and Medicaid Services, outlier payments to Texas hospitals for inpatient services totaled $310.5 million between fiscal years 2000 and 2003. A hospital's claim must meet specific criteria to be eligible for a day and/or a cost outlier payment. In the case of a high cost and long length of stay for a patient less than 21 years old, only the outlier resulting in the higher payment is made to the hospital. In fiscal year 2002, HHSC reduced the outlier payment percentage from 75 percent to 70 percent. HHSC generated a savings of $6.1 million in General Revenue Funds for fiscal years 2002 and 2003 by implementing this cost-containment initiative.

USE OF SELECTIVE CONTRACTING

Selective contracting may also affect a general, acute care hospital's payments. Medicaid offers states the option to develop a competitive contracting system for inpatient hospital services provided to Medicaid recipients (except for clients eligible for both Medicaid and Medicare). The Seventy-third Legislature, Regular Session, 1993, established a program to competitively bid for Medicaid acute inpatient hospital services in response to rising Medicaid expenditures. Texas' Medicaid initiative, LoneSTAR Select I, allowed HHSC to selectively contract with hospitals for nonemergency

FIGURE 1
MEDICAID PAYMENT METHODOLOGY FOR HOSPITAL INPATIENT SERVICES

HOSPITALS	REIMBURSEMENT SYSTEM	METHODOLOGY
General, Acute Care Hospitals	Prospective Payment System	The product of the DRG relative weight and the SDA for the hospital is used to calculate the hospital's payment. DRG relative weight = Average dollars paid per case within a DRG ÷ Average dollars for all cases. SDA= Standardized average cost per Medicaid inpatient day multiplied by inflation factor (includes a measure of severity of patients and the strain on hospital resources).
Children's Hospitals Small Hospitals Rural Hospitals	Retrospective Cost-based Reimbursement System (Tax Equity and Fiscal Responsibility Act)	An interim rate payment for Medicaid inpatient services is made to hospital based on the historical relationship of costs compared to charges. At the end of a reporting cycle, an audit of costs is completed and its determined if additional reimbursements or recoupments will occur.
Psychiatric Hospitals	Hospital Specific per Diem	Per diem is calculated based on hospital's total Medicaid cost, total Medicaid days, and their allocated Medicaid portion of physician expenses.

NOTE: Small hospitals and certain rural hospitals are reimbursed using DRG payments or the Tax Equity and Fiscal Responsibility Act process, whichever is higher.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

inpatient services for Medicaid recipients. Under LoneSTAR Select I programs, providers in urban areas bid a percentage discount from their normal Medicaid reimbursement rates. HHSC either accepted or negotiated the bids. A participating hospital had its payments reduced by the bid amount.

A Medicaid 1915(b) waiver for Texas authorized LoneSTAR I program in Texas from 1994 to 2002. The program was implemented only in urban areas, and nearly 200 hospitals and 6 children's hospitals participated. In fiscal year 1995, $58 million in General Revenue Funds was saved through selective contracting. Savings from selective contracting decreased every year since implementation, primarily due to smaller discounts negotiated through the years. For example, the percentage discounts obtained by HHSC in the third round of selective contracting ranged from no discount to 10 percent. The majority of discounts (63 percent) were less than 2 percent. The following reasons for such low discounts were mentioned in an independent evaluation by the Lewin Group of the LoneSTAR Select I program report from May 2002:

- In the first and second rounds of selective contracting final bids were made public, allowing hospital providers to learn what discounts their competition negotiated; and
- Hospital providers may not have provided higher discounts because they may have believed other measures would be taken to further reduce reimbursement.

HHSC chose not to renew the Medicaid 1915(b) waiver after determining that no savings were realized under the LoneSTAR Select I and II programs.

FEDERAL DISPROPORTIONATE SHARE HOSPITAL PROGRAM

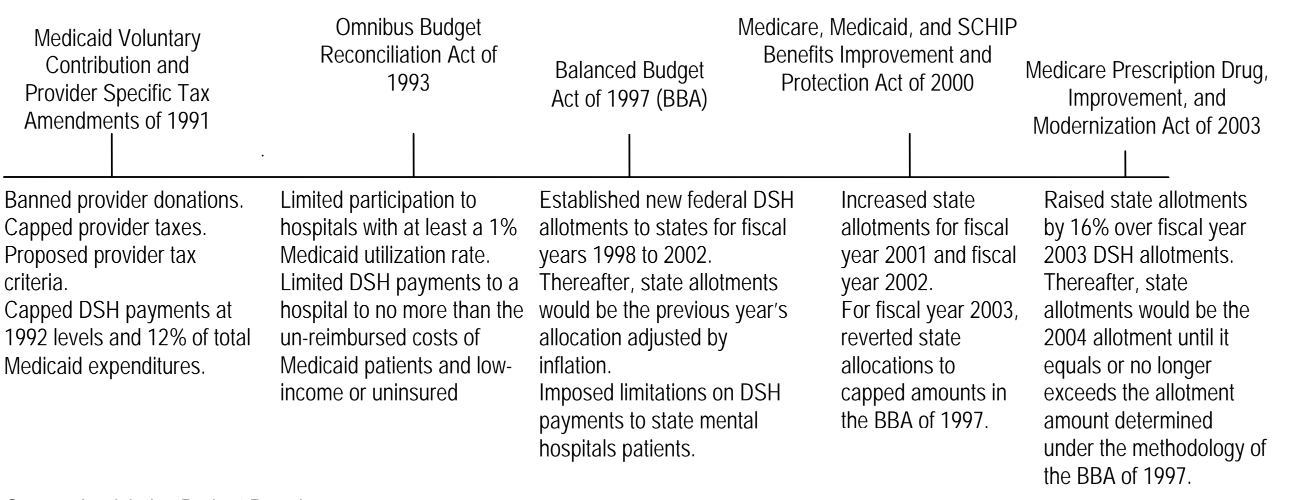
The Omnibus Budget Reconciliation Act of 1981 created the Disproportionate Share Hospital Program (DSH) to provide special Medicaid payments for hospitals that serve large numbers of Medicaid and uninsured patients. Hospitals receive DSH payments to offset the costs not covered by payments from Medicaid, third-party reimbursement, and patient revenue collections. States began in 1985 to expand their DSH programs by generating state matching funds through special, narrowly targeted provider taxes and/or donations. DSH payments grew nationally from $400 million in fiscal year 1988 to $17.5 billion in 1992. Texas' DSH program grew from $4.6 million to $1.4 billion in fiscal year 1992. This increase was attributed to the additional matching funds provided by large hospital districts, state-owned teaching hospitals, and state-owned psychiatric hospitals.

The federal government took notice of states' increasing levels of DSH funding and enacted several laws to curtail DSH spending. Beginning with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, state DSH payments were capped and could not exceed 12 percent of the state's total Medicaid costs. The Omnibus Budget Reconciliation Act of 1993 (OBRA) addressed concerns that some states were making DSH payments to hospitals that were not large Medicaid providers, while other states were making payments to hospitals in excess of their financial losses for providing care to Medicaid and uninsured populations. **Figure 2** shows the mandated criteria included in OBRA that hospitals must meet to receive DSH payments.

Congress later established new federal DSH fund allotments to states through the Balanced Budget Act of 1997 (BBA). For Texas, the cap was set at $806 million for federal fiscal year 2000, and then reduced to $765 million for the next two years. Beginning in fiscal year 2003, a state's total allotment could grow based on the percentage change in the Consumer Price Index (CPI) for the previous year. However, Congress provided some DSH fiscal relief to states by enacting the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) that temporarily increased DSH caps for states for fiscal years 2001 and 2002. In fiscal year 2003, Texas received a base amount of $765 million adjusted by the percent change in the CPI.

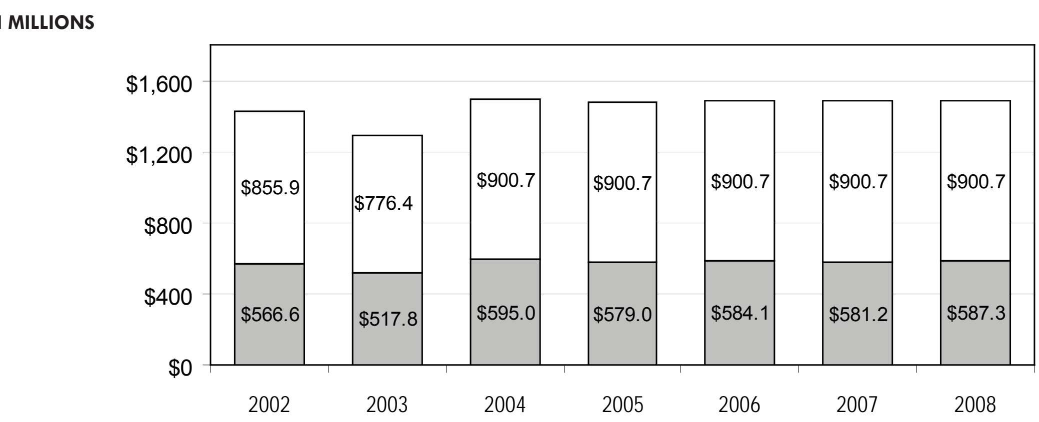
With the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress made changes to states' DSH allocations. Each state received a 16 percent increase over its fiscal year 2003 DSH allotment. Thereafter, each state continues to receive its fiscal year 2004 allotment until it equals or no longer exceeds the allotment amount determined under the methodology of the BBA of 1997. **Figure 3** shows that Texas' allocation of Federal Funds increased from $776.4 million in fiscal year 2003 to an estimated amount of $900.7 million in fiscal year 2004 (a gain of $124.2 million). This annual allocation continues through fiscal year 2010; beginning in fiscal year 2011 this amount may be adjusted by inflation. State allotments are still subject to the 12 percent cap.

FIGURE 2
MAJOR FEDERAL LEGISLATION IMPACTING DISPROPORTIONATE SHARE HOSPITAL PAYMENTS



SOURCE: Legislative Budget Board.

FIGURE 3
TEXAS DISPROPORTIONATE SHARE HOSPITAL FUNDING, FEDERAL FISCAL YEARS 2002 TO 2008



NOTE: Fiscal years 2007 and 2008 are estimates.
SOURCE: Legislative Budget Board.

TEXAS' DSH PROGRAM

DSH payments are funded using the same matching rate as medical services (60.66 percent Federal Funds, 39.34 percent state funds in federal fiscal year 2006). Both the state-owned and non-state DSH hospitals use intergovernmental transfers (IGTs) to supply the non-federal share of Medicaid funding. IGTs involve fund exchanges between different levels of government institutions. Appropriations made to state-owned hospitals are counted as match for the DSH Program. These include The University of Texas Medical Branch, The University of Texas M.D. Anderson Cancer Center, and The University of Texas Health Center at Tyler (UTHSC-Tyler), and nine state-owned or funded mental health facilities. Before fiscal year 2004, the Texas Center for Infectious Disease and The University of Texas Harris County Psychiatric Center participated. A second group of nine large-volume Medicaid public hospitals transfers Local Funds to draw down the remaining DSH Federal Funds. This coalition of hospitals, consisting of nine hospital districts, includes Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis. This is a voluntary arrangement, which HHSC negotiates with these hospitals. Although these local hospitals

put up the matching funds, about 174 local hospitals receive a DSH payment through this program.

To be considered for a DSH payment, hospitals must meet federal and state qualification criteria. Texas state policy defines nine minimum requirements for a hospital to apply for DSH hospital status (does not apply to state-owned teaching hospitals). Meeting these nine requirements alone does not guarantee a DSH payment, but it sets out the conditions of participation. For example, one condition of participation is that hospitals must develop an assessment of community healthcare needs. In addition, there are both federal and state qualifying formulas that will determine whether a hospital will actually receive a DSH payment. States must also follow federal payment limits for DSH hospitals. Specifically, no DSH hospital can receive a DSH payment that exceeds its individual DSH payment limit. The DSH hospital payment limit is calculated by adding the sum of a hospital's Medicaid shortfall (the difference between the cost of Medicaid inpatient and outpatient services and the hospital's non-DSH Medicaid payments) to its costs of services to uninsured patients (adjusted for inflation). In Texas, a hospital's Medicaid shortfall is determined each year by its two-year prior cost report. For example, DSH payments for fiscal year 2006 were based on cost reports from fiscal year 2004.

The U.S. Department of Health and Human Services released a report in March 2006 that consolidated the results of audits completed over the last several years of states' DSH program. The audit of Texas' DSH payments during the fiscal years 1996 and 1998 was released February 2003. The following recommendations related to hospital specific limits were included:

- The DSH payments ($319.2 million in Federal Funds) that were made in excess of hospital specific limits due to making payments on a prospective basis, with no adjustments made to reflect actual costs, should be repaid to the federal government.
- The state should not limit negative Medicaid shortfalls to zero, but instead reduce a hospital's specific limit when its Medicaid reimbursement exceeded Medicaid cost of services.
- A proxy should not be used to calculate uninsured patient costs for hospitals that do not provide, or are unable to accurately determine, costs and payment data for patients.

HHSC agreed with two of three audit recommendations listed above. When calculating a hospital specific limit, HHSC no longer sets a hospital's negative Medicaid shortfall to zero. The amount of the Medicaid shortfall will be subtracted from the cost of services to uninsured patients to ensure that a hospital does not receive more in total Medicaid payments than its cost of serving Medicaid patients and uninsured patients. According to HHSC, about 40 hospitals have their DSH payment limit reduced in any given year due to having a negative Medicaid shortfall. The HHSC will no longer use a proxy to calculate uninsured patient costs for hospitals that do not provide or cannot determine this information. The state agency did not agree with the first recommendation and stated that DSH payments were made in accordance with the approved Medicaid state plan.

PAYMENTS FOR STATE-OWNED HOSPITALS

State-owned facilities participating in the DSH program receive 100 percent of their adjusted hospital-specific limit. However, HHSC modified the DSH program to implement higher hospital specific limits for the three state-owned teaching hospitals during the 2004–05 biennium. BIPA federal legislation extended to all states a special DSH provision that raised the hospital-specific cap for public hospitals to compensate them for Medicaid shortfalls and uncompensated care. For state fiscal years 2004 and 2005, the hospital-specific DSH cap for all state-owned hospitals could be up to 175 percent of each state hospital's cost of uncompensated care. This provision was previously available only to California hospitals. The modification in Texas provided $127.8 million in additional federal DSH funds for state hospitals for the 2004–05 biennium. The federal provision that allowed states to increase the hospital-specific limit for public hospitals up to 175 percent of each hospital's cost of uncompensated care was authorized for only two years.

Recommendation 1 would encourage the Texas Legislature to petition the U.S. Congress to extend the federal provision that allows California to claim up to 175 percent of each public hospital's cost of uncompensated care to all states to enable qualifying state-owned hospitals to generate additional Disproportionate Share Hospital funds. This could be accomplished by: (1) passing a resolution; (2) directing the Texas Office of State-Federal Relations to establish the increase of the hospital-specific limit for public hospitals up to 175 percent of each hospital's cost of uncompensated care as a priority initiative; (3) directly contacting members of the Texas congressional delegation and members of the

Administration; and (4) working with organizations such as the National Conference of State Legislatures and other states seeking similar action.

MAXIMIZING MEDICAID REIMBURSEMENT FOR STATE-OWNED HOSPITALS

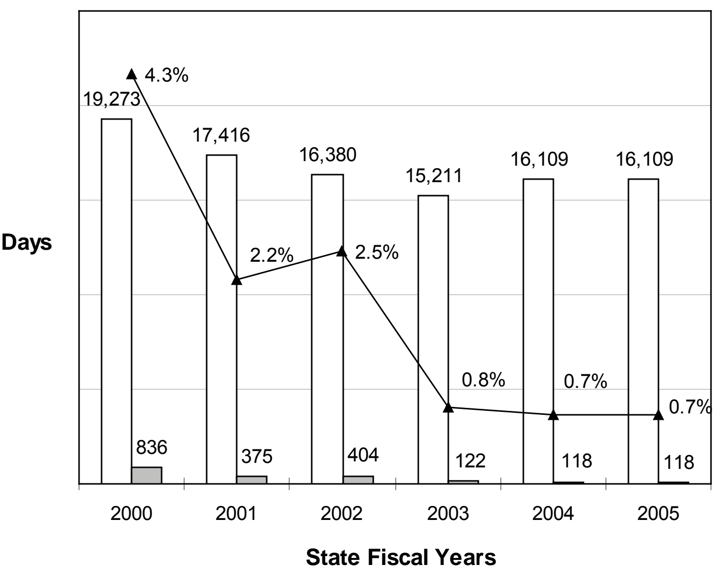
The Texas Center for Infectious Disease (TCID) is the Department of State Health Services' (DSHS) hospital in San Antonio. This 72-bed hospital provides medical care for patients with tuberculosis (TB) and other related contagious diseases. TCID generated $9.4 million in DSH Federal Funds in fiscal year 2004. However, TCID's Medicaid utilization rate decreased over the last few years. **Figure 4** shows TCID's Medicaid utilization rates first falling below 1 percent in fiscal year 2003. DSHS' TCID did not meet the required Medicaid utilization rate in state fiscal years 2003 and 2004 resulting in the loss of $21 million in federal DSH funds for state-owned hospitals in state fiscal years 2005 and 2006. TCID staff reported that many TB-infected individuals choose to receive treatment in community-based centers. TCID staff explained that in March 1999, the facility stopped providing outpatient services through its Internal Medicine Outpatient Clinic. This clinic primarily served patients that were eligible for Medicaid and/or Medicare. Since the prevalence of Medicaid-eligible clients at the facility has been minimal, in a given year the Medicaid utilization rate can fall below the required threshold.

In July 2002, HHSC selected a consulting firm to assist state agencies in assessing and implementing revenue maximization opportunities. This firm proposed a Medicaid revenue maximization project for TCID. According to the firm, the project would have focused on three distinct areas of revenue opportunity within the facility:

- Analyzing cost reports to identify Medicaid and Medicare revenue opportunities.
- Improving Medicaid eligibility and claims processing.
- Examining the viability of a Medicaid state plan amendment for TB services.

HHSC, based on recommendations by TCID, did not pursue this revenue maximization project. TCID staff claimed the consulting firm would be duplicating the work of current state staff and resources. TCID will not qualify for DSH payments in fiscal year 2006. Recommendation 2 directs the Texas Health and Human Services Commission, via a rider in the 2008–09 General Appropriations Bill, to analyze strategies to improve Medicaid reimbursement at TCID.

FIGURE 4
TEXAS CENTER FOR INFECTIOUS DISEASE MEDICAID INPATIENT DAYS, FISCAL YEARS 2000 TO 2005



NOTE: Fiscal year 2005 is an estimate.
SOURCES: Legislative Budget Board; Health and Human Services Commission; Texas Center for Infectious Disease.

On January 1, 2005, two hospitals, Zale Lipshy and St. Paul Hospitals, consolidated with UT Southwestern Medical Center. The Zale Lipshy Hospital is a 152-bed facility with physicians that specialize in the diagnosis and treatment of neurological diseases and hematologic malignancies (leukemia, lymphoma, myeloma, and myelodysplasia). St. Paul University Hospital operates 300 staffed beds with specialties in cardiology, emergency medicine, internal medicine, general surgery, obstetrics/gynecology and orthopedics. Based on state fiscal year 2004 data, these two hospitals had a Medicaid utilization rate higher than 1 percent. However, only one of these hospitals provides non-emergency obstetrical services to Medicaid clients. Preliminary analysis indicates that UT Southwestern Medical Center's St. Paul University Hospital might be eligible for the DSH program. Based on St. Paul University Hospital's uncompensated care and Medicaid shortfall in fiscal year 2004, this facility could receive $5.0 million in DSH payments. Recommendation 2 proposes the Texas Health and Human Services Commission, via a rider in the General Appropriations Bill to explore including The University of Texas Southwestern Medical Center's recently acquired hospitals in the Disproportionate Share Hospital program.

The 2008–09 General Appropriations Bill should include the following two riders to implement Recommendation 2:

Health and Human Services Commission

State-owned Hospital Medicaid Maximization.

a. The Health and Human Services Commission shall analyze strategies for improving Medicaid reimbursement at the Texas Center for Infectious Disease.

b. The Health and Human Services Commission shall explore including The University of Texas Southwestern Medical Center's recently acquired hospitals in the Disproportionate Share Hospital program to generate additional Federal Funds for state-owned hospitals.

The University of Texas Southwestern Medical Center at Dallas

Transfers of Appropriations - State-owned Hospitals. Contingent on The University of Texas Southwestern Medical Center at Dallas' hospitals qualifying for Disproportionate Share Hospital payments, the institution shall transfer from non-Medicaid state appropriated funds to match available federal funds. The amount, timing, and form of such transfers shall be determined by the Comptroller of Public Accounts in consultation with the Health and Human Services Commission. The Legislative Budget Board is authorized to adjust the amounts of such transfers as necessary to match available federal funds.

PAYMENTS FOR NON-STATE-OWNED HOSPITALS

After the state-owned hospitals' payments are calculated, the amount of DSH funding remaining under the federal cap is available for payment to non-state DSH hospitals under a different payment method. A hospital's DSH payment is based on its proportion of Medicaid inpatient days and low income (non-Medicaid) patient days. Both types of days are weighted if the hospital is a children's hospital (1.25 weight) or if it is in a larger metropolitan area (weights ranging from 2.75 to 3.75). DSH payments for non-state-owned hospitals are applied a conversion factor (ranging from 1.10 to .93). DSH payments to hospital districts located in large metropolitan areas are applied the highest conversion factor (1.10) and the lowest conversion factor (0.93) is applied to private, urban general hospitals.

If funds remain available in the non-state DSH hospital fund after distributing funds with the formula above, there is a second distribution of DSH funds. The remaining funds are distributed proportionally among hospitals that have not reached their hospital specific limit. The total amount of DSH funding any non-state hospital receives is the sum of the payment under the basic DSH formula and the payment, if any, under this second round distribution of remaining funds. The total of these two cannot exceed the hospital-specific limit.

The 2002–03 General Appropriations Act included a special provision regarding Medicaid cost-containment strategies. HHSC's appropriations were to be reduced by $205 million in General Revenue Funds due to cost-containment and savings initiatives, proposed by HHSC, to be implemented during the 2002–03 biennium. Two of the 17 initiatives listed in the rider were related to inpatient hospital reimbursement. One of the savings initiatives was the reduction of the outlier payment percentage (saving $6.1 million in General Revenue Funds). With input from hospital stakeholders, HHSC developed an initiative to achieve the remaining savings in General Revenue Funds ($48.5 million) and preserve the matching Federal Funds. HHSC and these groups developed a three-step initiative to achieve the cost savings in General Revenue Funds while maintaining the matching Federal Funds as follows:

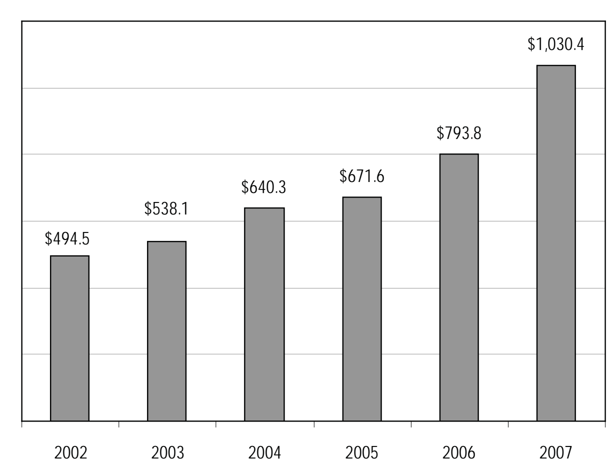
- Certain DSH non-state-owned public hospitals transfer an estimated $25 million annually to the Medicaid program.
- State DSH rules were amended to apply a conversion factor to DSH payments made to these select non-state-owned public hospitals. These conversion factors provide proportionate increases to the transferring public hospitals and proportionate reductions to urban, non-state, non-public DSH hospitals.
- To address the reductions to non-state, non-public DSH hospitals, approximately $10 million is used to draw additional Medicaid Federal Funds for supplemental payments for these hospitals and the remaining IGT ($15 million) is used to draw additional Medicaid Federal Funds for Diagnosis Related Group (DRG) payments to all hospitals.

Public hospitals have continued to provide IGTs to draw down these Federal Funds for the last three biennia. HHSC included in its 2008–09 Legislative Appropriations Request an exceptional item for $26.3 million in General Revenue Funds to replace these IGTs.

USE OF INTERGOVERNMENTAL TRANSFERS

States are permitted to obtain up to 60 percent of the state match for Medicaid from local sources other than state General Revenue Funds. Federal regulations clarify the conditions in which IGTs can be used to match federal Medicaid funds. Funds derived from IGTs must be appropriated directly to the state Medicaid agency, transferred from other public agencies to the state Medicaid agency, or be certified by the contributing unit of government as representing expenditures eligible for matching Medicaid Federal Funds. In addition, funds derived from IGTs may not be Federal Funds or Federal Funds authorized to match other Federal Funds. Texas' Medicaid program in the current biennium receives from non-state-owned public hospitals an estimated $1.8 billion to draw down Federal Funds. **Figure 5** shows the increase of IGTs from fiscal year 2002 to fiscal year 2007 (an increase of $570.9 million). The expansion of Upper Payment Limit payments to non-state-owned public and private hospitals and the increasing number of cost-containment initiatives have prevented further rate reductions to hospitals discussed in the next section and have contributed to the increases in IGTs.

FIGURE 5
INTERGOVERNMENTAL TRANSFERS BY TEXAS NON-STATE-OWNED PUBLIC HOSPITALS
FISCAL YEARS 2002 TO 2007



NOTE: Fiscal year 2007 is an estimate.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

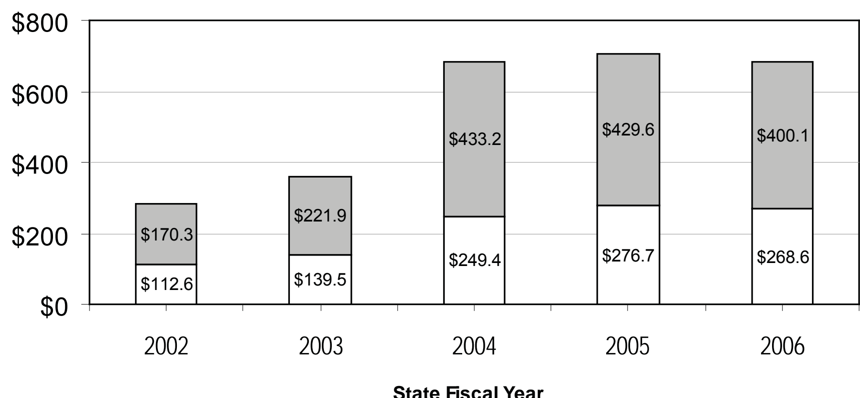
UPPER PAYMENT LIMITS FOR MEDICAID

Federal Medicaid law offers states flexibility regarding payments to healthcare providers. However, Medicaid payments can be no higher than the amount Medicare would pay for the same service (referred to as the Upper Payment Limit (UPL) for Medicaid). In April 2002, Texas' use of UPL to make supplemental payments to high-volume Medicaid providers was approved by CMS. Texas relies on IGTs from large public hospitals (rather than state expenditures) to make supplemental payments for both inpatient and outpatient care to hospitals in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Midland, Nueces, Potter, Tarrant, and Travis Counties. According to HHSC, 11 public hospitals will transfer $259.4 million and draw down an estimated $400.1 million in Federal Funds for fiscal year 2006. UPL payments have become an important financing supplement for large-volume Medicaid public hospitals. **Figure 6** shows the increase in UPL supplemental payments to these select hospitals.

Similar supplemental payments for rural, non-state-owned public hospitals were included in the Medicaid state plan in fiscal year 2002. Certain rural non-state-owned public hospitals in counties with populations less than 100,000 are eligible for supplemental payments. Twenty-four hospitals will provide $29.5 million in IGTs to draw down $45.5 million in Federal Funds for fiscal year 2006. These

FIGURE 6
UPPER PAYMENT LIMIT PAYMENTS TO TEXAS PUBLIC URBAN HOSPITALS

IN MILLIONS



NOTE: State fiscal years 2005 and 2006 do not include reconciliation payments.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

supplemental payments are distributed to an estimated 84 rural, non-state-owned public hospitals throughout Texas.

Beginning in 2004, HHSC implemented supplemental payments to certain state-owned hospitals. State-owned hospitals including UTMB, M.D. Anderson, and UTHSC-Tyler provide IGTs to draw down Federal Funds. For fiscal years 2004 and 2005, these state-owned hospitals provided $43.2 million in IGTs to match $69.1 million in Federal Funds. The Federal Funds allowed the state to save $69.1 million in General Revenue Funds. Supplemental payments to these hospitals will not save additional General Revenue Funds in the current biennium due to their effect on DSH payments. In the future, these supplemental payments will offset the loss of General Revenue Funds generated by DSH payments. A hospital's Medicaid shortfall must be reduced by any Medicaid payments.

The Seventy-ninth Legislature, Regular Session, 2005 appropriated $25 million in supplemental appropriations for HHSC to provide UPL payments to private hospitals. In fiscal year 2005, HHSC received approval from CMS to implement supplemental payments to private hospitals. HHSC distributed $63.8 million in supplemental payments to 50 private hospitals. The 2006–07 General Appropriation Act did not include this funding. The HHSC's 2008–09 Legislative Appropriations Request includes an exceptional item request of $27 million to reinstate supplemental payments to private hospitals.

By the end of fiscal year 2006, HHSC submitted several state plan amendments to expand the number of hospitals in Texas receiving supplemental payments. The state plan amendment allowing for select private hospitals to receive supplemental payments has already been approved by CMS. Non-public hospitals in Bexar, Hidalgo, Maverick, Midland, Montgomery, Potter, Randall, Travis, and Webb counties will receive estimated annual payments of $251.7 million. These counties will provide $98.9 million in IGTs to draw down $152.8 million in Federal Funds.

Another state plan amendment was approved to allow HHSC to provide supplemental payments to privately owned hospitals with an indigent care affiliation agreement with a hospital district or other local government entity. According to HHSC, approximately 75 hospitals will receive payments totaling $292.8 million ($115.2 million IGTs and $177.6 million Federal Funds) in fiscal year 2006. Counties provided the state matching funds to encourage non-public hospitals to treat more Medicaid-eligible patients.

The Seventy-ninth Legislature, Regular Session, 2005, added a special provision in the 2006–07 General Appropriations Act (GAA) regarding supplemental payments to children's hospitals. This act directed the HHSC to use $25 million in General Revenue Funds for the biennium to provide UPL reimbursement for children's hospitals. A state plan amendment has been submitted to CMS, and HHSC anticipates its approval. Annual estimated supplemental payments to children's hospitals could total $31.8 million

($12.5 million in General Revenue Funds and $19.3 million in Federal Funds).

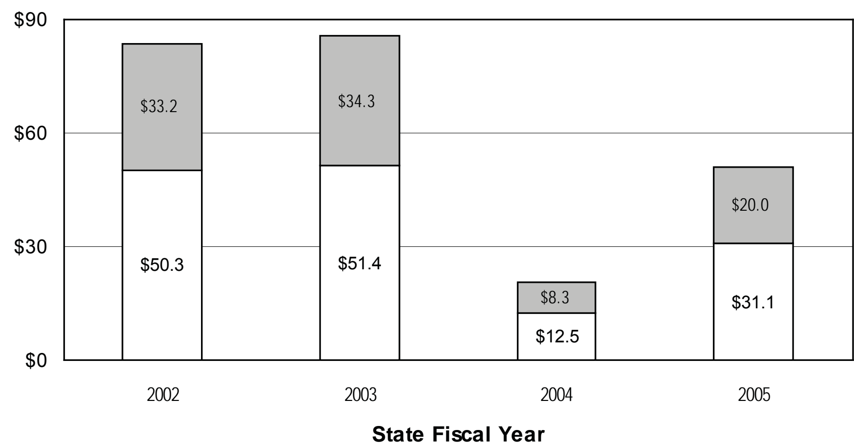
MEDICAID GRADUATE MEDICAL EDUCATION

The Medicaid program allows states to receive matching Federal Funds for Graduate Medical Education (GME). GME payments provide additional Medicaid reimbursement to teaching hospitals for treating patients who have more complex conditions and to cover some of the costs of training residents. Until fiscal year 2004, appropriations of General Revenue Funds have been provided for the state share of GME funding. For the 2004–05 biennium, GME funding would only be available to teaching hospitals if additional unclaimed state lottery proceeds were generated in excess of what was estimated by the Texas Comptroller of Public Accounts in the 2004–05 Biennial Revenue Estimate. **Figure 7** shows the state share of GME funds decreasing from $34.3 million in fiscal year 2003 to $8.3 million in fiscal year 2004 (a loss of $26 million).

The Texas Legislature did not make unclaimed state lottery proceeds available for GME payments for the 2006–07 biennium, instead an appropriations rider was included to authorize HHSC to expend up to $80.9 million for the state portion of GME payments to teaching hospitals. However, this authority was contingent upon receipt of IGTs from public teaching hospitals to serve as the state share for Medicaid GME. HHSC reported that public teaching hospitals have shown no interest in providing IGTs.

In fiscal year 2006, one public hospital, Parkland Health and Hospital System, received GME reimbursement. The Seventy-fifth Legislature, Regular Session, 1997, enacted legislation to modify the methodology used to reimburse teaching hospitals for their GME costs under Medicaid. This legislation included a specific methodology that provided greater reimbursement to hospitals. Due to limited appropriations, the former Texas Department of Health and later HHSC did not amend state rules and continued to reimburse hospitals under the previous methodology. In 2002, Parkland sued HHSC to have the agency reimburse GME costs based on the methodology enacted in 1997 legislation. The suit resulted in a decision favoring Parkland and HHSC was directed to only use the legislation methodology to calculate GME reimbursement to teaching hospitals. In 2003 the Legislature enacted legislation that voided the 1997 methodology effective September 1, 2003. However, Parkland claimed that GME funding should still be calculated under the 1997 methodology for the years 1998–2003. An agreement was reached in fiscal year 2006 that enabled Parkland to provide IGTs to draw the additional Federal Funds for GME costs. HHSC used $45.3 million in IGTs from Parkland to draw down $72.6 in Federal Funds (a total of $117.9 million).

FIGURE 7
GRADUATE MEDICAL EDUCATION PAYMENTS TO TEXAS TEACHING HOSPITALS
STATE FISCAL YEARS 2002 TO 2005



SOURCE: Texas Health and Human Services Commission.

MEDICAID SERVICES FOR MEDICALLY NEEDY

HHSC was not appropriated General Revenue Funds for the 2004–05 biennium to provide Medicaid services to Medically Needy (except for pregnant women). This group consists of adults whose income exceeds Medicaid eligibility limits, but who do not have the resources required to meet their medical expenses. The 2006–07 General Appropriations Act included a rider that would have partially restored Medicaid services to these individuals. The Legislature directed HHSC to restore Medicaid services to the Medically Needy population contingent on achieving savings from the implementation of a women's health waiver and receiving IGTs from local public hospitals. The Medically Needy program has not been restored because IGTs have not been provided by local public hospitals.

MANAGED CARE EXPANSION

The Seventy-ninth Legislature, Regular Session, 2005, enacted House Bill 1771 which directs the HHSC to establish a non-capitated managed care model (Integrated Care Management (ICM)) to better manage Medicaid services to the aged, blind, and disabled population. The Seventy-ninth Legislature also added a special provision in the 2006–07 General Appropriations Act regarding Medicaid managed care models. HHSC must achieve a savings of $109.5 million in General Revenue Funds by using cost-effective models to better manage the delivery of Medicaid health services to the aged, blind and disabled populations throughout the state. The special provision lists several conditions that HHSC must meet for the implementation or expansion of managed care models including primary care case management (PCCM), HMO carve out, or ICM. HHSC must also ensure that managed care models do not eliminate matching Federal Funds to local public hospitals under the federal UPL provisions.

HHSC anticipates the start of the ICM model in the Dallas and Tarrant service areas on July 1, 2007. Because of implementation delays, the $109.5 million in savings will not be generated by the end of fiscal year 2007. In fiscal year 2006, HHSC generated $36.5 million in agency savings, which reduced the savings needed to $73 million. HHSC amended state rules to add an 8 percent discount to the reimbursement rates of all hospitals for inpatient services provided to Supplemental Security Income (SSI) and SSI-related clients in select services areas. This discounted reimbursement to hospitals in Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant and Travis service areas will generate an estimated $14.5 million in fiscal year 2007. The Texas Coalition of Transferring Hospitals has agreed to make a non-recurring intergovernmental transfer of $58.5 million to HHSC to achieve the savings.

ADDITIONAL REIMBURSEMENT TO HOSPITALS

In 2003, legislation was enacted that established the Designated Trauma Facility and Emergency Medical Services (DTF/EMS) Account. General Revenue–Dedicated Account Funds collected under this account support a portion of the uncompensated trauma care provided by eligible trauma facilities. Funds deposited to the designated trauma account come from two revenue sources: the Driver Responsibility program, which provides for surcharge assessments for certain or habitual traffic violation convictions; and a $30 state traffic fine relating to traffic offense convictions. Designated trauma facilities, county and regional emergency medical services (EMS), and trauma-care systems are eligible to receive DTF/EMS funds. After an initial $0.5 million is set aside for an extraordinary emergency reserve, the remaining funds in the DTF/EMS Account are distributed as follows: 96 percent to fund a portion of the uncompensated trauma care provided by designated trauma facilities and those facilities actively pursuing trauma designation; 2 percent to EMS providers; 1 percent to Regional Advisory Councils in the trauma system; and 1 percent for administrative costs at DSHS.

With stakeholders input, DSHS developed the following formula to distribute the DTF/EMS Account funds:

- 15 percent shared equally among all eligible applicants up to $50,000 each, and
- 85 percent based on a pro-rata share of total uncompensated trauma care reported by eligible hospitals.

According to DSHS, the total cost of the uncompensated trauma care provided in calendar year 2004 by the 228 facilities was approximately $192.4 million. This amount of uncompensated trauma care was the basis for the distribution of $56.7 million in funding from the designated trauma account (see **Figure 8**) in fiscal year 2006. A total of $120.8 million has been distributed to eligible hospitals since the establishment of the DTF/EMS Account.

EMERGENCY MEDICAL SERVICES AND TRAUMA CARE SYSTEM ACCOUNT

The Emergency Medical Services and Trauma Care System account (EMS/TCS) was established in 1997 to provide General Revenue–Dedicated Funds for the continued

FIGURE 8
UNCOMPENSATED TRAUMA CARE DISTRIBUTIONS, FISCAL YEARS 2004 TO 2007

FISCAL YEAR	DTF/EMS FUNDS (MILLIONS)	EMS/TCS FUNDS (MILLIONS)
2004	$18.2	$0.6
2005	45.9	1.8
2006	56.7	1.4
2007	56.7	1.4
Total	**$177.5**	**$5.2**

Note: Fiscal Year 2007 is an estimate.
Source: Texas Department of State Health Services.

development, implementation, and evaluation of the Texas EMS/Trauma System. Up until fiscal year 2004, a small amount of the funds (2 percent) collected under the EMS/TCS account was distributed to hospitals for uncompensated trauma care. However, legislation enacted in 2003 increased the funding and amended the distribution method of EMS/TCS funds. As a result of Senate Bill 1131's passage, monies derived from an additional fine for intoxication-related offenses are deposited to the EMS/TCS account. In addition, the allocation available to hospitals for uncompensated care increased from 2 percent to 27 percent.

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES

The Social Security Act includes provisions that require Medicare-participating hospitals that offer emergency services to provide medical screening examinations, as well as necessary stabilizing treatment or appropriate transfer, to all individuals. These provisions (along with provisions that prohibit hospitals from delaying required medical screening or stabilizing treatment to determine patient's payment method or insurance status) are referred to as the Emergency Medical Treatment and Labor Act (EMTALA). These provisions were passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. Congress enacted EMTALA because of increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance.

With the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress appropriated Federal Funds to reimburse health care providers that provide emergency services to undocumented immigrants and other specified immigrants. Under MMA's Section 1011, the federal government will distribute $250.0 million annually for fiscal years 2005 to 2008 directly to enrolled providers:

- Two-thirds of the total ($167 million) will be distributed to eligible providers in all states based on each state's share of undocumented immigrants.
- One-third of the total ($83 million) will be distributed in the six states with the highest number of undocumented immigrant apprehensions.

MMA's Section 1011 defines an eligible provider as a hospital, physician, or provider of ambulance services (including an Indian Health Service facility). Enrolled providers are required to seek reimbursement from all available funding sources before requesting Section 1011 funds. For fiscal year 2005, Texas' allocation was an estimated $46.0 million. Due to a delay in developing a distribution methodology, Federal Funds have only been released for reimbursement of services provided in the last two quarters of fiscal year 2005. A total of 105 enrolled hospitals received just under $12.0 million in the third quarter. In the fourth quarter, $9.5 million in Federal Funds were released to 127 enrolled hospitals. For these two quarters in fiscal year 2005, Texas hospitals submitted payment requests totaling $77.2 million. **Figure 9** shows that 17 hospitals accounted for $58.8 million (more than three-fourths) of the payment requests. CMS will add the $24.5 million of the remaining fiscal year 2005 funds to the fiscal year 2006 allocation to Texas ($47 million).

UTMB at Galveston reported spending $1.7 million on emergency services to undocumented immigrants and received about $0.5 million in Section 1011 reimbursement.

FIGURE 9
SECTION 1011 FEDERAL FUNDING PAYMENT REQUESTS FROM TEXAS, FISCAL YEAR 2005

VALUE OF SUBMITTED PAYMENT REQUESTS	THIRD AND FOURTH QUARTERS TOTAL SPENDING REPORTED	HOSPITALS
Up to $5,000	$23,606	10
$5,001 - $100,000	$2,082,543	59
$100,001 - $200,000	$2,923,019	21
$200,001 - $500,000	$5,187,723	17
$500,001 - $1,000,000	$8,159,810	12
$1,000,001 - $5,000,000	$33,975,100	14
More than $5,000,001	$24,869,165	3
Total	**$77,220,966**	**136**

Sources: Center for Medicare and Medicaid Services; Trailblazer, Health Enterprises Inc.

The University of Texas Southwestern Medical Center's two hospitals, Zale Lipshy and St. Paul, are listed as Section 1011 enrolled providers but did not receive any Federal Funds. UT-Texas Southwestern Medicaid Center staff reported a delay in getting provider numbers and plan on submitting claims for the next quarter. Two state-owned teaching hospitals did not apply to become enrolled providers. The University of Texas M.D. Anderson Cancer Center and UTHSC-Tyler reported that there was little benefit to applying for Section 1011 Federal Funds due to the small number of undocumented immigrants that receive emergency services at their facility.

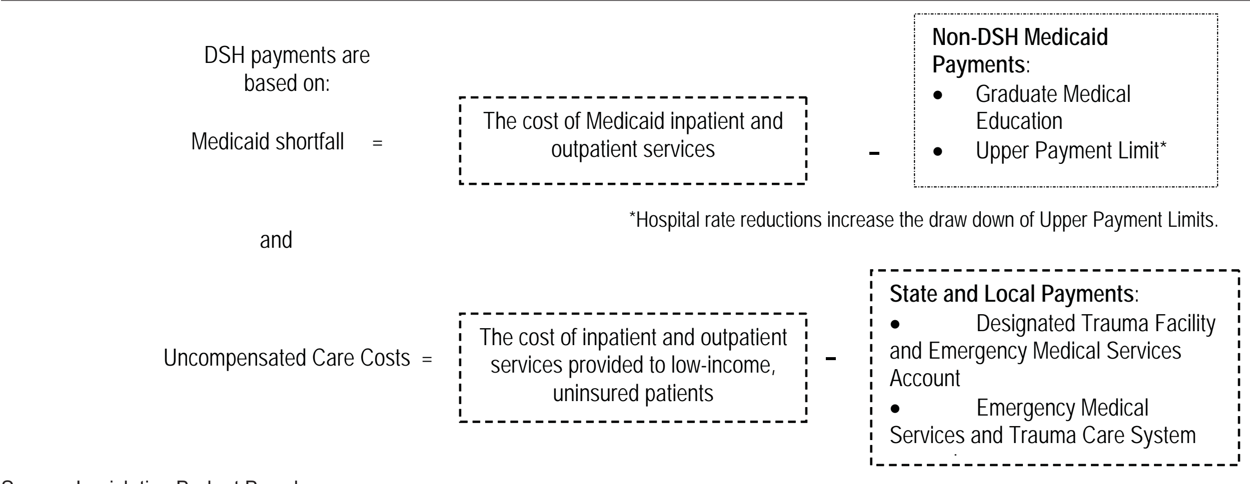
INTERACTION OF FUNDING STREAMS TO HOSPITALS

The different Medicaid funding streams described in the previous sections have a significant affect on a hospital's Medicaid shortfall and amount of uncompensated care provided to low income and uninsured patients. Medicaid rates paid to hospitals were first reduced by 5 percent during the 2004–05 biennium, and were not restored for the current biennium. Since DSH payments are based on a hospital's Medicaid shortfall (the difference between the cost of Medicaid inpatient and outpatient services and the hospital's non-DSH Medicaid payments) and its costs of services to uninsured patients, an increase in Medicaid shortfalls may increase a hospital's DSH payment limit. As shown in **Figure 10**, rate reductions would allow hospitals to draw down additional UPL supplemental payments due to the increased difference between Medicare and Medicaid rates. However, for state-owned hospitals UPL payments are considered in the calculation of a hospital's Medicaid shortfall. These additional Medicaid payments negatively affect a hospital's DSH payment limit. For example, state-owned teaching hospitals' DSH payments were reduced in fiscal year 2006, due to UPL payments implemented in fiscal year 2004. The portion of DSH funding that is distributed to non-state-owned hospitals increased because of state-owned teaching hospitals' decreased DSH payments.

The 2005 legislative session included various discussions regarding hospital reimbursement. The Texas Legislature directed HHSC (via a rider in the 2006–07 General Appropriations Act) to convene a workgroup to study and recommend changes to the hospital (both inpatient and outpatient services) reimbursement rate methodology. The workgroup was also charged to evaluate cost inflators, rebasing of the rates, and other alternatives, such as Medicaid waivers that would combine DSH, GME and UPL funds. HHSC contracted with Deloitte Consulting to draft a report based on some of the rider requirements.

HHSC's report concluded that Medicaid reimbursement for the same treatment differs among hospitals. HHSC proposes two methodologies to reform the components of the SDA (direct care, administrative and capital). The first methodology requires that the SDA components be reimbursed based on regional average costs. The second methodology includes capping the SDA components based on a percentage of regional costs. Direct care costs and administrative cost would be capped at the each hospital's region 80th percentile, and each hospital would have 9 percent of their capital costs reimbursed.

FIGURE 10
FACTORS IMPACTING HOSPITAL REIMBURSEMENT



Source: Legislative Budget Board.

HHSC's evaluation of Medicaid waivers that would combine DSH, GME and UPL funds was not included in the hospital reimbursement workgroup report. However, HHSC presented to the Texas Senate Finance Committee in October 2006 the following waiver considerations:

- Combine UPL and DSH funds into a low-income pool to be used to fund uncompensated care based on a market area network of healthcare providers.
- Stabilize UPL funding to address the CMS proposals that would restrict the use of IGTs.
- Consider Certified Public Expenditures as the basis for drawing Federal Funds for healthcare provided by public hospitals to the non-Medicaid medically indigent population.

Medicaid inpatient expenditures account for a large percentage of the Texas Medicaid Program. As a result, any changes to the methodology used to calculate hospital payments have a significant impact on the Medicaid program. The recommendations proposed in this review address maximizing Medicaid reimbursement for inpatient hospital services in Texas.

FISCAL IMPACT OF THE RECOMMENDATIONS

There are no significant direct fiscal impacts to petitioning Congress or directing the Health and Human Services Commission to analyze potential Medicaid funding related to the Texas Center for Infectious Disease and The University of Texas Southwestern Medical Center's hospitals. Recommendations 1 and 2 would not impact General Revenue Funds in the 2008–09 biennium. However, Recommendations 1 and 2, if implemented, could generate approximately $79.4 million in Federal Funds annually for state-owned hospitals. The introduced 2008–09 General Appropriations Bill does not address Recommendations 1 or 2.

INCREASE HEALTH INSURANCE PREMIUM PAYMENT ENROLLMENT TO GENERATE MEDICAID SAVINGS

Texas is not accessing the full savings potential Medicaid's Health Insurance Premium Payment program offers. The Health Insurance Premium Payment program allows Medicaid-eligible Texans, with access to employer-sponsored insurance, to enroll in their employer's insurance instead of Medicaid when it is cost effective to do so. Currently, less than 1 percent of the Medicaid population participates in the Health Insurance Premium Payment program but the Health and Human Services Commission estimates that approximately 217,000 Texans are working parents with employer-sponsored insurance and earn less than 100 percent of the federal poverty limit. At this income level, each child in the family may be eligible for Medicaid and the Health Insurance Premium Payment program since one or both parents work and have access to employer-sponsored insurance. Increasing the Health Insurance Premium Payment program enrollment enhances Medicaid savings and provides eligible Texans and their families with access to employer sponsored insurance.

Barriers to growing enrollment in the Texas Health Insurance Premium Payment program are related to outreach and operational issues. Currently, Texas businesses' awareness of the Health Insurance Premium Payment program and its benefits is low; moreover, the program is not well understood by those who may be eligible for it. Operationally, the Health Insurance Premium Payment program can improve how and when it receives referral information about potential enrollees and decrease the time to reimburse participants. Addressing the outreach and operational problems would increase the Health Insurance Premium Payment program enrollment and save state funds spent on Medicaid.

CONCERNS

- ♦ In fiscal year 2005, the Medicaid Health Insurance Premium Payment program avoided $18.3 million in costs. However, less than 1 percent of the Medicaid population is enrolled in the program. Increasing participation to 3 percent of the Medicaid population or 75,590 total participants could save $101.9 million per year in Medicaid costs, an increase of $83.6 million.
- ♦ Referrals to Health Insurance Premium Payment program do not occur at eligibility determination but 3 to 4 months afterwards. This delay represents lost months of program participation and reduces state savings.
- ♦ Health Insurance Premium Payment enrollees wait a minimum of two weeks for reimbursement of their health insurance premium payment. This delay can deter eligible Texans from inquiring about the program.
- ♦ Currently, the Health and Human Services Commission lacks targets or measures to hold the program vendor accountable for enrollment growth.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill that directs the Health and Human Services Commission to use at least $1.7 million per biennium for the creating and implementing of ongoing public awareness and outreach efforts to increase enrollment for the Health Insurance Premium Payment program.
- ♦ **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill that directs the Health and Human Services Commission to ensure training for the Health Insurance Premium Payment program is provided on an ongoing basis to workers who have contact with people inquiring or applying for benefit assistance.
- ♦ **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill that directs the Health and Human Services Commission to ensure that an automated referral system be incorporated into the Texas Integrated Eligibility Redesign System (TIERS) whereby referrals to the Health Insurance Premium Payment program occur at the time of application.
- ♦ **Recommendation 4:** Amend the Texas Human Resource Code §32.0422 to allow the Health and Human Services Commission to provide training about the Health Insurance Premium Payment program and its eligibility requirements to all interested licensed insurance agents in Texas and to provide financial compensation for each successful HIPP referral in an amount commensurate with the standard insurance agent commissions or other referral fees identified by

the Health and Human Services Commission for those licensed insurance agents who have received HIPP training.

- **Recommendation 5:** Include a rider in the 2008–09 General Appropriations Bill that directs the Health and Human Services Commission to work with the Health Insurance Premium Payment vendor to reduce the reimbursement period to less than seven days.
- **Recommendation 6:** Include a rider in the 2008–09 General Appropriations Bill that directs Health and Human Services Commission to report on the performance of the Health Insurance Premium Payment program to the Legislative Budget Board and the Governor by October 1, 2008.

DISCUSSION

Section 1906 of the federal Social Security Act, enacted in the Omnibus Budget Reconciliation Act of 1990, allows states using Medicaid funds to purchase employer-sponsored group health insurance on behalf of Medicaid-eligible individuals if it is available and if it is cost-effective to do so. States must also purchase employer-sponsored health insurance (ESI) for non-Medicaid-eligible family members if it is necessary for the Medicaid-eligible person to receive coverage and the insurance is still cost effective. States pay the enrollee's portion of premiums, deductibles, and coinsurance for Medicaid eligible individuals. For non-Medicaid-eligible family members, such as a parent of a Medicaid-eligible child, the states pay the insurance premiums but not the deductibles and coinsurance. Health Insurance Premium Payment (HIPP) program enrollees are entitled to all of the states' Medicaid benefits, including those not included in the employer-based insurance plans. The state Medicaid programs provide "wrap-around" coverage for services that the insurance plans do not cover by paying claims submitted by providers.

As defined by Section 1906 of the Social Security Act, an individual's enrollment in an employer-based plan is cost-effective if paying the premiums, deductibles, and coinsurance is lower than a state's expected cost of directly providing Medicaid-covered services. The Centers for Medicaid and Medicare Services (CMS), which oversees the Medicaid program, provided states with guidelines for calculating cost-effectiveness, including a suggested formula for determining expected deductible and coinsurance costs. If an employer-based health plan is determined likely to be cost-effective, individuals are required to enroll as a condition of their Medicaid eligibility. However, a child cannot be denied Medicaid eligibility or services because a parent does not enroll in an employer's plan. Medicaid eligible individuals enrolled in employer-sponsored health plans are entitled to receive full Medicaid benefits. The ESI health plans become the primary payers for the services they cover.

TEXAS' HIPP PROGRAM

MMC Group is the current vendor contracted to operate the Texas HIPP program and has operated the program since its 1994 inception. As of August 2006, the HIPP vendor has 18 full-time employees working on the HIPP program. As **Figure 1** shows, the HIPP program enrollment has grown gradually since 2001 to a current level of 6,565 families or 13,667 individuals.

SAVINGS TO THE MEDICAID PROGRAM

HIPP enrollees save the state money because of their access to ESI coverage. No Medicaid-eligible person is allowed to enroll in HIPP if it is not cost effective to do so, therefore, every HIPP enrollee saves the state money. The cost effectiveness test considers whether the state must pay for an additional family member's ESI premium (parent) in order to enroll the Medicaid-eligible (child) in the ESI plan. In this case, both the child and the parent, who may have been without health insurance, receive ESI coverage.

As shown in **Figure 2**, HHSC calculates that insuring people through ESI coverage via the HIPP program saved the state an estimated $18.3 million in All Funds in fiscal year 2005.

The cost savings for the program is the amount of money Medicaid saved by insuring Medicaid-eligible people through their ESI coverage rather than through Medicaid. HIPP

FIGURE 1
HEALTH INSURANCE PREMIUM PAYMENT ENROLLMENT HISTORY, FISCAL YEARS 2001 TO 2005

	2001	2002	2003	2004	2005
Active Cases/ Families	2,079	2,936	4,328	5,267	6,565
Unique Medicaid Eligible Clients	No Data	No Data	9,442	11,129	13,667

SOURCE: Texas Medicaid and Healthcare Partnership.

FIGURE 2
ANNUAL HEALTH INSURANCE PREMIUM PAYMENT-GENERATED SAVINGS TO MEDICAID, FISCAL YEARS 2001 TO 2005

	2001	2002	2003	2004	2005
Cost Savings	$13,912,391	$22,244,089	$25,378,391	$21,132,014	$35,160,316
Total Program Expense	($4,582,868)	($5,560,284)	($9,624,798)	($12,208,530)	($16,812,542)
Net Savings to Medicaid	$9,329,522	$16,683,805	$15,753,593	$8,923,484	$18,347,773
State General Revenue Funds Saving	$3,672,099	$6,640,154	$ 6,299,861	$3,551,546	$7,188,657
Federal Funds Savings	$5,657,423	$10,043,651	$9,453,732	$5,371,938	$11,159,116

Source: Texas Health and Human Services Commission.

generates savings by complementing Medicaid coverage and allowing the ESI to act as the client's primary insurance. The ESI is billed first for services and Medicaid is billed last. Medicaid pays for services that the ESI does not cover, if the services are covered by Medicaid. These savings are conservative estimates because they are based on claims submitted to Medicaid after being submitted to the client's ESI. At other times, Medicaid avoids a cost completely. For example, if a HIPP enrollee's ESI covers flu shots at 100 percent, then the cost of the flu shot is billed to the ESI and Medicaid never sees the cost.

Based on data from the Census Bureau's Current Population Survey, HHSC estimates that approximately 217,000 Texans are working parents with employer-sponsored insurance and earn less than 100 percent of the federal poverty limit. At this income level, each child in the family may likely be eligible for Medicaid and for the HIPP program since one or both parents work and have access to ESI. As shown in **Figure 3**, if 35 percent of low income working parents or 75,950 enrolled in the HIPP program, the state would save a total of $101.9 million a year in All Funds. In 2005, the net average savings per person in the HIPP program was $1,342. **Figure 3** also shows the estimated savings at various levels of participation based on the 2005 average savings per person.

ENROLLMENT PROCEDURE

Despite the benefits to the state and to Medicaid-eligible families, few eligible Texans access the HIPP program. Currently less then 1 percent (13,677) of the Medicaid population is enrolled in HIPP. **Figure 4** shows the enrollment process.

Several factors limit participation. There is a limited population who can access the HIPP program. Potential HIPP enrollees must first be Medicaid-eligible and have access to employer-sponsored insurance that meets the cost effectiveness test. These requirements limit who can apply for HIPP and are requirements of every HIPP program.

Other obstacles inhibiting HIPP enrollment include: (1) lack of cooperation from employers, (2) delayed or missed referral opportunities, (3) an extended reimbursement period, and (4) the lack of performance measures to track program growth. These obstacles are controllable factors and if improved upon may boost HIPP enrollment.

FIGURE 3
POTENTIAL HEALTH INSURANCE PREMIUM PAYMENT ENROLLMENT GROWTH AND ESTIMATED SAVINGS

PERCENTAGE OF 217,000 GOAL	(2005 ENROLLMENT) 6%	10%	15%	20%	25%	30%	35%
Number of Enrollees	13,667	21,700	32,550	43,400	54,250	65,100	75,950
Savings	$18,347,773	$29,121,400	$43,682,100	$58,242,800	$72,803,500	$87,364,200	$101,924,900
General Revnue Funds Savings	$7,188,657	$11,648,560	$17,472,840	$23,297,120	$29,121,400	$34,945,680	$40,769,960
Federal Funds Savings	$11,159,116	$17,472,840	$26,209,260	$34,945,680	$43,682,100	$52,418,520	$61,154,940
Total	**$18,347,773**	**$29,121,400**	**$43,682,100**	**$58,242,800**	**$72,803,500**	**$87,364,200**	**$101,924,900**

Source: Legislative Budget Board

FIGURE 4
STEPS TO PARTICIPATING IN HEALTH INSURANCE PREMIUM PAYMENT

Client is referred to HIPP Program.

Client contacts HIPP. HIPP takes client's information.

HIPP contacts employer for health insurance information.

HIPP receives insurance information and determines cost effectiveness.

If cost effective, HIPP sends acceptance letter to client and employer.

Client enrolls in ESI and submits pay stubs to receive reimbursement.

Client receives reimbursement.

SOURCE: MMC Group.

AFFECT OF UNCOOPERATIVE EMPLOYERS

All states' HIPP program personnel must rely on either the Medicaid-eligible individual or their employer to submit information about the employer's health plan to determine whether it is cost effective for the state to purchase ESI coverage. It is at this point in the HIPP process many applications do not advance because employers do not respond to the state's information request despite repeated attempts by HIPP personnel.

States agree that establishing positive ongoing relationships with employers is important and requires active ongoing outreach and education. According to the HIPP vendor, many businesses in Texas are poorly informed about the HIPP program and its benefits. For example, as more employees access ESI coverage, the size of the health risk pool increases and spreads the risk among a larger group, thereby reducing costs and allowing better rates to be negotiated for the entire group. Enrolling in ESI coverage can help to stabilize a workforce. Employees may be less likely to change jobs if they have access to health insurance benefits. Families with ESI can also seek care together because family members are receiving coverage from the same insurance plan. Outreach to employers is critical even when they are not directly involved in the program. Conducting outreach and increasing public awareness through public events and media activities, as is done in the Children's Health Insurance Program, could increase the response rate from businesses contacted by HIPP personnel. Additionally, educating Texans who are Medicaid-eligible with access to ESI about the opportunities the HIPP program offers could also increase HIPP enrollment.

Recommendation 1 directs the Health and Human Services Commission, via a rider included in the 2008–09 General Appropriations Bill, to allocate at least $1.7 million per biennium to increase public awareness about Medicaid's HIPP program in order to increase enrollment and retention of enrollees. Texas businesses and segments of the Medicaid-eligible population most likely to have access to employer-sponsored insurance should be the targets for the outreach and public awareness efforts. Sample rider language can be found at the end of this report.

HEALTH INSURANCE PREMIUM PAYMENT REFERRALS

The success of the HIPP program depends on the state's ability to identify promptly and accurately Medicaid clients who have access to employer coverage. For most states, including Texas, identifying potential participants for the HIPP program is an ongoing problem. For example, Medicaid-eligibles are not always forthcoming about their access to ESI because they do not understand that it will not adversely affect their Medicaid eligibility.

Word-of-mouth among current HIPP participants is one of the most prevalent ways of recruiting HIPP enrollees, according to the HIPP vendor. **Figure 5** shows that Texas receives HIPP referrals from the Social Security Administration, call centers, eligibility workers, and data matches through the Texas Workforce Commission (TWC).

Data matches are conducted by cross referencing employment data collected by TWC with Medicaid eligibility client information. Data matching effectiveness as a referral source is reduced because employer data is collected quarterly and once the HIPP program receives it, it can be six months old. During this time potential HIPP enrollees have often changed jobs or may be unemployed.

FIGURE 5
TEXAS HEALTH INSURANCE PREMIUM PAYMENT REFERRAL SOURCES, FISCAL YEAR 2005

SOURCE	ANNUAL TOTAL	PERCENTAGE OF TOTAL
Forms filled out by caseworkers	1,337	16.1%
TIERS	33	0.4
Outreach conducted by HIPP staff	2	0.0
Social Security Administration	1,260	15.2
800-number	812	9.8
Maximus (Enrollment Broker)	1,924	23.2
Follow up letter	332	4.0
Data Match	1,749	21.1
All Others	856	10.3
Total	**8,305**	**100%**

Source: MMC Group.

DELAYED OR MISSED REFERRAL OPPORTUNITIES

Timely and accurate referrals are needed to increase HIPP enrollment. Improving the referral process should begin with improving training for customer care representatives (CCR). Currently, CCRs receive training from several HHSC curricula to learn about benefit programs and their eligibility requirements. CCRs' training is four days for Texas Works, which includes learning about Temporary Assistance for Needy Families, food stamps, and Adult Medicaid. Training about Medicaid for the Elderly and People with a Disability is for two and one-half days. HIPP is cited briefly in the Texas Works Policy Training manual. It states that CCRs should complete form H1039 to report a client's medical insurance from a third party. According to the HIPP vendor, there is confusion about whether the form needs to be completed, thus resulting in missed opportunities to enroll people in HIPP.

Another missed opportunity to explain HIPP further to clients is in the CCR Scripts manual. The manual provides CCRs with scripted responses to commonly asked questions for all benefit programs. In the Medicaid and CHIP section, question 3 reads, "I have health insurance through my job but it's too expensive. Can I qualify for Medicaid or CHIP?" The scripted CCR response correctly informs the client that access to ESI does not affect Medicaid or CHIP eligibility but does not inform the client about HIPP nor is a referral made to the HIPP program.

Although, HIPP is a small program within Medicaid, it is capable of producing additional savings for the state. Consequently, it is worth the investment and time to give HIPP more attention during training so CCRs can dispel client misconceptions about HIPP and promote HIPP enrollment.

Recommendation 2 directs HHSC to ensure it provides HIPP training on an ongoing basis to workers who have contact with individuals inquiring or applying for benefit assistance programs. This recommendation could be implemented through a rider included in the 2008–09 General Appropriations Bill and can be found at the end of this report.

AUTOMATED REFERRAL SYSTEM IMPLEMENTATION

In addition to providing ongoing training to CCRs, implementing an automated referral system can improve the HIPP referral process. Presently, the application for assistance contains at least three questions inquiring about access to health insurance and/or employer information that could act as a trigger for a HIPP referral. For example, if an applicant answers "yes" to any of the three questions, an automated referral to the HIPP program could be generated allowing HIPP personnel to further investigate the client's access to ESI. Moreover, as seen in **Figure 6**, the questions are specific

FIGURE 6
ELIGIBILITY TRIGGER QUESTIONS

1. Does anyone in your household currently have medical coverage other than Medicare or Medicaid?
2. Does someone pay this premium for anyone listed in the above question?
3. Has anyone in your household been employed in the last 12 months?

Source: Health and Human Services Commission.

enough regarding access to employer-sponsored insurance that quality referrals to the HIPP program could be made.

As proposed by the HHSC, the Texas Integrated Eligibility Redesign System (TIERS) will provide eligibility workers with a single, integrated system to be used in delivering food stamps, cash assistance, medical, and community care services to Texans in need. HHSC also proposes that TIERS will support data sharing with 20 state agencies. The development of TIERS provides HHSC with an opportunity to implement an automated referral system for the HIPP program.

Pennsylvania has an active HIPP program and is recognized by the health policy experts as one of the country's most successful HIPP programs. Pennsylvania attributes much of their success and savings to their HIPP automated referral system.

The Pennsylvania system can interface with the mainframe eligibility files for Pennsylvania's Department of Public Welfare. Pennsylvania's application form for those applying for Medical Assistance includes three relevant questions, which are the backbone of their automated referral process. These questions are for triggering the automated referral process. Once an individual is found eligible for Medical Assistance clerical staff in each County Assistance Office enter the applicant's responses into the agency's mainframe eligibility file. On a weekly basis, a batch process pulls these responses and generates a HIPP referral letter to clients who answered "yes" to one or more of the three questions. After receiving information from the client, HIPP screens the referrals, and contacts employers for additional information when it appears a referral response could result in a HIPP enrollment. About 95 percent of all Pennsylvania HIPP referrals are received using this automated referral process.

Recommendation 3 directs the Health and Human Services Commission, via a rider included in the 2008–09 General Appropriations Bill, to ensure that an automated referral system be incorporated into the Texas Integrated Eligibility Redesign System (TIERS) whereby referrals to the HIPP program occur at the time of application. Sample rider language can be found at the end of this report.

ALTERNATIVE APPROACH TO REFERRALS

Currently, Texas state agencies do not use all available referral sources. Using alternative avenues for growing premium assistance programs is not a new concept to other states. Both Oregon and Massachusetts use brokers or insurance marketing representatives to market their premium assistance programs. Insurance carriers pay agents normal market commissions for referrals. Oregon estimates in 2005, approximately 22 percent of referrals to their premium assistance program were agent assisted. Oregon state personnel from the Office of Private Health Partnerships teach continuing education classes for licensed insurance agents to learn about their premium assistance programs and their state's high-risk health insurance pool.

Moreover, this method is already used successfully to refer people to Texas' high-risk health insurance pool. All licensed insurance agents who successfully refer an applicant to the pool receive a $50 referral fee from the pool's funds. Texas Department of Insurance personnel work with the Texas Association of Health Underwriters to provide training to licensed agents about the high-risk health insurance pool and its application process. Approximately half of all applications to the pool are agent assisted. The high-risk pool receives approximately 275 successful referrals per month from Texas insurance agents. Texas' high-risk health insurance pool's annual expenditures for referrals are estimated to be $165,000 based on an average of 275 successful referrals per month at $50 per referral.

While it is not expected that Medicaid clients will be visiting insurance agents for health insurance policy information, this referral source could assist businesses, particularly small to medium size businesses. A concern for business owners wanting to provide health insurance to their employees is the number of employees within the business who will participate or "take up" the employer-sponsored insurance. The greater the participation number, the more affordable it is for all employees. The Texas Insurance Code §1501.154 states insurance carriers cannot require more than 75 percent of eligible employees to enroll in a plan. However according to the Texas Department of Insurance (TDI), few, if any, insurance carriers will write a health insurance policy for any business unless there is a minimum of 75 percent participation by employees. Low wage workers may want to participate but may be financially unable to do so. In this case, an insurance agent who is aware of the HIPP program may be able to assist the business owner by helping her to identify how many employees may be eligible for the HIPP program thereby increasing the "take up" rate for health insurance offered by the business.

Recommendation 4 amends the Human Resource Code §32.0422 to allow the Health and Human Services Commission to provide training about the Health Insurance

Premium Payment program and its eligibility requirements to all interested licensed insurance agents in Texas. The Health and Human Services Commission would be authorized to provide financial compensation for each successful HIPP referral in an amount commensurate with the standard insurance agent commissions or other referral fees identified by the Health and Human Services Commission for those licensed insurance agents who have received HIPP training.

REDUCTION OF THE REIMBURSEMENT PERIOD

Despite the benefits of the HIPP program to participants, another obstacle that may be inhibiting enrollment growth is the two-week period it takes for clients to receive their premium reimbursement check. In general, cost is a barrier to enrollment in employer-sponsored insurance for low-income workers because the employee's share of premiums consumes a higher percentage of their income.

According to the HIPP vendor, 44 percent of enrollees in the HIPP program are families whose children are Medicaid-eligible and whose incomes are less than 133 percent of the federal poverty level. This percentage translates into a family of four earning less than $26,600 a year. While one of the benefits of the HIPP program is that a minimum employer contribution is not required as part of the cost effectiveness test, this may mean some HIPP enrollees may pay a significant portion of their paycheck for their health insurance premium. For example, if an employer does not contribute or contributes very little to the health insurance premium, then the employee must have the entire premium amount or most of it deducted from his/her paycheck and then wait two weeks to get reimbursed by HIPP. For some HIPP families this can be too much of a financial hardship to endure to have health insurance.

Rhode Island and Iowa reimburse employees weekly, biweekly, or monthly, depending on the frequency of the employer's payroll. In Iowa, the HIPP program addresses participants cash flow problems and ensures its clients are not penalized financially for participating in HIPP. For example, the Iowa HIPP program generates reimbursement checks and a mail service mails them two to five days before the employee's payroll deduction.

Presently in Texas, the HIPP vendor weekly compiles a list of names for reimbursement and sends the list to the Texas Comptroller of Public Accounts who releases the money to enrollees the following week. Previously, the HIPP vendor submitted that list to the primary Medicaid contractor, who maintained a reserve of income from which reimbursement payments were paid.

Recommendation 5 requires HHSC, via a rider included in the 2008–09 General Appropriations Bill, to work with the HIPP vendor to reduce the reimbursement period to less than seven days. Sample rider language can be found at the end of this report.

PERFORMANCE ASSESSMENT AND REPORTING

To ensure growth in the HIPP program continues, Recommendation 6 requires HHSC to report about the progress and growth of the program to the Legislative Budget Board and the Governor by October 1, 2008. This recommendation could be implemented through a rider included in the 2008–09 General Appropriations Bill and can be found at the end of this report.

SAVINGS FROM THE HEALTH INSURANCE PREMIUM PAYMENT PROGRAM GROWTH

Through implementation of the above mentioned recommendations, the HIPP program's enrollment could grow beyond its current yearly average growth of 20 percent. In addition, the cost to implement these recommendations would be offset by savings generated by increased HIPP enrollment. As a result, the Health and Human Service Commission's appropriation made above for Goal B, Medicaid could be reduced by $2.6 million All Funds or $1.0 in General Revenue Funds and $1.6 million in Federal Funds for fiscal year 2008 and $6.6 million in All Funds or $2.6 million in General Revenue Funds and $4.0 million in Federal Funds for fiscal year 2009. The additional savings the program produces could be returned to General Revenue fund.

The following Health and Human Services Commission rider could be included in the 2008–09 General Appropriations Bill to implement Recommendations 1 through 6.

Health Insurance Premium Payment (HIPP) program.

a. **Medicaid HIPP Outreach and Public Awareness.** Out of funds appropriated above in Goal B, Medicaid, The Health and Human Services Commission (HHSC) shall use at least $1.7 million in All Funds in the 2008–09 biennium to increase awareness and public knowledge about Medicaid's Health Insurance Premium Payment program in order to increase enrollment and retention of enrollees. Texas businesses and segments of the Medicaid-eligible population most likely to have access

to employer-sponsored insurance should be the targets for the outreach and public awareness efforts.

b. **HIPP Program Training.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall provide training on an ongoing basis about the Health Insurance Premium Payment program to workers who have contact with people inquiring or applying for benefit assistance.

c. **HIPP Automated Referral System.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall incorporate into the Texas Integrated Eligibility Redesign System (TIERS) an automated referral system whereby referrals to the Health Insurance Premium Payment program occur at the time of application for benefit assistance.

d. **HIPP Repayment Period Reduced.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall work with the Health Insurance Premium Payment vendor and other entities to reduce the Health Insurance Premium Payment client reimbursement period to less than seven days.

e. **HIPP Program Status Report.** The Health and Human Services Commission shall submit a report that includes an overview and evaluation of the state's Health Insurance Premium Payment (HIPP) program and recommendations to improve it. The report should address, but not be limited to, the progress the Health Insurance Premium Payment program has made in the following areas:

1. The number of businesses responding when HIPP personnel request health insurance information and the number of those who do not.
2. Reporting the number of Medicaid-eligible Texans exposed to HIPP outreach or public awareness efforts.
3. Increasing HIPP referrals each year.
4. Increasing the rate of HIPP enrollees from referrals.
5. Increasing number of HIPP participants by 30 percent from previous fiscal year.
6. Decreasing the reimbursement two week waiting period (with the ultimate goal being less than seven days).
7. Decrease the referral time to HIPP program with the ultimate goal of referral occurring at eligibility determination.
8. The report shall be submitted to the Governor and the Legislative Budget Board by October 1, 2008.

f. **HIPP Referral Fee and Licensed Insurance Representative Training.** Contingent upon the enactment of House/Senate Bill XX by the Eightieth Legislature, Regular Session, or similar legislation relating to the Health and Human Services Commission providing training about the Health Insurance Premium Payment program and its eligibility requirements to all interested licensed insurance agents in Texas, the Health and Human Services Commission is authorized to pay a referral fee commensurate with the standard insurance agent commission for each successful HIPP referral in an amount commensurate with the standard insurance agent commission or other referral fees identified by the Health and Human Services Commission for those licensed insurance agents who have received HIPP training. The Health and Human Services Commission shall allocate, out of funds appropriated above in Goal B, Medicaid, at least $330,000 in All Funds per biennium to pay HIPP-trained licensed insurance representatives the referral fee for each successful referral to the HIPP program.

FISCAL IMPACT OF RECOMMENDATIONS

Recommendation 1 directs HHSC through a rider to allocate at least $1.7 million per biennium to increase public awareness and educate businesses about the HIPP program. This recommendation would be implemented using approximately $857,150 in General Revenue Funds appropriated for the Medicaid program and approximately $857,150 in Federal Funds for the 2008–09 biennium. The match rate for administrative expenses is 50 percent which is the basis for estimating General Revenue Funds and Federal Funds for state fiscal year 2008–09. The estimated cost is based on 50 percent of the three-year average per person cost for CHIP media and outreach expenditures for 2003–05.

Recommendations 2, 3, 5, and 6 direct HHSC to make operation changes and to monitor HIPP enrollment growth. It is estimated that the Health and Human Service

Commission could implement these recommendations by using existing resources.

Recommendation 4 amends Texas Human Resource Code Section 32.0422 to require the Health and Human Services Commission to establish training and a payment program for successful referrals to the Health Insurance Premium Payment program by HIPP-trained licensed insurance agents. A contingency rider would direct HHSC to allocate at least $330,000 in All Funds per biennium to pay licensed insurance representatives a referral fee for each successful referral to the HIPP program. This recommendation could be implemented by using approximately $165,000 in General Revenue Funds already appropriated for the Medicaid program and approximately $165,000 in Federal Funds for 2008–09 biennium. The match rate for administrative expenses is 50 percent which is the basis for estimating General Revenue Funds and Federal Funds for state fiscal year 2008–09. The estimated cost of the referral fee is based on the current $50 fee paid by the state's high-risk health insurance pool to insurance agents who successfully refer clients to the pool.

The cost to implement these recommendations would be offset by savings generated by increased HIPP enrollment.

The following assumptions were made to calculate the savings:

- Based on data available from HHSC, the current enrollment growth of the HIPP program is 20 percent based on a two-year average (2003 to 2005).
- Based on the projected enrollment levels for fiscal year 2008, it is assumed the implementation of the recommendations could be demonstrated through additional enrollment beyond the baseline growth of 20 percent. Therefore, beginning in fiscal year 2008 a growth rate of 30 percent and continuing each fiscal year thereafter is assumed after implementing the recommendations.
- Levels of enrollment shown in **Figure 7** illustrate the potential savings with additional enrollment in HIPP.
- To determine savings to Medicaid the additional enrollment could generate, the 2005 average net savings per client ($1,342) was applied to the difference between targeted enrollment and baseline enrollment figures.

As depicted in **Figure 8**, Recommendations 1 through 6 would increase HIPP participation in the 2008–09 biennium saving $3.6 million in General Revenue Funds in the 2008–09 biennium.

The introduced 2008–09 General Appropriations Bill includes a reduction of $1 million in General Revenue Funds and $1.6 million in Federal Funds for fiscal year 2008 and $2.6 million in General Revenue Funds and $4 million in Federal Funds for fiscal year 2009 pursuant to the recommendations. It also includes a rider implementing all recommendations, except Recommendation 4.

FIGURE 7
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM
ESTIMATED LEVELS OF ENROLLMENT
FISCAL YEARS 2008 TO 2012

HIPP LEVELS	2008	2009	2010	2011	2012
Baseline Enrollment (20% growth)	23,617	28,340	34,008	40,809	48,971
Target Enrollment (30% Growth)	25,585	33,260	43,238	56,209	73,072
Difference	1,968	4,920	9,230	15,400	24,101

Source: Legislative Budget Board.

FIGURE 8
FISCAL IMPACT - FISCAL YEARS 2008–2012

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE – ENROLLMENT GROWTH	PROBABLE SAVINGS/(COST) TO FEDERAL FUNDS – ENROLLMENT GROWTH
2008	$1,042,277	$1,599,743
2009	$2,639,378	$3,965,673
2010	$4,951,517	$7,439,666
2011	$8,261,469	$12,412,877
2012	$12,929,198	$19,426,153

CREATE A COORDINATED STATE INFRASTRUCTURE TO SUPPORT CHILDREN'S BEHAVIORAL HEALTH SERVICES

The funding and delivery of children's behavioral health services in Texas are dispersed across nine state agencies and various local entities. The public mental health and substance abuse, general health, child welfare, juvenile justice, and education systems each provide or fund behavioral health services for children. State agencies reported a combined total of $570.1 million spent on children's behavioral health services during state fiscal year 2005. The current structure results in a fragmented service delivery system whereby consumers must access and integrate behavioral healthcare and support services across multiple, disconnected programs, and may face service gaps. The fragmented service delivery system increases the possibility for duplication of effort and inefficiencies. Furthermore, access to certain intensive community-based services and supports, which have the potential to improve outcomes and reduce the need for institutional care, is limited in Texas. As a result, children with behavioral health needs may not always be served in the most appropriate and cost-effective setting.

The "system of care" concept and philosophy, which provides a framework for organizing and financing children's behavioral health services, can reduce service and funding fragmentation and improve access to and availability of community-based services. Steps taken in other states to support local systems of care include innovative financing mechanisms, such as integrated funding and the use of alternative financing options under Medicaid. Other states have also created a central location in state government for the coordination of children's behavioral health services. By supporting local systems of care, Texas could realize long-term cost savings through reductions in spending on psychiatric inpatient hospitalizations, residential treatment center stays, and decreased involvement with the juvenile justice system.

CONCERNS

- ♦ The funding and delivery of children's behavorial health services in Texas is fragmented. No one entity in Texas is responsible for overseeing or coordinating all publicly-funded behavioral health services for children at the state-level. Consequently, there is no statewide effort to establish priorities, track spending, assess potential gaps and duplications, and coordinate policies specific to children's behavorial health services.
- ♦ Children with behavioral health needs may not always be served in the most appropriate and cost-effective setting. Consumer access to certain intensive community-based services and supports, which have the potential to improve outcomes and reduce the need for institutional care, is limited.
- ♦ Texas has taken steps to support systems of care for Texas children with behavioral health needs. However, efforts are limited to certain geographic regions and do not consistently include all of the operational components necessary to achieve an optimal system of care, such as integrated financing. Furthermore, the state is currently not taking advantages of alternative financing options under Medicaid to increase access to community-based services for children with behavioral health needs, such as requesting federal approval to implement a Medicaid 1915(c) Home and Community-Based Services Waiver.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend the Texas Government Code to establish the Texas Children's Council administratively attached to the Health and Human Services Commission and governed by the administrative head or designee of each state agency responsible for serving children and youth to provide a coordinated, comprehensive, interagency approach to system of care development for children.
- ♦ **Recommendation 2:** Amend the Texas Government Code to require the Texas Children's Council to design an integrated cross-agency funding structure for children's behavioral health services using existing categorical and/or non-categorical Federal Funds, General Revenue Funds and/or General Revenue–Dedicated Funds, and Local Funds in a coordinated manner to support systems of care, focusing on blended or braided funding arrangements.
- ♦ **Recommendation 3:** Amend the Texas Government Code to abolish the Texas Integrated Funding Initiative Consortium, transfer responsibility for overseeing the

Texas Integrated Funding Initiative from the Health and Human Services Commission and the Texas Integrated Funding Initiative Consortium to the Texas Children's Council, and establish the Advisory Council for Children comprised of family and youth representatives and other community stakeholders appointed by the Governor to provide recommendations to the Texas Children's Council.

- **Recommendation 4:** Amend the Texas Government Code to require the Health and Human Services Commission to maximize Medicaid financing for home and community-based services for children with behavioral health needs by requesting federal approval to implement a Medicaid 1915(c) Home and Community-Based Services Waiver and/or to amend the Medicaid State Plan no later than fiscal year 2009 if these options are found cost-effective and can be implemented within existing resources.
- **Recommendation 5:** Include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $200,000 in fiscal year 2008 and $200,000 in fiscal year 2009 in General Revenue Funds to the Health and Human Services Commission for the purposes of expanding the role of its Office of Program Coordination for Children and Youth to serve as staff to the Texas Children's Council, to coordinate the Advisory Council for Children, to support the statutorily-required activities of the Texas Children's Council, and to hire a consultant with expertise in system of care development to assist the Texas Children's Council with designing an integrated cross-agency funding structure for children's behavioral health services.

DISCUSSION

"Behavioral health" is a term used to encompass both mental and chemical dependency disorders and services. For purposes of this report, children are defined to include those persons who meet eligibility requirements for a given program. According to the National Institute of Mental Health (NIMH), many children have mental health or addictive disorders that interfere with normal development and functioning. The 1992 NIMH MECA Study (*Methodology for Epidemiology of Mental Disorders in Children and Adolescents*) estimated that almost 21 percent of children age 9 to 17 in the United States had a diagnosable mental or addictive disorder associated with at least minimum impairment. When diagnostic criteria required the presence of significant functional impairment, estimates were 11 percent. When extreme functional impairment is the criterion, the estimates were 5 percent. There is no consensus on the best criteria for defining the prevalence of mental health disorders in children under age 9. **Figure 1** shows the projected prevalence of mental or addictive disorders in Texas based on the NIMH MECA Study.

FIGURE 1
PROJECTED NUMBER OF YOUTH AGE 9 TO 17 IN TEXAS WITH MENTAL OR ADDICTIVE DISORDERS: 2007

LEVEL OF IMPAIRMENT	PERCENTAGE OF YOUTH (U.S. ESTIMATE)	TOTAL YOUTH (TEXAS ESTIMATE)
Minimal Impairment	21%	647,783
Significant Impairment	11%	339,315
Extreme Impairment	5%	154,234

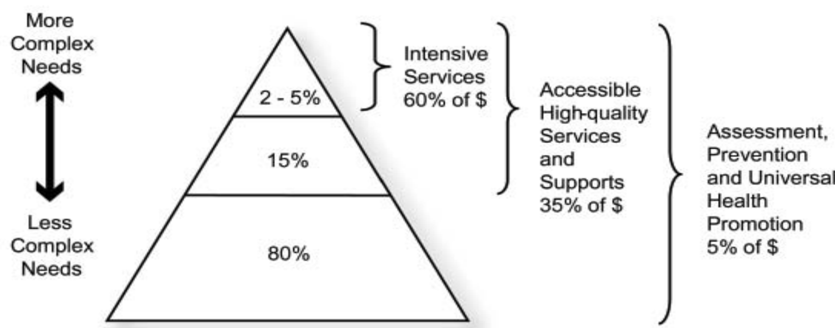
Source: Legislative Budget Board.

There are varying levels of need and interventions across the population of children with behavioral health disorders. As shown in **Figure 2**, approximately 2 percent to 5 percent of children with a serious emotional disturbance (SED) require the most intense interventions and consume 60 percent of behavioral health spending. SED is defined as a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to age 18. There are an estimated 15 percent of children with significant needs who require targeted interventions. If these children do not receive treatment, the severity of their needs may increase to the level of SED. Finally, approximately 80 percent of youth have less complex needs that prevention strategies can address. This report focuses on the top 5 percent of youth who require the most intense interventions. However, a fully developed system of care will include strategies to address the needs of all youth with behavioral health needs.

FRAGMENTED FUNDING AND DELIVERY STRUCTURE OF THE CURRENT SYSTEM

The behavioral healthcare system refers to the full array of programs for anyone with a mental or chemical dependency disorder. There are programs at every level of government and throughout the private sector with varying missions, settings, and financing. Multiple public programs, each with their own set of rules and eligibility criteria, finance services

FIGURE 2
LEVELS OF NEED AND INTERVENTIONS AMONG YOUTH POPULATION WITH BEHAVIORAL HEALTH NEEDS, 2006



Source: Human Service Collaborative.

and supports for children with behavioral health needs. Often the programs are tightly restricted in their use and in who can access services. Although each program provides essential assistance, together they create a financing approach that is complex and fragmented.

Some of the programs are administered by separate entities, contributing to a fragmented service delivery system. The fragmented service delivery system results in difficulties for consumers and the state. In July 2003, the President's New Freedom Commission on Mental Health reported that consumers often feel overwhelmed when they must access and integrate mental health care and support services across multiple, disconnected programs and may face service gaps, especially for children involved in multiple public systems, such as education, juvenile justice, and mental health. Furthermore, no one entity in Texas is responsible for overseeing or coordinating all publicly-funded behavioral health services for children at the state-level. As such, there is no statewide effort to establish priorities, track spending, assess potential gaps and duplications, and coordinate policies specific to children's behavorial health services. The fragmented service delivery system and limited coordination among state agencies increases the possibility for duplication of effort and multiple service delivery approaches, treatment plans, service definitions, billing processes, and reporting requirements for similar or related services.

Multiple Texas state agencies, spanning the systems of education, child welfare, juvenile justice, general health, mental health, and substance abuse, provide or fund behavioral health services for persons under age 21. As shown in **Figure 3**, eight state agencies reported a combined total of $570.1 million spent on children's behavioral health services during state fiscal year 2005. The amount reported includes federal and state dollars. Local dollars are also included for the Department of State Health Services, the Juvenile Probation Commission, and the Department of Aging and Disability Services.

Following are details related to the data reported in **Figure 3.**

Health and Human Services Commission (HHSC): Spending reported by HHSC includes Medicaid and the Children's Health Insurance Program (CHIP) that provide basic insurance coverage for behavioral health services. Spending reported by HHSC also includes the School Health and Related Services (SHARS) program, administered by HHSC in cooperation with the Texas Education Agency, which allows public schools to receive Medicaid reimbursement for certain services, including psychological services. Medicaid is also a payor of specialty behavioral health services and as such, it funds targeted case management and rehabilitative services operated and reported by DSHS.

Department of State Health Services (DSHS): Spending reported by DSHS includes community and residential services provided through local mental health authorities and funded with General Revenue Funds, Medicaid specialty behavioral health service funding, federal block grant funds,

FIGURE 3
PUBLIC SPENDING ON CHILDREN'S[1] BEHAVIORAL HEALTH SERVICES REPORTED BY STATE AGENCIES: FISCAL YEAR 2005

AGENCY	MENTAL HEALTH	SUBSTANCE ABUSE[2]	TOTAL CHILDREN'S BEHAVIORAL HEALTH SPENDING
Health and Human Services Commission	$351,434,819	$8,006,101	$359,440,920
Department of State Health Services	121,810,671	18,743,716	140,554,387
Department of Family and Protective Services	1,979,303	19,637	1,998,940
Department of Assistive and Rehabilitative Services	88,124	n/a	88,124
Department of Aging and Disability Services	318,409	n/a	318,409
Texas Education Agency (Data Unavailable)	–	–	–
Texas Department of Criminal Justice	4,550,368	n/a	4,550,368
Juvenile Probation Commission	20,488,697	11,502,902	31,991,599
Texas Youth Commission	18,244,952	12,923,146	31,168,098
OVERALL TOTAL	**$518,915,343**	**$51,195,502**	**$570,110,845**

[1]Children are defined to include persons who meet eligibility requirements for programs administered by the respective agencies.
[2]Items listed as n/a are not applicable as they do not fund substance abuse services.
Source: Legislative Budget Board.

other federal grant funding, and Local Funds. Reported spending also includes services provided through NorthSTAR—an integrated behavioral health initiative that provides managed behavioral healthcare to individuals living in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties.

Department of Family and Protective Services (DFPS): Spending reported by DFPS includes General Revenue Funds and Federal Funds. These Federal Funds include federal child welfare service funding, and federal block grant funding through the Temporary Assistance for Needy Families (TANF) program, but does not include room and board expenditures for residential treatment center stays paid with federal Title IV-E foster care funds. Medicaid spending reported by HHSC and DSHS includes behavioral health services provided to children in the foster care system overseen by DFPS.

Department of Assistive and Rehabilitative Services (DARS): Spending reported by DARS includes services provided through Early Childhood Intervention funded with General Revenue Funds, Medicaid, federal vocational rehabilitation funds, and federal Individuals with Disabilities Education Act (IDEA) funds.

Department of Aging and Disability Services (DADS): Spending reported by DADS includes services provided through long-term care programs funded with General Revenue Funds, Medicaid, and Local Funds.

Texas Education Agency (TEA): School districts use Local Funds, General Revenue Funds and Federal Funds, including federal IDEA funds, to provide behavioral health services to students. However, total reported spending does not include amounts spent on behavioral health services by school districts because this data is not reported to TEA. TEA reported that 37,548 students age 3 to 21 have an emotional disturbance listed as their primary disability and may receive behavioral health treatment provided through school districts.

Department of Criminal Justice's Texas Correctional Office on Offenders with Medical and Mental Impairments (TDCJ TCOOMMI): Spending reported by TDCJ's TCOOMMI includes services provided to special needs youth involved with the juvenile justice system and funded with General Revenue Funds.

Juvenile Probation Commission (JPC): JPC does not directly provide or fund behavioral health services, but allocates state funding to local juvenile probation departments that may be used to provide or purchase behavioral health services. Data reported under JPC includes expenditures reported by 53 percent (89/168) of juvenile probation departments and includes Local Funds, General Revenue Funds, and limited Federal Funds (grants).

Texas Youth Commission (TYC): Spending reported by TYC includes non-TCOOMMI aftercare services, residential treatment centers, the specialized mental health treatment

program, the specialized chemical dependency treatment program, and mental health services provided to the general population. These services are funded with General Revenue Funds and limited Federal Funds (grants).

Figure 4 shows the number of children who received behavioral healthcare services and reported spending by program. There is duplication in the number served across programs because children may receive services through multiple programs. Although it is not possible to provide the total number of unduplicated children who received behavioral health services across all state agencies, the total number of unduplicated children who received behavioral health services across health and human services agencies during state fiscal year 2005 is 255,117.

Children with mental or chemical dependency disorders may receive services in community-based or residential settings. As shown in **Figure 5**, of the $539.1 million spent on children's behavioral services reported by state agencies, $356.7 million (or 66 percent) was spent on care provided in the community. Spending for NorthSTAR could not be split between community and residential settings and is therefore not included in **Figure 5**. As a result, the amount spent on children's behavioral health services reported in **Figure 5** is reduced from $570.1 million to $539.1 million. Services provided in the community may include traditional psychiatric and clinical treatment, such as physician services and counseling, as well as intensive services, such as Multi-Systemic Therapy. The remaining $182.3 million (or 34

FIGURE 4
CHILDREN[1] SERVED AND REPORTED SPENDING BY PROGRAM, FISCAL YEAR 2005

	MENTAL HEALTH[2]		SUBSTANCE ABUSE[2]	
PROGRAM	CHILDREN SERVED (DUPLICATED ACROSS PROGRAMS)	SPENDING	CHILDREN SERVED (DUPLICATED ACROSS PROGRAMS)	SPENDING
Medicaid Fee-for-Service and Primary Care Case Management (HHSC)	154,262	$163,676,634	6,762	$7,365,465
Medicaid Health Maintenance Organizations (HHSC)	34,348	16,043,222	773	253,143
Medicaid Vendor Drug[3] (HHSC)	118,747	146,501,789	**	**
Children's Health Insurance Program (HHSC)	43,079	24,931,470	486	387,493
Medicaid School Health and Related Services (HHSC)	855	281,704	n/a	n/a
Community and Residential Services[4] (DSHS)	33,998	93,018,161	7,466	16,544,053
NorthSTAR (DSHS)	10,411	28,792,510	622	2,199,663
Child Welfare (DFPS)	5,669	1,979,303	94	19,637
Early Childhood Intervention (DARS)	265	88,124	n/a	n/a
Performance Contract with Mental Retardation Authorities (DADS)	70	106,823	n/a	n/a
In-Home Family Support for Mental Retardation (DADS)	99	168,947	n/a	n/a
Home and Community-based Services Waiver (DADS)	158	40,055	n/a	n/a
Texas Home Living Waiver (DADS)	10	2,584	n/a	n/a
Texas Correctional Office for Offenders with Medical and Mental Impairments (TDCJ)	2,278	4,550,368	n/a	n/a
Local Juvenile Probation Departments (JPC)	Data Unavailable	20,488,697	Data Unavailable	11,502,902
Non-TCOOMMI Aftercare Services (TYC)	195	98,128	710	272,631

FIGURE 4 (CONTINUED)
CHILDREN[1] SERVED AND REPORTED SPENDING BY PROGRAM, FISCAL YEAR 2005

	MENTAL HEALTH[2]		SUBSTANCE ABUSE[2]	
PROGRAM	CHILDREN SERVED (DUPLICATED ACROSS PROGRAMS)	SPENDING	CHILDREN SERVED (DUPLICATED ACROSS PROGRAMS)	SPENDING
Residential Treatment Centers for Incarcerated Youth (TYC)	484	$10,679,258	110	$1,668,253
Specialized Mental Health Treatment Program (TYC)	361	5,519,086	n/a	n/a
Specialized Chemical Dependency Treatment Program (TYC)	n/a	n/a	870	10,982,262
Services to General Incarcerated Youth Population (TYC)	1,431	1,948,480	n/a	n/a
TOTAL	**--**	**$518,915,343**	**--**	**$51,195,502**

[1]Children are defined to include persons who meet eligibility requirements for programs administered by the respective agencies.
[2]Items listed as n/a are not applicable because they do not fund either substance abuse or mental health services depending on the program.
[3]Data for the Medicaid Vendor Drug program is reported under mental health, but may also include substance abuse services.
[4]Due to agency data limitations, the number of children served by DSHS Community and Residential Services may include children whose services were funded by TDCJ's Texas Correctional Office for Offenders with Medical and Mental Impairments.
SOURCE: Legislative Budget Board.

FIGURE 5
CHILDREN'S[1] BEHAVIORAL HEALTH SERVICES BY SERVICE DELIVERY SETTING
REPORTED BY STATE AGENCIES, FISCAL YEAR 2005

	COMMUNITY SERVICES		INSTITUTIONAL AND RESIDENTIAL SERVICES		TOTAL CHILDREN'S BEHAVIORAL HEALTH SPENDING
PROGRAM BY AGENCY	CASES	SPENDING	CASES	SPENDING	
Health and Human Services Commission	358,561	$268,334,078	12,744	$91,106,842	$359,440,920
Department of State Health Services[2]	34,981	$66,161,148	4,823	$43,401,066	$109,562,214
Department of Family and Protective Services	5,763	$1,998,940	$0	$0	$1,998,940
Department of Assistive and Rehabilitative Services	265	$88,124	$0	$0	$88,124
Department of Aging and Disability Services	337	$318,409	$0	$0	$318,409
Texas Education Agency (Data Unavailable)	–	–	–	–	–
Texas Department of Criminal Justice	2,278	$4,550,368	$0	$0	$4,550,368
Juvenile Probation Commission	Data Unavailable	$14,916,459	Data Unavailable	$17,075,140	$31,991,599
Texas Youth Commission	905	$370,759	3,256	$30,797,339	$31,168,098
OVERALL TOTAL	**403,090**	**$356,738,285[3]**	**20,823**	**$182,380,387**	**$539,118,672**

[1]Children are defined to include persons who meet eligibility requirements for programs administered by the respective agencies.
[2]Data reported by DSHS does not include TDCJ TCOOMMI spending, but does include the number served with TDCJ TCOOMMI funds.
[3]The total for community services includes Medicaid-funded services provided to children placed in residential settings by DFPS.
SOURCE: Legislative Budget Board.

percent) was spent on care provided in institutional or residential settings. These settings include inpatient hospital services (i.e., state-owned psychiatric hospitals, private general hospitals, and private psychiatric hospitals), residential treatment centers, and secure and non-secure facilities operated by local juvenile probation departments and TYC.

LIMITED ACCESS TO INTENSIVE COMMUNITY BASED TREATMENT ALTERNATIVES

Research literature indicates that children with mental and chemical dependency disorders should have access to a continuum of care. The most widely available services include traditional psychiatric and clinical treatment and institutional care. Certain community-based services and supports, when provided in sufficient quantity on their own or in combination with another service, constitute intensive community-based services and have the potential to improve outcomes and reduce the need for institutional care. Access to some of these services in Texas is limited. As a result, children with behavioral health needs may not always be served in the most appropriate and cost-effective setting.

Children in Texas may receive intensive community-based services funded through the public mental health and substance abuse, general health, child welfare, juvenile justice, and education systems. However, access to intensive services may be limited due to resource constraints, including lack of funding and/or provider availability. For example, children who attempt to access publicly-funded services through local mental health authorities (LMHAs), which are under contract with DSHS, may not always receive all recommended services. Children who access services through LMHAs and meet eligibility requirements are assessed through the Texas Recommended Authorization Guidelines (TRAG) system, a uniform assessment process. The TRAG assessment results in a recommended service package. Some children are not served in the service package recommended due to resource constraints. **Figure 6** shows the number of children who, due to resource constraints, received an alternative service package. In most cases, the alternative service package was less intensive than the recommended package.

Children who receive a recommended intensive service package do not always receive all the services included in the service package. Children may or may not receive services in a given service package depending on a child's needs and/or resource constraints. **Figure 7** shows the individual community mental health services that are included in one or more intensive service packages that serve a relatively low number of children. The figure also includes three services (Family Training, Family Case Management, and Respite) that are not included in the intensive service packages, but are required to be provided by LMHAs given funding and provider availability.

USING SYSTEMS OF CARE TO IMPROVE SERVICE ACCESS AND REDUCE FRAGMENTATION

For the past 20 years, the concept and philosophy of a "system of care" has provided a guide and organizing framework for system reform in children's mental health. A system of care, described further in **Figure 8**, is a comprehensive approach to coordinating and delivering an array of services from multiple agencies. The systems of care concept offers a framework for organizing and financing services to reduce service and funding fragmentation and improve access to and availability of services. Systems of care efforts can apply to children with serious emotional disturbances (SED) only, children at risk for SEDs, and/or all children who depend on public systems.

The system of care concept holds that all life domains and needs should be considered rather than addressing mental health treatment needs in isolation. **Figure 9** shows how systems of care are organized around eight overlapping dimensions.

Figure 10 shows the operational components of systems of care as a customized approach to service delivery. A key element in system of care is interagency collaboration and

FIGURE 6
COMPARISON OF INTENSIVE SERVICE PACKAGE NEED TO RECEIPT, FISCAL YEAR 2005

INTENSIVE SERVICE PACKAGE	CHILDREN DETERMINED TO NEED SERVICE PACKAGE	CHILDREN WHO RECEIVED ALTERNATE SERVICE PACKAGE
Level of Care 2.1 Multi-Systemic Therapy	540	84
Level of Care 2.2 Externalizing Disorders	3,847	456
Level of Care 2.3 Internalizing Disorders	1,143	117
Level of Care 2.4 Major Disorders	3,833	0
Level of Care 3 Treatment Foster Care	57	31
TOTAL	**9,420**	**688**

SOURCE: Texas Department of State Health Services.

FIGURE 7
COMMUNITY MENTAL HEALTH SERVICES WITH LOW USE
FISCAL YEAR 2005

SERVICE	INCLUDED IN ONE OR MORE INTENSIVE SERVICE PACKAGES	CHILDREN SERVED BY LOCAL MENTAL HEALTH AUTHORITIES
Group Skills Training	Yes	27
Family Partner	Yes	711
Parent Support Group	Yes	226
Flexible Community Supports	Yes	174
Respite	No	34
Family Training	No	0
Family Case Management	No	0

Source: Legislative Budget Board.

FIGURE 8
SYSTEM OF CARE DEFINITION, CORE VALUES, AND GUIDING PRINCIPLES

SYSTEM OF CARE DEFINITION:

A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

CORE VALUES:

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations the serve.

SUMMARY OF GUIDING PRINCIPLES:

Services should be:

- Comprehensive, incorporating a broad array of services and supports
- Individualized
- Provided in the least restrictive, appropriate setting
- Coordinated both at the system and service delivery levels
- Involve families and youth as full partners
- Emphasize early identification and intervention.

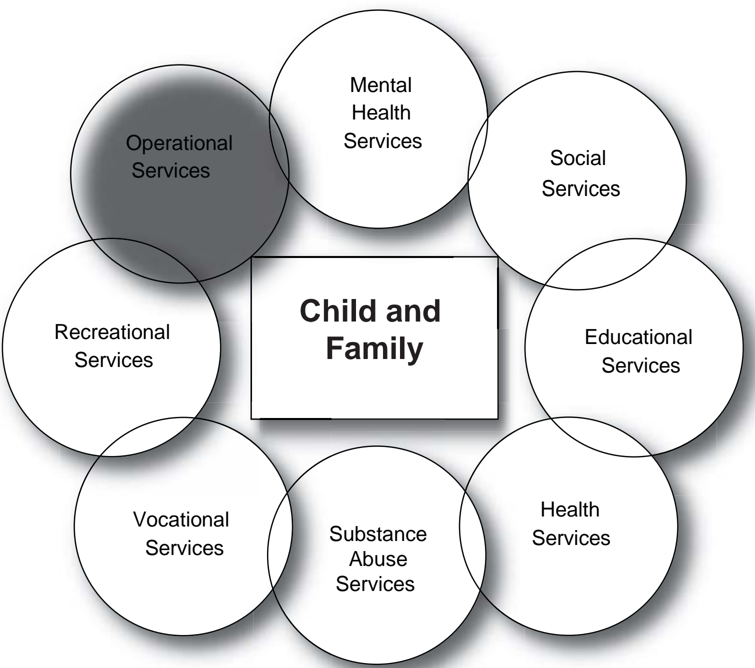
Source: Georgetown University.

partnership with families to develop a single plan of care. The single plan of care may be financed using coordinated funds and will include services and supports that are "wrapped around" the child and family.

Texas Initiatives to Support Local Systems of Care: Texas has taken steps to support systems of care for Texas children with behavioral health needs. However, efforts are limited to certain geographic regions and do not consistently include all of the operational components necessary to achieve an optimal system of care service delivery and financing structure. The following initiatives are now underway specific to system of care development.

Community Resource Coordination Groups: In 1987, the Texas Legislature enacted legislation directing state agencies serving children to develop a community-based approach to better coordinate services for children and youth who have multi-agency needs and require interagency coordination. Community Resource Coordination Groups for Children and Youth (CRCGs) were established on a county-by-county basis in response to this legislation. CRCGs are local

FIGURE 9
SYSTEM OF CARE FRAMEWORK



SOURCE: Georgetown University.

FIGURE 10
SYSTEM OF CARE OPERATIONAL COMPONENTS

- Collaboration across agencies
- Partnership with families
- Cultural and linguistic competence
- Blended, braided, or coordinated financing
- Shared governance across systems and with families
- Cross-agency care coordination
- Individualized service/supports "wrapped around" child and family
- Home and community-based alternatives
- Broad, flexible array of services, supports
- Shared outcomes across systems, reflecting community values
- Organized pathway to services and supports
- Interagency/family services planning teams
- Interagency/family services monitoring teams
- Single plan of care
- One accountable care manager
- Integration of clinical treatment services and natural supports
- Integration of evidence-based treatment approaches
- Cross-agency management information systems

SOURCE: Human Service Collaborative.

interagency groups comprised of public and private agencies who come together to address needs of individuals and families that require interagency coordination and cooperation. Although a local CRCG is available to children in all Texas counties, the extent of CRCG involvement varies by community.

Texas Integrated Funding Initiative: In 1999, legislation created the Texas Integrated Funding Initiative (TIFI) to develop systems of care in local communities for Texas children with SEDs through the integration of Federal Funds, General Revenue Funds, and Local Funds. The legislation also created the TIFI Consortium, comprised of state agencies and family advocates, to assist with TIFI implementation. TIFI sites are expected to partner with families to plan, implement, and evaluate individual service plans based on their child's behavioral health needs. From September 1, 2000 through August 31, 2006, four sites received TIFI grants awarded by the state. Each site received $330,000 over six years for a combined total of $1,320,000. These sites served approximately 220 children. DSHS is conducting a re-procurement of TIFI grants for state fiscal year 2007.

Previous sites and new communities that are not currently receiving federal funding can apply for TIFI grants.

The integration of funds under TIFI has been limited. First, although initial state funding for TIFI included blended funds contributed by the child-serving state agencies, the source of current state funding for TIFI is General Revenue Funds appropriated to HHSC. Funds are transferred from HHSC to DSHS to manage TIFI contracts. Second, TIFI sites have used TIFI grant funds and/or resources from local collaborating partners to hire facilitators to develop individual care plans; however, none of the sites currently purchase services from an integrated or blended funding pool.

SAMHSA Grants: The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) administers federal grants for local system of care development under the Comprehensive Community Mental Health Services for Children and Their Families Program (CMHS). Since 1998, four Texas communities have received CMHS grants. Currently, three Texas communities are operating CMHS grants. CMHS sites have used grant funds and/or resources from local collaborating partners to hire facilitators to develop individual care plans. Two of the four sites have pooled local funds to purchase flexible services. **Figure 11** shows the Texas communities that have received TIFI and/or CMHS grants.

NorthSTAR: In 1999, Texas implemented NorthSTAR—an integrated behavioral health initiative that provides managed behavioral healthcare to individuals living in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties. NorthSTAR integrates funding, delivery, and oversight of behavioral health services to improve efficiency and care outcomes. NorthSTAR blends state and federal funds from DSHS and HHSC with local funding to provide all mental health and substance abuse services through a single delivery system. The state of Texas contracts directly with a private behavioral health organization, currently Value Options, on a capitated basis to manage NorthSTAR. According to a review of behavioral health in managed care conducted by HHSC, NorthSTAR has resulted in more comprehensive behavioral health service packages and greater continuity of care.

System of care components implemented in Texas: The following two services, provided by local mental health authorities (LMHAs), are components of systems of care.

Wraparound Planning: All Texas children with complex needs and multi-agency involvement who access behavioral health services through a LMHA should receive a wraparound plan as part of intensive case management. A wraparound plan, which is a component of system of care, is developed by a team comprised of the child, family, intensive case manager, treatment providers, representatives from other agencies, and other informal support persons. The plan is individualized to meet the needs of the child and family and includes services offered by the LMHA, community-funded resources, and informal supports.

Flexible Supports: Access to flexible supports is a component of systems of care. Funding for flexible non-clinical

FIGURE 11
TEXAS COMMUNITIES WITH TIFI OR CMHS GRANTS

TEXAS INTEGRATED FUNDING INITIATIVE SITES			
SITE	COUNTIES	DATE RECEIVED TIFI GRANT	GRANT STATUS
Tarrant County	Tarrant	2000	Ended August 2006
Harris County	Harris	2000	Ended August 2006
Floydada	Parmer, Swisher, Castro, Dickens, Briscoe, Bailey, Lamb, Hale, Floyd, Motley	2000	Ended August 2006
Tri-County	Montgomery, Walker, Liberty	2000	Ended August 2006
COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM GRANT RECIPIENTS			
SITE	COUNTIES	DATE RECEIVED CMHS GRANT	GRANT STATUS
Travis County	Travis	1998	Ended August 2005
City of Fort Worth	Tarrant	2002	Active
El Paso County	El Paso	2002	Active
Harris County	Harris	2005	Active

Source: Legislative Budget Board.

community supports are allocated by DSHS to LMHAs as part of the annual General Revenue Fund allocations. However, funding limitations may prevent all children with complex needs from having access to flexible supports.

Systems of Care Activity in Other States: The system of care concept is an organizing framework and value base, not a prescription for replication. The concept emphasizes flexibility to implement systems of care in a way that fits a particular state or community. Thus, different states have implemented systems of care in different ways and are at different stages of development. However, effective systems of care development requires state policies and practices that support local systems of care. Steps taken in other states to support local systems of care include:

- Centralized state-level structure to guide cross-agency activities;
- Wraparound planning for all children with complex needs;
- Access to flexible funds used to purchase non-clinical supports;
- Technical assistance and training to local sites;
- Support to encourage statewide implementation of system of care sites; and
- Integration of categorical and/or non-categorical funding streams.

Figure 12 shows selected states with well-developed system of care initiatives.

Potential benefits from supporting systems of care: Several studies on the effectiveness of systems of care have been conducted in recent years. These studies have assessed systems of care across a range of outcome domains. Some studies have used comparison groups to evaluate systems of care and others have used pre-post evaluation designs. Although there are limited studies with comparison groups, making it more difficult to infer that the improved outcomes were causally linked to system of care intervention, researchers who have reviewed completed effectiveness studies indicate that the overall results are encouraging. Evaluation studies support the conclusion that system of care practices are associated with the following benefits:

- Reduced use of restrictive placements, particularly juvenile justice recidivism and psychiatric inpatient stays;
- Reduced service cost associated with the reduction in high-cost restrictive placements;
- Improved functional and symptom status in participating youth;
- Improved academic retention and performance; and
- Increased satisfaction with services.

Evaluations of systems of care in three states have found positive system-level and youth outcomes. A 1995 study of the system of care in Vermont found that participating youth had reduced rates of reinstitutionalization and individualized care was found to be cost-effective as compared to youth receiving traditional services. These youth also reported high service and life satisfaction. Similarly, an evaluation in Kentucky of a system of care approach found evidence of clinical gains, including large reductions in psychiatric hospitalizations, reductions in behavior problems, stronger family support, and consumer satisfaction. Finally, a 1997 evaluation study, which compared systems of care in three California counties with non-system of care counties, found that children served in the system of care counties had decreased expenditures and less use of restrictive placements.

Based on outcomes experienced in other states, efforts in Texas to support systems of care have the potential to improve outcomes and reduce psychiatric inpatient hospitalizations. In state fiscal year 2005, Texas spent $119.3 million on inpatient hospitalizations for children with mental health or substance abuse needs. Funding for these inpatient hospitalizations comes from the Medicaid and CHIP programs, and through General Revenue Funds. This amount does not include NorthSTAR because spending could not be split between community and institutional settings. As shown in **Figure 13**, reducing psychiatric inpatient hospitalizations could save the state between $5.9 million to $35.7 million depending on the rate at which psychiatric inpatient hospitalization spending is reduced. Additional savings could be realized by reducing residential treatment center stays and decreasing involvement with the juvenile justice system.

Medicaid Financing Options to Support Local Systems of Care: Access to a broad array of home and community-based alternatives is a key operational component of systems of care. Two potential options for increasing access to community-based services are: (1) obtaining a Medicaid 1915(c) Home and Community Based Services waiver for children with mental health needs who would otherwise

FIGURE 12
SYSTEM OF CARE INITIATIVES IN SELECTED STATES

STATE	SUMMARY OF ACTIVITY
New Jersey	The state has braided child welfare, mental health, Medicaid, and juvenile justice funds to create a single behavioral health delivery system for all children requiring publicly-funded behavioral health services. The state has contracted with Value Options to serve as the Contracted Systems Administrator at the state level. Value Options is responsible for assessing level of care, authorizing services, identifying the payment source for each service, and assigning the child to a local community agency (uncomplicated cases), a local non-profit Youth Case Management - YCM (moderate cases), or a local non-profit Care Management Organization - CMO (complex multi-system children). CMOs and YCMs work with Child and Family Teams to develop individual service plans that include informal services and formal services authorized by Value Options. Family Support Organizations and Mobile Response and Stabilization Services also work at the local level to provide assistance to children and families.
Hawaii	Locally-based case managers employed by the state Mental Health Agency (MHA) develop a Coordinated Service Plan ("wraparound plan") for every child who accesses services from the agency. The Coordinated Service Plan is developed by a team that includes the case manager, child, and family as core members and individuals from other child-serving agencies as needed depending on the specific case. The state MHA braids mental health General Revenue funds and Medicaid funds behind the scenes to provide the services agreed upon by the team. The state MHA has a Memorandum of Agreement with the state Medicaid Agency to provide services to Medicaid clients whereby the MHA is paid a per member per month amount with an end of the year reconciliation so the MHA is not at risk. Local community resources provide funding for non-categorical flexible services (no GR or Medicaid funds for this purpose).
Vermont	Vermont law stipulates that every child experiencing a severe emotional disturbance is entitled to a Coordinated Services Plan (CSP). The CSP outlines how services will be coordinated between agencies. The local entity who takes the lead in completing the CSP depends on the child's circumstance and may include the school, the child welfare system, or a local community mental health center. The state operates a braided funding system using categorical and non-categorical funds from child welfare, juvenile justice, mental health, and special education to pay for all traditional and non-traditional services and supports identified on the CSP. Services identified on the CSP are funded from a unified budget managed by Local Interagency Teams operating in all 12 regions. Services for children with the most complex needs are funded through a unified budget managed by the State Interagency Team. The State Interagency Team also approves all residential treatment and manages the Medicaid 1915(c) waiver program.
Maryland	The state established a state-level Children's Cabinet, a Governor's Office for Children (GOC), and an Advisory Council for Children. The Children's Cabinet is charged with developing a 3-year plan for the coordinated delivery of state interagency services. The state also created Local Management Boards (LMBs) in each of the 24 jurisdictions comprised of state and local agency representatives to coordinate the delivery of state-funded services. LMBs can apply to GOC for funds to create integrated systems of care for all youth in their communities with behavioral health needs. LMBs can choose to create a Care Management Entity (CME) to receive a set payment rate per eligible child in exchange for providing all necessary mental health services identified in the packaged rate. The rate can be used to purchase Medicaid-reimbursable specialty mental health services and non-Medicaid covered services. LMBs may also purchase flexible services and supports using allocations from an interagency blended funding pool managed by the Children's Cabinet.

SOURCE: Legislative Budget Board.

FIGURE 13
ESTIMATED SAVINGS FROM REDUCED PSYCHIATRIC INPATIENT HOSPITALIZATIONS, FISCAL YEAR 2005

	POTENTIAL RATE OF SAVINGS FOR PSYCHIATRIC INPATIENT HOSPITALIZATION SPENDING					
	5%	10%	15%	20%	25%	30%
All Fund Savings	$5,964,706	$11,929,412	$17,894,118	$23,858,825	$29,823,531	$35,788,237

SOURCE: Legislative Budget Board.

qualify for hospital-level care; and/or (2) amending the Medicaid State Plan under Section 1915 (i) of the Social Security Act. Both options would allow the state to expand the array of community-based services funded by Medicaid.

Medicaid 1915(c) waivers allow states to use Medicaid funds to pay for community-based treatment alternatives in lieu of care provided in institutional settings. Federal law defines institutions as "hospitals, nursing facilities, and Intermediate Care Facilities for persons with Mental Retardation." A 1915(c) waiver could expand the range of community-based services and increase access to these services through expanded eligibility. Budget neutrality provisions require that the

amount of federal funds spent remain the same after a waiver is implemented. As of June 2005, five states have used the 1915(c) waiver specifically for children with mental illness—Indiana, Kansas, New York, Vermont, and Wisconsin.

In 2003, HHSC received a Systems Change Grant from the Centers for Medicare and Medicaid Services to conduct a feasibility study to identify community-based treatment alternatives for children with a serious emotional disturbance (SED). One of the options evaluated was the use of a 1915(c) waiver. The study concluded that Texas could feasibly use a 1915(c) waiver to increase its ability to provide community-based treatment alternatives to children diagnosed with a SED who are at risk of inpatient mental health hospitalization. Specifically, the study identified 4,660 children who received services in an inpatient mental health hospital setting in fiscal year 2003 via Medicaid and non-Medicaid state funding. The cost of services for those children was approximately $150,463,407 or $32,288 per child. The report indicates that this value is "well within the range established for services provided via other 1915(c) HCBS waivers serving SED children in other states." HHSC and DSHS staff are currently developing a draft program model and analyzing data to determine if the proposed waiver can meet federal budget neutrality requirements, and be implemented within available resources.

The federal Deficit Reduction Act of 2005 (DRA) includes a provision to allow states to offer home and community-based services to eligible populations without obtaining federal Medicaid waivers. Specifically, beginning January 1, 2007, states can amend their Medicaid State Plans to offer home and community-based services as an optional state plan benefit. The provision is detailed in Section 1915(i) of the Social Security Act or Section 6086 of DRA. HHSC and DSHS staff are currently evaluating options available under the 1915(i) provision.

As shown in **Figure 14**, options for expanding income eligibility and the type of services that can be offered are more limited under the 1915(i) provision than through a 1915(c) waiver. However, the 1915(i) provision is more flexible because functional eligibility criteria can be defined by the state, there is no requirement to demonstrate budget neutrality, and there is no renewal. Under both options, the federal government allows the state to limit the number of children served and to limit the geographic location in which services are provided.

CREATE A COORDINATED STATE INFRASTRUCTURE TO SUPPORT LOCAL SYSTEMS OF CARE

Nine state agencies provide or fund behavioral health services for children resulting in fragmented service delivery and potential inefficiencies. Furthermore, Texas children have limited access to certain services and supports that have the potential to improve outcomes and reduce the need for institutional care. State efforts to support local systems of care for children with behavioral health needs can reduce service and funding fragmentation and improve access to and availability of community-based services. Despite steps taken in Texas to support systems of care for children with behavioral health needs, efforts are limited to certain geographic regions and do not consistently include all of the operational components necessary to achieve an optimal system of care.

There is no one entity in Texas responsible for overseeing or coordinating all publicly-funded behavioral health services for children at the state-level. Recommendation 1 would amend the Texas Government Code to establish the Texas Children's Council (TCC) administratively attached to HHSC and governed by the administrative head or designee of each state agency responsible for serving children and youth to provide a coordinated, comprehensive, interagency approach to system of care development for children. TCC statutory responsibilities should include the following activities to address fragmentation and provide state-level support to system of care development:

- Development and implementation of coordinated state policies to improve the behavioral health of children;
- Assessment of potential duplication of effort across the programs that fund children's behavioral health services and identification of opportunities to streamline operations;
- Development of a coordinated system of planning and budgeting to establish priorities and strategies for the coordinated delivery of children's behavorial health services;
- Development of a coordinated system to track and report behavioral health spending among the multiple state agencies that fund behavioral health services for children;
- Administration of state grants, including TIFI, to be used for local system of care development;
- Development of a plan to support statewide expansion of local systems of care sites;
- Provision of technical assistance and training to local systems of care sites; and

FIGURE 14
COMPARISON OF MEDICAID FINANCING OPTIONS TO INCREASE ACCESS TO COMMUNITY-BASED SERVICES FOR CHILDREN WITH BEHAVIORAL HEALTH NEEDS

OPTION	ALLOWABLE SERVICES	POTENTIAL ELIGIBLE POPULATION	STATE FUNDING OPTIONS	BUDGET NEUTRALITY
1915(c) waiver	Case management services; habilitation services; respite care; day treatment; partial hospitalization; psychosocial rehabilitation services; clinic services; other services requested by the State as the Secretary may approve. The term "habilitation services" includes services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.	Children eligible for Medicaid under the state plan and children who qualify for Medicaid by not counting parental income. Children must meet hospital functional level of care criteria.	Transfer funds from within HHSC's budget for start-up or obtain a new appropriation of funds. Potential to redirect institutional dollars in the long-term. State has ability to limit the numbers served and to limit the geographic location in which services are provided.	The federal government requires the state to demonstrate budget neutrality.
1915(i) State Plan Amendment	Limited to services listed in 1915(c)(4)(b) of the Social Security Act. These include: case management services; habilitation services; respite care; day treatment; partial hospitalization; psychosocial rehabilitation services; clinic services.	Children eligible for Medicaid under the state plan with incomes up to 150% of the federal poverty level. Children must meet functional eligibility criteria defined by the state.	Transfer funds from within HHSC's budget for start-up or obtain a new appropriation of funds. Potential to redirect institutional dollars in the long-term. State has ability to limit the numbers served and to limit the geographic location in which services are provided.	The federal government does not require the state to demonstrate budget neutrality.

Source: Legislative Budget Board.

- Design of an integrated cross-agency funding structure for children's behavioral health services using existing categorical and/or non-categorical federal, state and local funds.

Effective systems of care seek to integrate funds to support coordinated service delivery. The intent of integrated funding, which is a key component of efforts in other states to support systems of care, is to make the most efficient use of all available resources and provide a seamless service delivery system for clients. Blended and braided funding approaches are methods used to integrate funds and may combine categorical and non-categorical (i.e., discretionary) funds from different federal, state, and local programs into a single funding source from which all behavioral health services are purchased. Under blended funding, funding streams are literally combined into a single pool. Under braided funding, various funding sources are used to pay for services for an individual child, but tracking and accountability for each pot of money is maintained at the administrative level. The funds remain in separate strands, but are joined or braided for the individual child and family. **Figure 15** provides an example of a funding model that integrates categorical and non-categorical funds for children's behavioral health services. Alternatively, states may choose to blend only non-categorical funds to establish an account for the purchase of flexible supports in addition to traditional services.

Recommendation 2 would amend the Texas Government Code to require the TCC to design an integrated cross-agency funding structure for children's behavioral health services using existing categorical and/or non-categorical Federal Funds, General Revenue Funds and/or General Revenue–Dedicated Funds, and Local Funds in a coordinated manner to support systems of care, focusing on blended or

FIGURE 15
INTEGRATED FUNDING MODEL EXAMPLE FOR CHILDREN'S BEHAVIORAL HEALTH SERVICES

Medicaid
Mental Health
Substance Abuse
Other
Child Welfare
Juvenile Justice
System Administrator
Care Coordination
Child and Family Team
Provider Network
Plan of Care

SOURCE: Legislative Budget Board.

braided funding arrangements. The TCC should submit a report to the Governor and the Legislative Budget Board by June 1, 2008, that describes the chosen integrated funding structure and implementation steps, including necessary statutory changes or federal approvals.

When designing the integrated funding structure, the TCC will have to decide which funds should be used to finance the system of care and how the funds would be structured and managed. The integrated funding structure could include the blending or braiding of categorical funds to provide a complete package of behavioral health services to children on a statewide or regional basis. Alternatively, the integrated funding structure could be limited to the blending of non-categorical funds to establish an account for the purchase of flexible supports. The TCC should take into account who will control and manage the dollars, including consideration of managed care financing strategies. Financial management options include, but are not limited to, selecting a lead government agency, a new quasi-governmental agency, a contracted care management entity, or an interagency body (e.g., TCC), to manage the integrated funds.

Currently, HHSC, the TIFI Consortium, and DSHS through an interagency contract with HHSC, are responsible for activities related to TIFI. As discussed under Recommendation 1, TIFI administration should become one of the statutory requirements of the newly created TCC. Family and youth representatives should provide input into TIFI administration and other TCC activities through a newly created Advisory Council for Children (ACC). Recommendation 3 would amend the Texas Government Code to abolish the TIFI Consortium, transfer responsibility for overseeing TIFI from HHSC and the TIFI Consortium to the TCC, and establish the Advisory Council for Children comprised of family and youth representatives and other community stakeholders appointed by the Governor to provide recommendations to the TCC. In summary, the TIFI Consortium would be replaced by an executive-level council and an advisory council with statutory responsibilities that expand beyond TIFI.

Access to a broad array of home and community-based alternatives is a key operational component of systems of care. Two potential options for increasing access to community-based services are: (1) obtaining a Medicaid 1915(c) Home and Community Based Services waiver for children with mental health needs who would otherwise qualify for hospital-level care; and/or (2) amending the Medicaid State Plan under Section 1915 (i) of the Social Security Act. Both options would allow the state to expand the array of community-based services funded by Medicaid while allowing the state to limit the number of children served and to limit the geographic location in which services are provided.

Recommendation 4 would amend the Texas Government Code to require HHSC to maximize Medicaid financing for home and community-based services for children with behavioral health needs by requesting federal approval to implement a Medicaid 1915(c) Home and Community-Based Services Waiver and/or to amend the Medicaid State Plan no later than fiscal year 2009 if these options are found

cost-effective and can be implemented within existing resources. HHSC could consider implementing either of these initiatives in a current TIFI or CMHS grant site.

Recommendation 5 would include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $200,000 in fiscal year 2008 and $200,000 in fiscal year 2009 in General Revenue Funds to HHSC for the purposes of expanding the role of its Office of Program Coordination for Children and Youth (OPCCY) to serve as staff to TCC, to coordinate ACC, to support the statutorily-required activities of the TCC, and to hire a consultant with expertise in system of care development to assist TCC with designing an integrated cross-agency funding structure for children's behavioral health services. HHSC's OPCCY currently provides oversight and coordination for several projects related to children and youth, including system of care projects. Staff resources would need to be expanded to support the increased responsibility of serving as staff to TCC, coordinating ACC, and supporting the statutorily-required activities of the TCC, for example providing technical assistance and training to local systems of care sites. Finally, designing an integrated funding structure is a significant undertaking. There are other states and national organizations with expertise in this area that could help Texas design an effective and efficient funding structure.

The following Texas Health and Human Services Commission rider could be included in the 2008–09 General Appropriations Bill to implement Recommendation 5:

> **Systems of Care Support.** Contingent on passage of House/Senate Bill XXXX, or similar legislation by the Eightieth Legislature, Regular Session, 2007, establishing a state children's council and advisory council for children, the Health and Human Services Commission is appropriated, in addition to amounts appropriated above, $200,000 in fiscal year 2008 and $200,000 in fiscal year 2009 in General Revenue Funds to support the operations of a state children's council and advisory council for children. In addition, the full-time equivalent (FTE) cap for the Health and Human Services Commission is hereby increased by three for each year of the 2008–09 biennium.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations would cost $400,000 General Revenue Fund in the 2008–09 biennium. However, creating a state infrastructure to support local systems of care for children's behavioral health services has the potential to increase the efficient use of existing funds, reduce fragmentation, improve access to and availability of cost-effective community-based services, and reduce long-term spending on psychiatric inpatient hospitalizations, residential treatment center stays, and the juvenile justice system. As a result, the cost to implement the recommendations may be all or partially offset by potential cost savings from these outcomes.

Recommendations 1, 2, 3, and 4 would amend the Texas Government Code to create a state infrastructure to support local systems of care for children's behavioral health services. As shown in **Figure 16**, Recommendation 5 would include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $200,000 in fiscal year 2008 and $200,000 in fiscal year 2009 in General Revenue Funds to HHSC. The $200,000 in fiscal year 2008 includes $150,000 for salary, benefits, and travel for three additional full-time equivalents in HHSC's OPCCY to provide additional support to meet increased responsibilities created through establishment of the TCC and ACC, and $50,000 to support the statutorily-required activities of the TCC, including hiring a consultant to assist with designing an integrated cross-agency funding structure. The $200,000 in fiscal year 2009 is for salary, benefits, and travel to maintain the three full-time equivalents hired in 2008, and to support the statutorily-required activities of the TCC.

The introduced 2008–09 General Appropriations Bill does not address these recommendations.

FIGURE 16
FISCAL IMPACT OF CREATING A STATE INFRASTRUCTURE TO SUPPORT LOCAL SYSTEMS OF CARE FOR CHILDREN'S BEHAVIORAL HEALTH SERVICES

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2006–07 BIENNIUM
2008	($200,000)	3
2009	($200,000)	3
2010	($200,000)	3
2011	($200,000)	3
2012	($200,000)	3

Source: Legislative Budget Board.

USE THE MEDICAID PROGRAM TO SERVE ELIGIBLE TEXANS WITH TRAUMATIC BRAIN INJURY

Most states provide services to people with traumatic brain injuries through various programs and funding streams. The state of Texas is currently serving people with brain injuries through a program administered by the Department of Assistive and Rehabilitative Services that is funded by General Revenue Funds from the Comprehensive Rehabilitation Account. For the 2006–07 biennium, the Comprehensive Rehabilitation Services program was appropriated $25.6 million in General Revenue Funds and expects to serve approximately 850 individuals with traumatic brain and/or spinal cord injury.

At least 23 states established Medicaid waivers to provide treatment and long-term care support services to people with brain injuries. Some of the services currently funded with General Revenue Funds could be provided through the Medicaid program, allowing the state to draw down Federal Funds. Individuals who are not eligible for Medicaid would still receive services through the existing Comprehensive Rehabilitation Services program. This approach would allow the state to draw down approximately $450,000 annually in Federal Funds, which would free up enough General Revenue Funds to serve 15 individuals from the program's waiting list.

FACTS AND FINDINGS

- ♦ In fiscal year 2006, there were 143 people on the Comprehensive Rehabilitation Program's waiting list. Services for these individuals depend on the availability of funding.
- ♦ Individuals with traumatic brain injury, who do not receive necessary services when needed may experience a decreased quality of life, eventually leading them to more costly alternatives including prisons, mental institutions and nursing homes.

CONCERN

- ♦ Some services currently provided by the Comprehensive Rehabilitation Program and funded with General Revenue Funds could be provided through Medicaid or a Medicaid waiver. This approach would allow the state to draw down Federal Funds to help pay for these services.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend the Texas Human Resource Code to require the Department of Assistive and Rehabilitative Services in conjunction with other Health and Human Services agencies to evaluate cost-neutral ways to include eligible services for people with traumatic brain injury and spinal cord injury in the Medicaid program, and require the Health and Human Services Commission to request federal approval to implement a Medicaid 1915(c) Home and Community-Based Services Waiver and/or to amend the Medicaid State Plan.
- ♦ **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill authorizing the Department of Assistive and Rehabilitative Services to use funds appropriated in the Comprehensive Rehabilitation strategy to provide services through the Medicaid program.

DISCUSSION

According to the statistics from the U.S. Centers for Disease Control and Prevention, 144,000 Texans experience a traumatic brain injury (TBI) each year and more than 5,700 are permanently disabled each year. Overall, more than 410,000 Texans live with a TBI disability. While some individuals with TBI do not require lengthy treatment and can continue with their lives as it was before the injury, others require treatment and assistance for extended periods.

Funding for acute care for people with TBI comes from public and private sources. Although coverage for acquired brain injury treatment and services is a mandated state benefit, private insurance generally limits post-acute services and does not cover long-term care for individuals with TBI. State and federal governments pay for a large part of post-acute care services as individuals exhaust their financial resources, including community-based support services and long-term care.

Consumer Choice Health Plans, which are limited benefits plans, are not required to cover all state-mandated benefits, and are more likely to exclude coverage of brain injuries. Additionally, individuals without health insurance are most likely to receive minimum or no rehabilitation services

depending on the availability of financial resources or corresponding public funding. As a consequence, persons without adequate access to necessary post acute therapies are less likely to fully recover.

According to the United States Government Accountability Office (GAO):

- almost half of all TBIs result from transportation-related accidents;
- younger adults are more likely to be injured than older adults;
- adult males are twice as likely to suffer a TBI than women; and
- persons at the lowest income levels are at the greatest risk of sustaining a TBI.

Individuals with a TBI can experience physical, cognitive, emotional, and sometimes behavioral changes. These changes can be temporary for some, and long lasting for others. Some individuals recover physically, but have significant consequences from cognitive and emotional changes, which can limit their ability to live normally in the community.

There are significant costs associated with TBI. According to the Texas Traumatic Brain Injury Advisory Council (TBIAC), medical and work loss costs associated with TBI hospitalizations among Texans is approximately $1.1 billion each year. In addition, individuals who do not receive appropriate services when needed, especially those with behavioral issues, may be inappropriately institutionalized or incarcerated. As a result, the cost to Texas can become substantially higher when appropriate and timely treatment and support is not available.

COMPREHENSIVE REHABILITATION SERVICES PROGRAM IN TEXAS

In 1991, Texas established a Comprehensive Rehabilitation Services (CRS) program to provide services to Texas residents (citizens or immigrant aliens who are at least age 16) with traumatic brain and/or spinal cord injury. The program helps individuals re-enter the community and live as independently as possible. CRS covers inpatient rehabilitation, outpatient services and post-acute rehabilitative services to enable persons who suffered a TBI to recover to the fullest extent possible. The program is generally funded with General Revenue–Dedicated Funds from the Comprehensive Rehabilitation Account No. 107. These funds are from court costs assessed on individuals convicted of certain offenses under the Texas Penal Code. In addition to these funds, the Seventy-ninth Legislature, Regular Session, 2005, appropriated $4.5 million in General Revenue Funds to address waiting lists in the 2006–07 biennium. **Figure 1** shows the history of the CRS appropriations and the number of individuals receiving and waiting for services, respectively. According to the agency, approximately 76.6 percent of funding was spent on direct services for individuals with brain injuries between fiscal years 2002 to 2005.

More than two-third of the individuals receiving services through the CRS program are male, and 75 percent of the individuals are age 22 or older. The CRS program had one case open for nine years, and several open for four years. On average, participants stay in the program 20 months.

COMPREHENSIVE REHABILITATION SERVICES PROGRAM SERVICES

CRS covers inpatient hospitalization at a comprehensive rehabilitation facility, outpatient services, and residential and

FIGURE 1
COMPREHENSIVE REHABILITATION SERVICES APPROPRIATIONS AND INDIVIDUALS SERVED OR ON WAITING LIST, FISCAL YEARS 2002 TO 2007

		INDIVIDUALS SERVED				
FISCAL YEAR	EXPENDED/BUDGETED	BRAIN INJURY ONLY	BRAIN AND SPINAL CORD INJURY	SPINAL CORD INJURY	ALL CONSUMERS	WAITING LIST FOR CRS PROGRAM
2002	$10,706,713	321	16	134	471	314
2003	$9,737,513	319	19	132	470	421
2004	$10,206,228	306	19	133	458	164
2005	$10,560,501	275	17	127	419	238
2006	$11,383,608	269	19	116	404	143
2007	$12,813,420	265	20	116	401	183

SOURCES: Legislative Budget Board; Department of Assistive and Rehabilitative Services.

nonresidential post-acute services. Although there is no limit for the time an individual can stay in the CRS program, there are certain limits for the types of services that the program can provide at specialized facilities. The program covers up to 90 days of hospitalization for inpatient comprehensive medical rehabilitation services, and the average length of stay is about 42 days. Only individuals who sustained an injury within the previous 12 months qualify for these services. Post acute services provided at residential or daycare facilities can be covered for up to six months, and do not have a time limit concerning the onset of the injury unlike requirements for inpatient hospitalization. **Figure 2** shows services covered by the CRS program.

Figure 3 shows the program's expenditures by type of service. As the figure shows, post-acute rehabilitation services represent the biggest category of spending for the CRS program.

BARRIERS FOR SERVING PEOPLE WITH TBI THROUGH THE MEDICAID PROGRAM

Individuals eligible for Medicaid receive the services specified in each state's Medicaid Plan or Medicaid waivers. State plans describe the nature and scope of the state's programs. Services provided under state Medicaid plans are available to all program enrollees. To amend the nature and scope of the Medicaid program, states submit State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS) for approval.

Medicaid waivers allow states flexibility in operating their Medicaid program. There are several waivers that can be authorized by CMS: Section 1115 Research and Demonstration Projects, Section 1915(b) Managed Care/ Freedom of Choice Waivers and Section 1915(c) Home and Community-Based Services Waivers. These waivers allow states to provide coverage to individuals previously not eligible for Medicaid (categorically or because of income), deliver services through managed care with more limited

FIGURE 2
COMPREHENSIVE REHABILITATION PROGRAM SERVICES

INPATIENT SERVICES	OUTPATIENT SERVICES	POST-ACUTE SERVICES
(1) Medical management;	(1) Physical therapy;	(1) Cognitive retraining;
(2) Rehabilitation nursing;	(2) Occupational therapy;	(2) Behavioral management;
(3) Physical, occupational, and speech-language pathology;	(3) Speech-language pathology;	(3) Coping skills;
(4) Pulmonary medical services;	(4) Psychological/neuropsychological services;	(4) Compensatory skills;
(5) Laboratory testing;	(5) Personal assistance services;	(5) Traditional therapies;
(6) X-Ray services;	(6) Recreational services;	(6) Orthotic and prosthetic devices;
(7) Orthotics and prosthetics;	(7) Cognitive therapy;	(7) Clinic follow-up visits; and
(8) Communication devices:	(8) Clinic follow-up visits;	(8) Drugs and medical supplies.
(9) Drugs, medical supplies and equipment;	(9) Orthotic and prosthetic devices;	
(10) Psychological/ neuropsychological services;	(10) Communication devices; and	
(11) Social services;	(11) drugs and medical supplies.	
(12) Recreational services;		
(13) Nutritional services;		
(14) Patient and family education;		
(15) Discharge planning; and		
(16) Drugs and medical supplies at discharge.		

SOURCE: Texas Administrative Code.

FIGURE 3
COMPREHENSIVE REHABILITATION SERVICES EXPENDITURES BY TYPE OF SERVICE, FISCAL YEARS 2004 TO 2005

	ACUTE REHABILITATION		OUTPATIENT THERAPIES		POST ACUTE REHABILITATION	
SERVICE	2004	2005	2004	2005	2004	2005
All Consumers	$2,217,521	$2,174,183	$251,717	$366,670	$5,629,117	$5,786,945
Consumers with TBI only	$726,486	$679,350	$251,717	$74,699	$5,581,567	$5,663,845
Consumers with TBI and SCI	$118,727	$29,809	$13,022	$11,412	$47,550	$254,394

Sources: Legislative Budget Board; Department of Assistive and Rehabilitative Services.

network, and provide services in the community setting. In addition to services provided under waivers, individuals enrolled in these programs have access to services provided under the State Medicaid Plan. Contrary to traditional Medicaid, waivers allow the states to define a maximum number of waiver participants, target specific populations, and choose what services to provide through the waiver programs. Furthermore, states do not have to implement waiver programs on a statewide basis and have the option to use a regional implementation.

MEDICAID FINANCING FOR TRAUMATIC BRAIN INJURY SERVICES

For a traumatic brain injury (TBI), Medicaid-eligible individuals under the age of 18 can receive inpatient services covered by the CRS program through Medicaid. Individuals who sustained an injury before age 22, or those who have a medical condition requiring skilled nursing care, can receive services under the Community Living Assistance and Support Services Medicaid waiver administered by the Department of Aging and Disability Services (DADS). Those individuals that sustain a brain injury when they are older than age 22 are rarely eligible for the Medicaid because Texas does not cover adults unless they are pregnant women, disabled or persons eligible for Temporary Assistance for Needy Families program. Some states provide coverage for adults through expansion mechanisms for optional populations. In these states, adults with TBI that are eligible for the Medicaid program could receive services through a state-federal program.

However, Texas Medicaid does not cover all services necessary for individuals with TBI. Medicaid covers acute rehabilitation, but not post-acute rehabilitation, which includes speech, physical and occupational therapies among others services. Other states cover, to some degree, post acute rehabilitative services, which are optional Medicaid services.

Texas could expand the list of services provided under Medicaid to incorporate CRS services including acute treatment in rehabilitation hospitals and various therapy services, through a state plan amendment. The Department of Assistive and Rehabilitative Services (DARS) estimates that 53 individuals with TBI could be eligible for the Medicaid program under such a scenario. However, services provided through the Medicaid program cannot be limited to only individuals with TBI; therefore, such an inclusion may add costs to the Medicaid program.

Individuals with a Supplemental Security Income (SSI) disability determination could also be eligible for the Medicaid program. However, not all eligible individuals with a TBI seek SSI disability status from the Social Security Administration or are able to receive SSI disability status in time to receive medical services, since this determination can take several years. In addition, lack of understanding of brain injuries and their affect on cognitive function may result in the denial of the disability status for an individual with TBI, despite the individual meeting diagnostic criteria for the disability. According to the agency, the reason for not applying for disability services may be caused by an individual's confusion and overestimation of personal strength, and capabilities subsequent to the TBI.

MEDICAID WAIVERS FOR TRAUMATIC BRAIN INJURY SERVICES

Most states provide assistance to individuals with the TBI. States choose different mechanisms for this coverage, which can include revenues from Trust Funds, General Revenue Funds appropriation, and Medicaid waivers. At least 23 states implemented Medicaid waivers specifically for individuals with TBI. These states use 1915(c) Home and Community-Based Services (HCBS) waivers, which allow the states to deliver long-term care services in the community settings. HCBS waivers give the states more flexibility in designing their programs. States can choose to implement the program regionally instead of statewide approach, do not have to provide the same services to all eligible for the Medicaid, and have more flexibility in setting income eligibility requirements for the target population.

These waivers target long-term community-based services available to disabled individuals. Eligibility criteria set by the federal government are based on physical limitations, rather than cognitive function. This requirement limits states' ability to provide waiver coverage to all individuals with TBI.

However, states can develop programs and set eligibility requirements targeting at least some individuals with TBI. The design of the waiver determines who would receive services and what kind of services the program would provide. This information helps the state estimate how long an individual would receive services through the waiver. For instance, states may target individuals at risk of institutionalization or already in nursing facilities. With this design, it is likely that individuals will require services for an extensive period. States may choose to target individuals with

TBI undergoing treatment in hospital, and provide waiver services for post-acute care. Using this approach, the state could estimate the potential length of time the individuals would be eligible to receive services from the program and budget for potential expenditures. For example, when GAO reviewed Colorado's waiver in 1998, it estimated that individuals with TBI received services from the program for two years. If the individuals needed more services from the long-term care list after that, these individuals could apply for HCBS waiver for elderly, blind and disabled.

MEDICAID WAIVERS IN OTHER STATES

There is a lot of variation among the states in Medicaid waiver programs. Some states target only individuals with TBI diagnosis, while others include individuals with traumatic spinal cord injuries as well. Most states cover individuals between the ages of 15 and 64; however, several states cover eligible persons from infancy. Even though most waivers cover some services (such as case management and assessment and evaluation), there are many differences in the benefit structure of the waivers. Moreover, states can cover additional services that are not standard HCBS services. **Figure 4** shows services covered by the TBI waivers in other states.

Since states cover different services in their waivers, it is not useful to compare their programs and savings. Analyzing individual state's experience shows that states can contain costs by providing services through waiver programs. As described in the TBIC report, Kansas estimates its costs to provide services to individuals with TBI through its HCBS waiver program are half the costs of institutionalized care at a head injury rehabilitation facility. The state saves up to $63,000 for each individual participating in the waiver and provides services for a longer period.

Overall, participation in state waiver programs remains low. According to the National Association of State Head Injury Administrators, approximately 8,000 people were served by TBI waivers nationally in 2004. According to the GAO,

FIGURE 4
SERVICES COVERED BY TRAUMATIC BRAIN INJURY WAIVERS IN OTHER STATES

SERVICE	DESCRIPTION
Service coordination	Services that assist individuals to navigate social system and have access to necessary services (medical, social, educational) in various programs.
Homemaker	General household activities provided by a trained homemaker, when a person is unable to manage the home or when the person regularly responsible for these activities is temporarily absent or unable to manage the home.
Home health aide services	Home health service to provide medically oriented task(s) to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence.
Personal care services	Assistance with eating, bathing, dressing, personal hygiene, activities of daily living.
Respite care	Services provided to persons unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care
Adult day health	Services including physical, occupational and speech therapies provided in out-patient setting needed to ensure the optimal functioning of the person.
Habilitation	Services designed to assist individuals in acquiring, retaining and improving the self-help, socializing and adaptive skills necessary to reside successfully in home and community settings.
Day habilitation	Services provided in non-residential setting.
Prevocational services	Services that are aimed at preparing an individual for paid or unpaid employment, but not job-task oriented – teaching such concepts as compliance, attendance, task completion.
Supported employment services	Services to assist persons with significant disabilities become and remain successfully and competitively employed in integrated workplace settings.
Educational services	Help an individual to re-learn or regain skills and knowledge.
Environmental modifications	Physical adaptations to the person's home and/or vehicle.
Skilled nursing	Services provided by a registered nurse or licensed practical nurse to initiate and complete professional nursing tasks based on the assessed need for services to maintain or restore optimal health.
Non-medical transportation	Services offered to enable consumers to gain access to various services in the community.

(continued on next page)

FIGURE 4 (CONTINUED)
SERVICES COVERED BY TRAUMATIC BRAIN INJURY WAIVERS IN OTHER STATES

SERVICE	DESCRIPTION
Assistive technology/ specialized medical equipment and supplies	Devices, which enable individuals to increase their ability to perform activities of daily living.
Chore services	Services to maintain a person's home as a clean, sanitary and safe environment.
Personal emergency response system	PERS is an electronic device which enables certain individuals at risk of institutionalizing to secure help in an emergency.
Companion service	Non-medical care, supervision and socialization, provided to a functionally impaired adult.
Private duty nursing	Provision of professional nursing services based on an assessment of the medical/healthcare needs of the person within the scope of state law.
Family training	Service that provides training and education to a parent or primary caregiver when the primary caregiver is not employed by a corporation to provide supervision and care for the person.
Attendant care	Both supportive and health-related assistance specific to the needs of the individual.
Adult residential care	Can include adult foster care and assisted living.
Adult foster care	Personal care and services, homemaker, chore, attendant care and companion services provided in a licensed private home.
Assisted living	Services provided in a home-like environment in a licensed community care facility.
Extended medicaid state plan services	Includes physician service and/or home healthcare service, and/or physical therapy services; and/or speech therapy services; and/or prescribed drugs.
Other	Part-time nursing; behavioral programming; community/transition services; coaching; night supervision; structured day program; cognitive therapy; counseling; community integration.

Source: Legislative Budget Board.

individuals with cognitive impairment but with no physical disabilities, or individuals without effective advocates who can navigate the social services system and persons with problematic or unmanageable behaviors, have the most difficult time accessing services. Inability to access necessary services could significantly affect person's life and could result in an individual becoming homeless or institutionalized in a mental facility or prison.

To overcome difficulties in navigating the system and accessing services, some states established central registries for brain and spinal cord injury programs. In Florida, physicians, hospitals and various social service agencies are required by law to report new cases to the central registry. Assigned caseworkers help individuals with TBI and their families explore services from different programs and determine eligibility. Tennessee requires hospitals to report information including the nature and cause of the injury to the central registry overnight. This data helps the state analyze common causes for the trauma and determine whether preventive initiatives can be implemented.

MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVER AND STATE PLAN OPTIONS

Section 6086 of the Deficit Reduction Act (DRA) of 2005 established a new optional benefit that allows states to cover HCBS services beginning in January 2007. This provision allows states to provide standard HCBS services without obtaining a waiver. States can target individuals who meet state specified needs-based criteria and limit the number of individuals who receive these services.

Even though HCBS waiver and optional HCBS benefit under DRA have many similarities, there are certain differences between these two options. The DRA provision limits eligibility of individuals with income up to 150 percent of the federal poverty level (FPL), while states can choose to cover eligible individuals with income up to 222 percent of FPL under the waiver option. The optional Medicaid benefit provision under DRA allows the states to cover standard HCBS services but would not allow the states to request coverage for other services, which is possible under HCBS waiver.

Individuals with TBI could benefit from waiver programs that provide treatment and community-based services.

However, some individuals would not qualify for waiver services because eligibility determination is often based on physical rather than cognitive disabilities. The Department of Assistive and Rehabilitative Services (DARS) estimates that only 10 percent of clients with TBI would meet waiver's medical necessity requirement. The statute amendment would address this barrier by requiring DARS, with assistance from DADS, the Health and Human Services Commission (HHSC) and TBIAC, to analyze the best design for the waiver.

The Legislative Budget Board staff review of the services provided by the CRS program and the services provided through TBI waivers in other states found that Texas could offer some services currently provided by CRS through a Medicaid waiver. **Figure 5** shows some common services that are currently provided by the CRS program with General Revenue Funds that are included in TBI waivers in other states.

Depending on the design of the waiver, Texas could provide some services that are currently not provided or provided only for a limited period. Texas could also consider providing more services in community based settings instead of institutional settings, which could lower costs. Furthermore, the state would access additional Federal Funds for services provided through the Medicaid program. Based on DARS estimate that only 10 percent of individuals with TBI would be eligible for Medicaid, Texas would draw down approximately $450,000 annually in Federal Funds if income eligibility were set at the current level of HCBS waiver in Texas. This approach would allow the agency to serve 15 additional individuals from the waiting list that are not eligible for Medicaid through the CRS program.

Recommendation 1 would amend the Texas Human Resource Code to require DARS, in assistance with HHSC, DADS and TBIAC to determine the approach which would allow the agencies best to provide necessary services to individuals with TBI in a manner that is cost-neutral to General Revenue Funds and maximizes Federal Funds. The agencies will need to evaluate whether the goal could be achieved by including individuals with TBI in an existing Medicaid waiver, a new HCBS waiver or through a Medicaid State Plan Amendment. The agencies would be required to evaluate cost-effectiveness of such inclusion and determine what populations and at what income eligibility would allow the state to maximize Federal Funds.

To ensure coordination of funding streams and services for the benefit of the individuals with TBI, it would be beneficial if DARS would continue coordinating services for all individuals with TBI and spinal cord injuries. Should agencies recommend establishing a new HCBS waiver or amendment of the State Medicaid Plan, DARS could be a designated agency for program implementation.

If the agencies recommend including targeted population through existing waivers and determine that a portion of the DARS appropriations needs to be transferred to another agency, Section 13 of the Special Provisions relating to all Health and Human Services agencies that is currently contained in the General Appropriation Act for 2006–07 would apply. This section allows HHSC to transfer funds across the agencies for the efficient and effective operation of the Medicaid program (as long as the transferred amount does not exceed 10 percent of the annual appropriation).

DARS would also be required to provide a report with agencies' recommendations to the Legislative Budget Board and the Governor no later than November 1, 2007.

HHSC would be required to apply for a new HCBS waiver, request an amendment to the existing HCBS waiver or to submit a State Plan Amendment under Section 6086 of the DRA, based on the agencies' analysis of the best way to include services in Medicaid.

FIGURE 5

SERVICES PROVIDED BY THE COMPREHENSIVE REHABILITATION SERVICES PROGRAM AND TBI WAIVERS

ASSESSMENT/EVALUATION	INPATIENT COMPREHENSIVE MEDICAL REHABILITATION	POST-ACUTE TRAUMATIC BRAIN INJURY SERVICES
Case Management Coordination	Behavioral or Psychological Services	Physical, Occupational, Speech, Psychological and Cognitive Therapies
Consumer and Family Education	Assistive Technology	Counseling and Guidance
Transportation	Personal Care Assistants	Recreation training

SOURCE: Legislative Budget Board; Department of Assistive and Rehabilitative Services.

The following DARS rider could be included in DARS bill pattern to implement Recommendation 2.

Provision of Services for Individuals with Traumatic Brain Injury and Spinal Cord Injury through Medicaid.

Contingent upon the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation allowing the Department of Assistive and Rehabilitative Services to serve individuals with traumatic brain injuries through the Medicaid program, the Department of Assistive and Rehabilitative Services is authorized to use a portion of the funding from Strategy B.3.4, Comprehensive Rehabilitation as state match for Medicaid, in an amount not to exceed the amounts appropriated in this strategy.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 and 2, if implemented, would not have significant fiscal impact during the 2008–09 biennium. In the future biennia, as shown in **Figure 6**, the state would access Federal Funds that would fund more services for individuals with TBI. The introduced 2008–09 General Appropriation Bill does not address either recommendation.

FIGURE 6
FIVE-YEAR FISCAL IMPACT

FISCAL YEAR	PROBABLE REVENUE GAIN/(LOSS) FROM FEDERAL FUNDS
2008	$0
2009	$0
2010	$450,000
2011	$450,000
2012	$450,000

SOURCE: Legislative Budget Board.

MAXIMIZE FEDERAL FUNDS FOR LONG-TERM CARE REBALANCING DEMONSTRATION

Aged and disabled clients make up one-fifth of the Texas Medicaid population, yet they account for about three-fifths of the state's Medicaid expenditures. According to recent U.S. Census figures, the state's general population will increase by about 50 percent by the year 2020, but the elderly population will almost double, from 1.9 million to 3.8 million. With population migration to Texas among retirees and with aging baby-boomers rapidly approaching their elder years, long-term care costs of Medicaid are expected to grow significantly.

Long-term care funded by Medicaid has been biased towards institutional care in nursing facilities for the aged and disabled and towards intermediate care facilities for the persons with mental retardation. Trends show that aged and disabled Texans continue to choose to live in their community at home or in an assisted living facility rather than a nursing facility. To address these trends, the Texas Department of Aging and Disability Services can access additional Federal Funds through a new "Money Follows the Person" Rebalancing Demonstration authorized in the federal Deficit Reduction Act of 2005 to expedite the transition of individuals from institutional settings to home and community-based care settings. The federal government approved the agency's proposal in January 2007. Over the lifetime of the grant the Department of Aging and Disability Services estimates the state Money Follows the Person program could receive up to $17.8 million in enhanced matching Federal Funds.

CONCERNS

- In addition to nursing home residents, the Texas Department of Aging and Disability Services' Rebalancing Demonstration proposal addresses clients transitioning from intermediate care facilities for the mentally retarded. The agency's costs for serving those clients receiving residential services are generally higher in the community than in the institution.
- Under the new Money Follows the Person (MFP) Rebalancing Demonstration, Federal Funds will flow as an Enhanced Federal Medical Assistance Percentage (FMAP) grant that would replace approximately $7.1 million in General Revenue Funds for the 2008–09 biennium. The 2006–07 General Appropriations Act limits the expenditure of General Revenue Funds replaced by an Enhanced FMAP. This provision restricts use of the funds for addressing barriers to transitioning to the community.

RECOMMENDATION

- **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill that allows an exception to the restriction on use of General Revenue Funds replaced by an enhanced rate for the Money Follows the Person Rebalancing Demonstration.

DISCUSSION

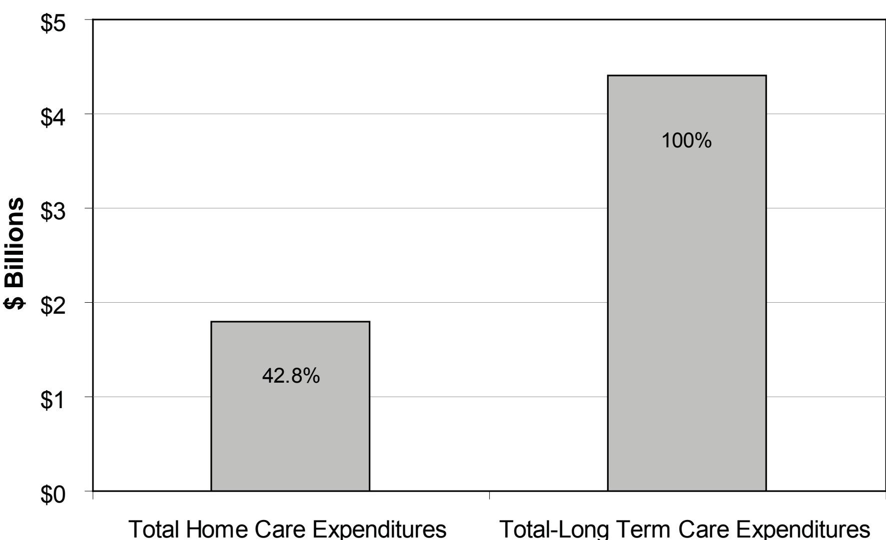
The Texas Department of Aging and Disability Services (DADS) administers a variety of Medicaid-funded long-term care services. **Figure 1** shows the proportion of home and community-based services expenditures to total long-term care service expenditures in Texas in fiscal year 2005. Of the $4.4 billion in state and federal long-term care expenditures, less than half goes to non-institutional care in Texas.

Along with nursing facility services and community care services, DADS also oversees seven Medicaid waiver programs, the largest of which are Community Based Alternatives (CBA), Home and Community-based Services (HCS), and Community Living and Assistance Support Services (CLASS). Waiver programs, authorized under Section 1915(c) of the federal Social Security Act, provide a comprehensive array of services, including some that are not available to the general Medicaid population, such as respite, home modifications, and specialized therapies. The 1915(c) provisions allow the federal government to waive certain federal requirements regarding comparability of services, resources and statewideness. To receive federal Medicaid reimbursement, the cost for providing waiver services must not exceed institutional costs. Because the number of clients served through waivers is limited, there are waiting lists for admission to waiver programs.

"MONEY FOLLOWS THE PERSON" FINANCING MECHANISM

As part of the state's Promoting Independence initiative to assist disabled persons in living in the community, Texas created a financing mechanism known as "Money Follows

FIGURE 1
HOME AND COMMUNITY-BASED SERVICES AS A PROPORTION OF TOTAL MEDICAID LONG-TERM CARE EXPENDITURES IN FISCAL YEAR 2005



Source: Centers for Medicare and Medicaid Services.

the Person" (MFP), the first program of its kind in the nation. This program became effective on September 1, 2001. As originally designed, Medicaid funds transferred from nursing facility services to the budget for waiver programs as residents moved from institutions to the community. Now the state forecasts a caseload for MFP and determines costs based on the average amount spent on waiver services. The state appropriates funds for the program's clients to a separate budget strategy called "Promoting Independence Services." Clients transitioned from nursing homes do not count against the slots allotted for each waiver program.

To support the process, the state also appropriates $1.3 million for fiscal years 2006 and 2007 in General Revenue Funds. These funds provide for relocation specialists who help identify persons in nursing facilities who want to transfer to home and community-based services, and then continue to help them during the transition. In 2003, the state received a grant from the federal Centers for Medicare and Medicaid Services (CMS) to develop supportive local nursing facility transition teams to identify obstacles in the process.

The MFP program has successfully relocated aged and disabled individuals to the community without any additional costs to the state. DADS reported in August 2006 that 11,651 individuals transferred from nursing facilities to the community since September 2001. Of that number, 5,597 individuals remain in the community. **Figure 2** shows the demographic and residency characteristics of Texas' MFP clients.

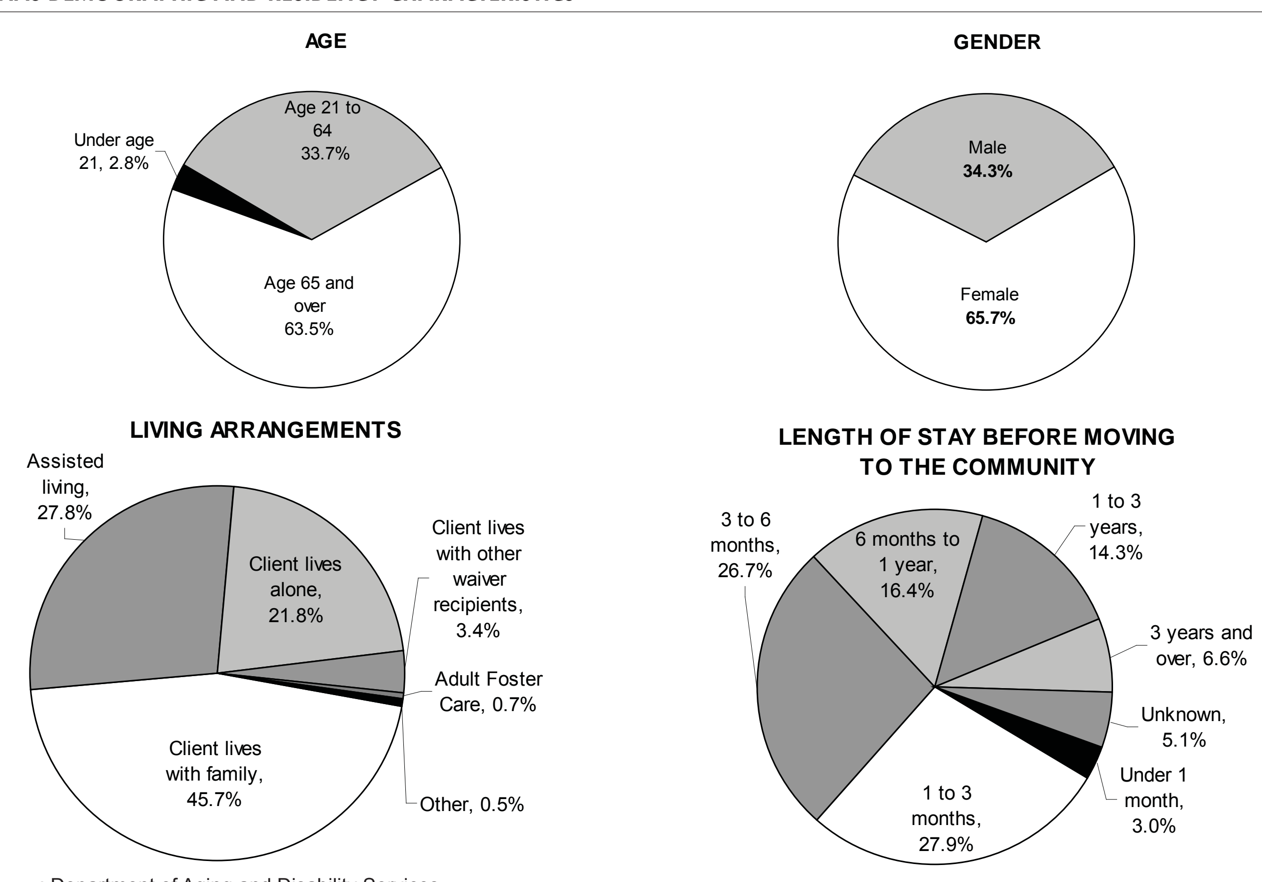
Historically, when nursing residents left the facility, a new admission filled the bed, so states did not associate nursing facility transition programs with cost savings. However, with low occupancy rates at nursing facilities, transferring a patient to the community no longer necessarily means a bed will be filled by a new admission. Texas' occupancy rate was 77 percent in 2005, significantly below the national rate of 86 percent. Texas' supply of beds is higher than the national average; in 2004, Texas had 58 beds per 1,000 persons age 65 and over, compared to 51 beds nationally.

BARRIERS TO COMMUNITY TRANSITION

A DADS's August 2006 survey of Texans residing in nursing facilities shows that 17.5 percent of residents wanted to leave the nursing facility (**Figure 3**). The report of the survey notes that the health status and related level of care needed by some of the persons expressing a desire to leave the nursing facility may preclude their transition to the community. Barriers to relocation exist due to healthcare staffing shortages in the community, the lack of affordable housing, and the absence of family or volunteer assistance.

In its orientation manual for transition facilitators, the Independent Living Research Utilization program (a national center for information, training, research, and technical assistance in independent living, based in Houston), states

FIGURE 2
MONEY FOLLOWS THE PERSON
TEXAS DEMOGRAPHIC AND RESIDENCY CHARACTERISTICS



SOURCE: Department of Aging and Disability Services.

FIGURE 3
SURVEY RESULTS OF TEXANS RESIDING IN NURSING FACILITIES
NOVEMBER 2006

DADS REGION	RESIDENTS	NUMBER OF RESIDENTS WHO WISH TO LEAVE THE FACILITY	PERCENTAGE OF RESIDENTS WHO WISH TO LEAVE THE FACILITY
1	5,529	1,176	16.4%
2	5,038	697	14.7
3	24,956	5,188	20.0
4	9,578	1,656	16.4
5	5,135	649	11.7
6	15,245	2,947	21.7
7	14,212	2,192	12.9
8	12,479	2,396	17.7
9	2,962	363	11.5
10	1,641	372	23.4
11	7,237	1,460	20.8
Total	**104,012**	**19,096**	**17.3%**

NOTE: Residents include persons not eligible for Medicaid.
SOURCE: Department of Aging and Disability Services.

that the proper assessment of a client is key to ensuring a person's successful community integration. Components to consider in the assessment include healthcare, housing, financial issues, transportation, social supports, and volunteer assistance. The assessment gives the transition facilitator an opportunity to gather as much information as possible about the person and to identify additional issues that may need to be addressed such as alcohol or substance abuse, mental illness, or a criminal record. Nationally, it takes three to six months to transition a client from the nursing facility to a home and community-based setting.

In a July 2006 report on Money Follows the Person initiatives, which included Texas, CMS noted that a lack of care coordinators and a shortage of personal care attendants continue to hamper efforts in transitioning nursing facility clients into more independent living situations. Coordination of services is especially difficult with complex cases, such as the frail elderly and individuals with intellectual and developmental disabilities. Due to a number of factors, including low wages, the community-based healthcare system has high turnover rates for direct care employees.

In 2005, the U.S. Bureau of Labor Statistics predicted a 39 percent growth in direct service worker occupations over the next 10 years. DADS requests additional General Revenue Funds in the 2008–09 biennium for inflation-based rate increases for community care, nursing facilities, and rehabilitation service providers. This amount may allow providers to increase pay rates of direct-care employees, and fund community services to ensure a fiscally healthy community provider base. The Health and Human Services Commission (HHSC) also supports increasing the appropriation of General Revenue Funds for wages and benefits to attract and retain qualified community-care attendants and nursing facility aides.

There is an ongoing need to build provider networks with appropriate agencies and to continue development of a comprehensive care coordination system for all persons with significant physical and/or cognitive disabilities and their families. Part of this system of follow-up must include criteria for successful transition and placement and criteria for measuring quality of care, and coordination of everyday life needs (food, clothing, utilities, attendant care if necessary, etc.). This may require additional funding to ensure the provision of follow-up services.

Families and volunteers often make up the difference in the lack of healthcare workers and can be a crucial factor in determining whether a person returns to the community. As **Figure 2** shows, only 21.8 percent of MFP clients live alone.

Housing has also proven to be a barrier to independence since most persons who find themselves in a nursing facility cannot finance the cost of maintaining their home while in the nursing facility. Local housing inventory compatible with client requirements for accessibility and security is often in short supply. Rental costs and costs for furnishings or equipment adapted to an individual's particular circumstances all add to the complexity and expense of finding suitable housing. In the past, DADS requested subsidies for clients moving out of institutions who are waiting for federal housing assistance.

The state uses federal grants and other strategies to reduce some transition barriers. In cooperation with the Texas Department of Housing and Community Affairs and local housing authorities, Texas has established an initiative to set-aside as many Section 8 housing vouchers as possible each year for use by persons transitioning from nursing facilities. Also, waivers provide a one-time use of up to $2,500 for housing and utility deposits, and costs for setting up a household. Texas contracts with six regional relocation organizations that help clients find housing, coordinate paperwork, assist with the move, and help establish households.

Federal regulations requiring cost neutrality may affect individuals with complex medical needs who want to leave nursing facilities and access community services. To ensure cost neutrality in the HCS waiver program, DADS Rider 20 limits the average annual HCS expenditure per client to 80 percent of the average annual ICF/MR expenditure per client. There are also caps on certain devices and equipment to contain waiver program costs. There is an appeals process to justify the need of services beyond the cap, but it is cumbersome and not easily accessed.

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION PROGRAM

The Deficit Reduction Act of 2005 created the MFP Rebalancing Demonstration. Congress provided $1.8 billion to states to increase the use of community care versus institutional long-term care services. It provides for an Enhanced Federal Medical Assistance Percentage (EFMAP) for 12 months for community-based services for each qualified person transitioned from an institution during the demonstration period. The EFMAP is equal to the state's

standard FMAP plus the number of percentage points that is 50 percent of the regular state share. For Texas, this percentage means the federal government will pay about 80 percent of the cost of Medicaid services for persons served through the demonstration (rather than about 60 percent).

CMS published a Request for Proposals on July 26, 2006 and DADS submitted a grant proposal to CMS on November 1, 2006. In January 2007 CMS approved the proposal and committed to awards totalling $142.7 million in Federal Funds over the course of the program. The DADS proposal seeks to provide home and community-based services to more individuals and to invest more funds in the transition process. The agency will use the grant to transition 2,616 persons over the next five years, of which 1,400 will transition from nursing facilities and 1,216 will transition from facilities serving persons with mental health and developmental disabilities. Overall program costs with the MFP Rebalancing Demonstration EFMAP are $179.5 million in state and federal funding over the course of the five-year demonstration. DADS estimates the MFP Rebalancing Demonstration grant will generate $17.8 million in enhanced matching Federal Funds over five years. In addition, DADS will claim 50 percent match for administrative and evaluation costs estimated at $1.3 million for the 2008–09 biennium.

States must ensure that total Medicaid expenditures for home and community-based services during the demonstration period will not be less than fiscal year 2005. DADS reported in the MFP Rebalancing Demonstration grant proposal to CMS that it expended $1.9 billion in state and federal funding on Medicaid home and community-based and long-term care services in fiscal year 2005. DADS assures CMS that the state will continue to provide at least this amount during the demonstration project, unless the Texas Legislature reduces the appropriation for these services. DADS and HHSC have requested funding above this level for the first two years of the project.

DADS proposes to use the MFP grant to implement a strategy that will assist individuals in nursing facilities with complex needs and persons living in State Mental Retardation Facilities and intermediate care facilities for the mentally retarded (ICFs/MR). Some of the figures below reflect a savings between institutional and community-based care options; however, costs are generally higher for transitioning ICF/MR clients who receive residential services. Under the Rebalancing Demonstration plan submitted to CMS by DADS, the average monthly cost per person transitioning from the nursing facility would change from $2,558 in the nursing home to $1,452 in the community, a $1,106 savings. Transitioning individuals from State Mental Retardation Facilities to community-based care could represent the greatest cost savings with average monthly costs per person of $8,066 in a state facility, compared to $4,468 in the community. However, many of the State Mental Retardation Facilities' costs are fixed; savings would not be fully realized unless a state facility closed. The proposal does not address the closure of state facilities, which would require legislative action.

DADS does not have a budgeting mechanism for ICFs/MR residents similar to the one used for residents of nursing facilities, whereby a specific line item is funded to assist residents wishing to transfer from nursing facilities to community-based settings. DADS states in its MFP grant proposal that a similar approach is necessary for persons in ICFs/MR. Due to cost constraints, DADS seeks a cost-effective mechanism to support transitions from ICFs/MR to home and community-based services in addition to the current program for Promoting Independence. This is difficult to do without placing an economic burden on ICFs/MR providers.

For the state to receive the EFMAP, the individual must reside in an inpatient facility for at least six months and relocate to a residence where no more than four unrelated individuals reside. DADS proposes that the state use the enhanced federal match to transition individuals living in medium (9 to 13 beds) to large (more than 14 beds) ICFs/MR to community settings. Among the medium-sized ICFs/MR, the agency proposes to target institutions that voluntarily offer to close. Community-based services for this population are likely to cost more per person than services in the ICFs/MR. The average monthly cost per person in a 9 to 13 bed ICF/MR is $4,149 as compared to $4,443 in the community, an additional $294 cost under the Rebalancing Demonstration plan. Also, the average monthly cost per person for an individual in an ICF/MR of 14 or more beds is $4,149 as compared to $4,468 in the community, an additional $319 cost under the Rebalancing Demonstration plan. DADS proposes to use any additional savings or funds generated through the Rebalancing Demonstration to supplement reimbursement to closing ICFs/MR while clients transition. DADS reports that many ICFs/MR have converted or will convert to providers of home and community-based care. The enhanced matching funds available under the waiver will only cover the additional short-term costs to transition individuals in ICFs/MR. Maintaining these higher costs over

the long term would have to be addressed in the next legislative session.

Under the new MFP Rebalancing Demonstration, Federal Funds will flow as an Enhanced FMAP, replacing approximately $7.1 million in General Revenue Funds for the 2008–09 biennium. A rider in the 2006–07 General Appropriation Act limits the expenditure of General Revenue Funds made available through an Enhanced FMAP. Recommendation 1 is to include a rider in the 2008–09 General Appropriations Bill that allows an exception to the restriction on use of General Revenue Funds that are made available due to Enhanced FMAP so that the funds can be used for the MFP Rebalancing Demonstration:

> **Special Provisions Rider, Article II, Section 7, Disposition of State Funds Available Resulting from Federal Match Ratio Change:** If the Federal Medical Assistance Percentage (FMAP) should be greater than 60.53 percent for federal fiscal year 2008 and 60.00 percent for federal fiscal year 2009, or the Enhanced Federal Medical Assistance Percentage (EFMAP) should be greater than 72.37 percent for federal fiscal year 2008 and 72.00 percent for federal fiscal year 2009, the Health and Human Services Commission and the health and human services agencies listed in Chapter 531, Texas Government Code, shall be authorized to expend General Revenue Funds thereby made available due to the greater FMAP or EFMAP only to the extent authorized in writing by the Legislative Budget Board and the Governor. A copy of such authorization shall be provided to the Texas Comptroller of Public Accounts to assist in monitoring compliance with this provision. Notwithstanding the above provisions, the restriction on use of General Revenue Funds made available by an EFMAP does not apply to the Money Follows the Person Rebalancing Demonstration.

FISCAL IMPACT OF THE RECOMMENDATION

Recommendation 1 has no fiscal impact.

The introduced 2008–09 General Appropriations Bill includes the rider contained in Recommendation 1.

IMPLEMENT EFFORTS TO SUPPORT INFORMAL CAREGIVERS

Informal caregivers are family and friends who provide unpaid care to people who want to remain in their homes, but need assistance with daily activities. Most people who need long-term care depend exclusively on help from family and friends, not on paid service providers or institutions. Care provided by family and friends can determine whether individuals with long-term care needs can remain at home. Informal caregivers commonly face physical and mental health risks, financial pressures, and workplace issues, which affect their ability to provide care. Research suggests that caregiver support services can help reduce the strain of caregiving responsibilities, allow informal caregivers to remain in the workforce, and delay or prevent institutionalization of the care recipient. Respite care, which temporarily relieves the informal caregiver, is the support service most frequently requested by informal caregivers. Yet, the delivery of respite care in Texas is affected by limited funding and provider availability. Other states have implemented lifespan respite programs to build state and local infrastructure to improve access to respite care.

There are an estimated 606,000 older adults and non-aged persons with disabilities in Texas who need help with daily living who are at or below 220 percent of the federal poverty level, or have monthly incomes below 300 percent of the monthly income limit for Supplemental Security Income (i.e., currently $1,809 per month), and are potentially eligible for Medicaid. Of this amount, it is estimated that 393,900 receive all of their long-term care from family and friends. If these individuals were instead to receive care in a nursing facility paid by Medicaid, the annual cost is estimated to range from $2.7 billion to $10.7 billion in state and federal funds depending on the number of persons who meet Medicaid nursing facility medical necessity and asset test criteria. The cost could be even higher if some of these individuals received care in an intermediate care facility for persons with mental retardation or a state school. Efforts to support informal caregivers, such as increasing access to respite care, could help prevent or delay institutionalization of the care recipient, thus avoiding future Medicaid long-term care institutional spending. The Texas Department of Aging and Disability Services should implement a lifespan respite pilot program to help informal caregivers continue to provide care at home by improving access to respite care for people with long-term care needs.

CONCERN

- ♦ Access to respite care, which can help prevent or delay institutionalization and avoid future Medicaid institutional spending, is limited. The majority of respite care spending administered by the Department of Aging and Disability Services is provided through one program in one region. Specifically, of the $132.4 million spent on respite care administered by the Department of Aging and Disability Services, 77 percent is spent on Medicaid-funded Day Activity and Health Services, primarily in health and human service Region 11, including the Coastal Bend, South Texas, and Lower Rio Grande areas.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend the Texas Human Resources Code to require the Department of Aging and Disability Services to implement a lifespan respite pilot program based on models implemented in other states that would improve access to respite care for persons with long-term care needs by building state and local infrastructure to support the provision of respite services.
- ♦ **Recommendation 2:** Amend the Texas Government Code to require the Texas Health and Human Services Commission, in consultation with the Department of Aging and Disability Services, to conduct an evaluation study to assess the impact of the lifespan respite pilot program on access to respite care and Medicaid long-term care institutional expenditures and report the findings to the Governor and the Legislative Budget Board by November 1, 2010.
- ♦ **Recommendation 3:** Include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $150,000 in General Revenue Funds for each fiscal year of the 2008–09 biennium to the Texas Department of Aging and Disability Services for implementing a lifespan respite pilot program.

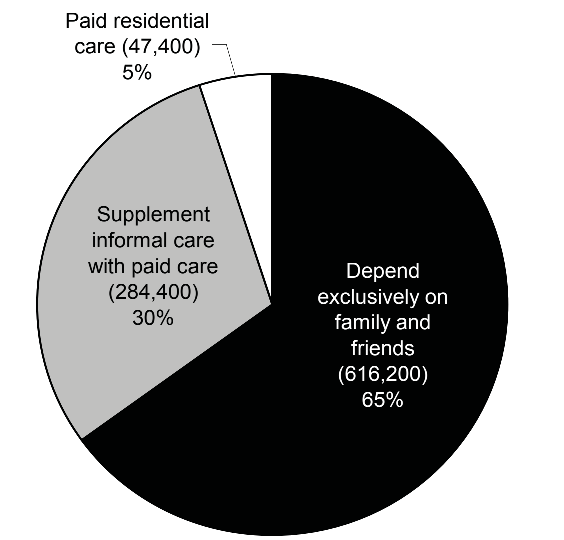
DISCUSSION

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness or frailty. Long-term care services

include a continuum of health and social services provided in institutions, in the community and at home. The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care services. For many individuals, an illness or a chronic condition does not result in functional impairment or dependence, and they are able to conduct daily routines without assistance. Long-term care services may be required when the illness or condition results in a functional or activity limitation. Major groups of persons needing long-term care services and supports include older adults and non-aged persons with disabilities. Although persons with mental illness may need long-term care and could potentially benefit from the recommendations outlined in this report, the information presented in this report does not focus on this population.

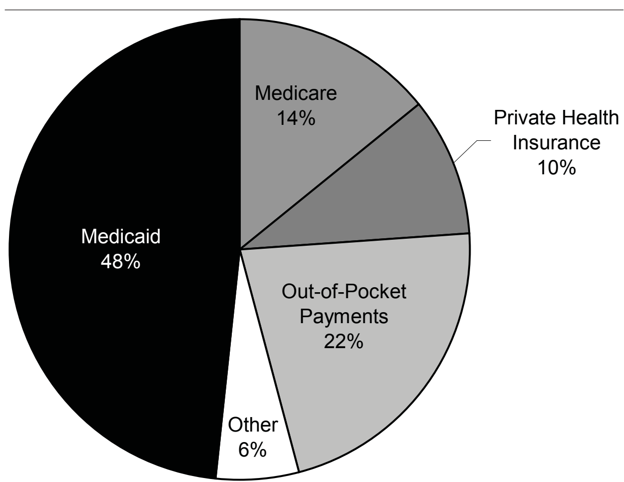
Most people who need long-term care depend exclusively on help from family and friends, not on paid service providers or institutions. According to the U.S. Administration on Aging, among older people who need help with daily activities, 65 percent depend solely on family and friends, 30 percent supplement informal care with services from paid providers, and 5 percent rely exclusively on paid residential services. These national percentages were applied to the population of approximately 948,000 older adults and non-aged persons with disabilities in Texas who need help with daily living to provide an estimate of the type of care received by these populations. **Figure 1** shows the type of long-term care that older people and non-aged persons with disabilities in Texas are estimated to receive based on the national percentages.

FIGURE 1
TYPE OF CARE RECEIVED BY OLDER ADULTS AND NON-AGED PERSONS WITH DISABILITIES RECEIVING ASSISTANCE WITH DAILY LIVING IN TEXAS, 2006



Source: Legislative Budget Board.

FIGURE 2
U.S. PUBLIC AND PRIVATE SOURCES OF FORMAL LONG-TERM CARE SPENDING, 2001



Source: U.S. House of Representatives, Committee on Ways and Means.

FORMAL LONG-TERM CARE SPENDING

Although family and friends provide most long-term care informally, the long-term care system includes thousands of formal care providers. They range from institutional providers, including nursing homes and residential care facilities for persons with mental retardation and developmental disabilities, to a variety of agencies and programs that provide a wide array of home and community-based services. **Figure 2** shows the public and private financing sources of formal long-term care across the U.S. Spending for long-term care financed under the Social Services Block Grant, the Older American Act, and state-only funded programs are not included. These programs do not provide significant funding for long-term care relative to other public funding sources.

Medicaid is the single largest source of public financing for long-term care. In Texas, Medicaid long-term care spending totaled approximately $4.5 billion in All Funds in state fiscal year 2005. Of this amount, 56.9 percent (or $2.6 billion) was spent on care provided in institutional settings and 43.1 percent (or $1.9 billion) was spent on home- and community-based services. Growth in Medicaid long-term care expenditures is expected due in part to the increasing population of older adults, especially those who are in the oldest age categories. According to the Department of Aging and Disability Services (DADS), between 2000 and 2010,

the 60-plus population will grow by almost 30 percent and the 85-plus population will grow by 11.9 percent. By 2040, older adults will compose almost one-quarter of the Texas population.

ROLE OF INFORMAL CAREGIVERS

The growth in the older population will also affect caregiving demands on families and friends who are the primary source of long-term care assistance. According to the National Conference of State Legislatures, there are an estimated 1.9 million informal caregivers in Texas who provide help to older people and adults with disabilities who need assistance with daily activities. These caregivers provide an estimated 2.1 billion hours per year of care with a market value of $18.0 billion. These amounts would be even higher if persons providing care to children with long-term care needs were included. The provision of informal care and the use of caregiver support services can prevent or delay placement in more costly institutional settings. Specifically:

- Care provided by family and friends can determine whether individuals with long-term care needs can remain at home and avoid placement in institutional settings, thus avoiding future Medicaid institutional expenditures. For example, according to the U.S. Administration on Aging, 50 percent of older adults who have a long-term care need, but no family available to care for them are in nursing facilities, while only 7 percent who have a family caregiver are in institutional settings. Furthermore, a review of current literature supports the conclusion that the availability of informal care helps prevent client transition to formal care, including institutionalization.

- Informal caregivers commonly face physical and mental health risks, financial pressures, and workplace issues due to their caregiving responsibilities, which affect their ability to provide care. Specifically, studies find higher levels of depressive symptoms and other emotional problems among family caregivers than among their non-caregiving peers. Other studies have also linked caregiving with negative affects on caregiver physical health. Finally, studies have concluded that caregivers whose health declined are more likely to end their caregiving role as compared to their healthy counterparts. The status of caregiver physical and mental health has been found to influence placement of the care recipient in institutional settings.

- Research suggests that caregiver support services can help to reduce the strain of caregiving responsibilities, allow informal caregivers to remain in the workforce, and delay or prevent institutionalization of the care recipient. For example, researchers suggest that providing support services to caregivers during the early stages of their role can delay institutionalization. Caregiver support services may include information about available services; assistance in gaining access to services; counseling, support groups, and training to assist caregivers in their roles; respite care to temporarily relieve caregivers from their caregiving responsibilities; and supplemental services to complement the care provided by caregivers.

RESPITE CARE IN TEXAS

Respite care, which gives caregivers a temporary short-term break, is the family support service most frequently requested by family caregivers to help them continue to provide care at home. Respite care may include in-home services, adult day services, and/or overnight stays in facilities. Several federal programs include respite care as one of the services that states or localities can choose to fund. In addition, states may offer respite as a specific service within state-funded programs. Programs that offer respite often have specific eligibility criteria restricting access to certain populations.

In Texas, the Department of Aging and Disability Services (DADS) administers respite care for older adults and certain non-aged persons with disabilities. **Figure 3** shows the number of persons who received respite services administered by DADS and reported spending by program. Individuals may receive services from more than one program to meet the needs of the caregiver. DADS reported spending $132.4 million on respite care delivered in state fiscal year 2005. Respite care spending represents about 2.6 percent of publicly-funded long-term care spending reported by DADS in state fiscal year 2005. Total reported respite spending does not include respite services provided by mental retardation authorities or through the state-funded In-Home and Family Support Program due to agency data reporting limitations. DADS also administers other services, in addition to respite care, that provide support to informal caregivers. Other agencies may also include coverage for respite care in some of the programs they administer.

Access to respite care for persons with long-term care needs in Texas is limited, primarily due to limited funding and provider availability. Most respite care spending administered

FIGURE 3
DEPARTMENT OF AGING AND DISABILITY SERVICES RESPITE SERVICES BY PROGRAM, FISCAL YEAR 2005

	RESPITE SERVICES		
PROGRAM	PERSONS SERVED	TOTAL REPORTED SPENDING	PERCENTAGE OF TOTAL SPENDING
Day Activity and Health Services – Medicaid Entitlement Service	22,553	$101,506,020	76.7%
Medicaid Home and Community-Based Services Waiver Programs	5344	23,460,928	17.7
Day Activity and Health Services – Social Services Block Grant	1,389	3,932,367	3.0
Older Americans Act	3,500	3,434,074	2.6
State Mental Retardation Facilities	3	26,036	0.02
Mental Retardation Authorities	Data Unavailable	Data Unavailable	--
In-Home and Family Support Program	Data Unavailable	Data Unavailable	--
Total	**--**	**$132,359,425**	**100.0%**

Source: Texas Department of Aging and Disability Services.

by DADS is provided through one program in one region. Specifically, about $101.5 million, or 77 percent of total respite spending administered by DADS, is funded through a Medicaid entitlement service—Day Activity and Health Services (DAHS). Medicaid DAHS limits eligibility to persons with a monthly income of 100 percent of the monthly income limit for Supplemental Security Income or currently $603 per month and resources of no more than $2,000, and who meet medical necessity criteria. Furthermore, of the $101.5 million spent on Medicaid-entitlement DAHS, 73 percent was spent on services delivered in Region 11, including the Coastal Bend, South Texas, and Lower Rio Grande areas.

As shown in **Figure 4**, spending on respite services administered by DADS varies by region. Respite care spending ranges from about $1.1 million in Region 9 to $77.7 million in Region 11. Per capita spending adjusted for regional population size ranges from $1.23 in Region 3 to $39.74 in Region 11. As described earlier, the significantly higher amount of respite spending in Region 11 as compared to other regions is due to Medicaid-entitlement DAHS spending.

A review of the potential client population and the number of persons receiving respite services indicates limited provision of respite care. Specifically, of the 948,000 older adults and non-aged persons with disabilities who need help with daily living, approximately 606,000 are in the Medicaid long-term

FIGURE 4
SPENDING ON RESPITE SERVICES ADMINISTERED BY THE TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES BY REGION, FISCAL YEAR 2005

HHS REGION	CORRESPONDING AAA	TOTAL REPORTED SPENDING	PER CAPITA SPENDING
1	Panhandle, South Plains	$2,120,473	$2.55
2	North Texas, West Central	1,583,573	2.95
3	Texoma, Dallas, Tarrant, North Central	7,605,525	1.23
4	Ark-Tex, East Texas	3,664,131	3.58
5	Deep East, South East	1,906,729	2.54
6	Harris, Houston-Galveston	7,690,954	1.42
7	Central Texas, Capital, Heart of Texas, Brazos Valley	3,785,434	1.48
8	Middle Rio, Alamo, Bexar, Golden Crescent	18,926,813	8.04
9	Concho Valley, Permian Basin	1,063,774	2.02
10	Rio Grande	5,831,904	7.81
11	Coastal Bend, South Texas, Lower Rio Grande	77,107,689	39.74
Unknown	--	1,072,425	--
Total	**--**	**$132,359,425**	**$5.79**

Source: Legislative Budget Board.

care target population (i.e., at or below 220 percent of the federal poverty level). Of this amount, it is estimated based on national data that 65 percent, or 393,900, receive all of their long-term care from family and friends and could potentially benefit from respite care. The total number of persons who received respite services through programs administered by DADS is at most 32,789 assuming no duplication in the number of persons served across programs providing respite services.

OTHER STATE ACTIVITY TO STRENGTHEN RESPITE SYSTEMS

Four states, Oregon, Nebraska, Wisconsin, and Oklahoma, have implemented Lifespan Respite Programs to expand the supply of and improve access to respite care for individuals. Older adults and non-aged persons with disabilities who have long-term care needs are among the populations served by the programs. Each program has been adapted to meet individual state needs, but the defining characteristic of each is a coordinated approach to respite care.

Oregon, Nebraska and Wisconsin support respite at the state-level and contract with community-based networks to develop local infrastructures for increasing access to respite care. The community-based networks provide a one-stop resource for caregivers. Activities conducted at the state-level and/or by local contracting entities include:

- Connecting families with existing respite resources
- Recruiting and training respite providers
- Maintaining registries of respite providers
- Providing respite vouchers to certain families not eligible to receive respite services through existing programs as funding allows
- Technical assistance
- Partnership building
- Public awareness activities

Oklahoma established a statewide partnership of public and private agencies that pool resources to fund respite vouchers. Most critical to the success of lifespan respite programs is the coordination and sharing of resources among state, federal, and local programs. **Figure 5** shows a summary of the lifespan respite programs operating in other states.

POTENTIAL BENEFITS OF STRENGTHENING THE PROVISION OF RESPITE CARE

Evaluation studies support the conclusion that respite care is associated with reduced or delayed out-of-home placements, reduced hospitalizations, improved caregiver health and well-being, improved family functioning, and prevention of abuse or neglect. Furthermore, states with lifespan respite programs report the ability to leverage new dollars from public and private sources and reduce state administrative costs. For example:

- Nebraska has leveraged Medicaid funds to recruit respite providers.
- Oregon, Oklahoma, and Wisconsin have leveraged funds from private organizations and foundations.
- All states report that having one entity administer a lifespan respite program saves funds in comparison to the costs associated with implementing individual respite initiatives.

In Texas, there are approximately 606,000 older adults and non-aged persons with disabilities who need help with daily activities who are at or below 220 percent of the federal poverty level, or have monthly incomes below 300 percent of the monthly income limit for Supplemental Security Income (i.e., currently $1,809 per month), and are potentially eligible for Medicaid. Of this amount, it is estimated based on national percentages that 65 percent, or 393,900, receive all of their long-term care from unpaid family and friends. As shown in **Figure 6**, if these individuals were instead to receive care in a nursing facility paid by Medicaid, the annual cost is estimated to range from $2.7 billion to $10.7 billion in state and federal funds depending on the number of persons who meet Medicaid nursing facility medical necessity and asset test criteria. The cost could be even higher if some of these individuals received care in an intermediate care facility for persons with mental retardation or a state school because the average monthly cost per client for these types of care, $4,155 and $6,829, respectively, is higher than for nursing facility care ($2,272). The provision of respite care could help prevent or delay institutionalization.

IMPLEMENT A LIFESPAN RESPITE PILOT PROGRAM

Most people who need long-term care depend exclusively on help from family and friends, not on paid service providers or institutions. Efforts to support caregivers play an important role in sustaining the informal care system and helping to avoid future Medicaid institutional spending. Respite care is the support service most frequently requested by informal caregivers to help them continue to provide care at home. However, access to respite care for persons with long-term care needs in Texas is limited, primarily due to limited funding and provider availability.

Recommendation 1 would amend the Texas Human Resources Code to require the Department of Aging and

FIGURE 5
LIFESPAN RESPITE PROGRAMS IN OTHER STATES

STATE	STATE-LEVEL LEAD AGENCY	SUMMARY	ESTIMATED ANNUAL FUNDING
Oregon	State Department of Human Services (1997)	The Oregon Lifespan Respite Program is funded through the state general fund and administered by the Oregon Department of Human Services. Funds are distributed through contracts to local networks covering all counties. Each local network has an advisory committee made up of community partners and consumers. Local networks have their own registries of providers and often share recruitment and training activities with other programs such as Medicaid.	$550,000
Nebraska	State Health and Human Services System (1999)	The Nebraska Lifespan Respite Program is funded with tobacco settlement funds, Medicaid, and education funds, and is administered by Aging and Disability Services within the Nebraska Health and Human Services System (HHSS). Contracts are in place between HHSS and six local networks, one in each region. Respite voucher applications are available from local network coordinators, on the HHSS website, or HHSS offices.	$1.9 million
Wisconsin	Respite Care Association (1999)	The Wisconsin Lifespan Respite Program is funded through the state general revenue fund and administered by the Respite Care Association of Wisconsin (RCAW) under contract with the Wisconsin Department of Health and Family Services (DHFS). Funds are distributed through contracts with local networks serving seven counties. The local networks are required to demonstrate strong collaboration and networking with other agencies in the community.	$225,000
Oklahoma	Oklahoma Respite Resource Network (2000)	The Oklahoma Lifespan Respite Program is administered by a statewide partnership of public and private agencies – the Oklahoma Respite Resource Network. State agencies, including developmental disabilities, mental health, aging, maternal and child health and others, have come together voluntarily with private agencies and foundations to pool resources for respite. Funds are disbursed to family caregivers though a voucher program managed by the Oklahoma Area-wide Services Information System (OASIS), the statewide information and referral agency. Families applying to the state for a respite voucher submit their applications for service to OASIS who forwards them to the appropriate state agency for approval under their respective eligibility criteria.	$851,000

Source: Legislative Budget Board.

FIGURE 6
ESTIMATED ANNUAL COST TO PROVIDE MEDICAID-FUNDED NURSING FACILITY CARE TO POTENTIAL MEDICAID CLIENTS CURRENTLY RECEIVING ALL CARE FROM UNPAID FAMILY AND FRIENDS

Percent of Potential Medicaid Clients Currently Receiving All Unpaid Care Projected to Meet Medicaid Nursing Facility Medical Necessity and Asset Test Criteria	25%	50%	75%	100%
Number of Persons	98,475	196,950	295,425	393,900
Estimated Total Annual Cost to Provide Medicaid-Funded Nursing Facility Care	$2,684,822,400	$5,369,644,800	$8,054,467,200	$10,739,289,600

Note: Estimated total annual cost to provide Medicaid-funded nursing facility care is based on average monthly Medicaid nursing facility per person costs obtained from the Department of Aging and Disability Services.
Source: Legislative Budget Board.

Disability Services (DADS) to implement a lifespan respite pilot program based on models implemented in other states that would improve access to respite care for persons with long-term care needs by building state and local infrastructure to support the provision of respite services. The pilot program could be designed to serve individuals currently eligible for Medicaid entitlement services and those eligible for Medicaid waiver programs, but with limited access to respite services due to limited funding and/or provider availability. The pilot program could also serve those who might spend down their

resources to qualify for Medicaid. Individuals providing care to other populations could potentially benefit depending on the pilot program's design. DADS should consider contracting with at least two local community-based networks—one in an urban area and one in a rural area—to develop local infrastructures for increasing access to respite care. DADS should consider geographic areas that currently have limited access to respite care as compared to other areas of the state. Contracts could require local networks to:

- Coordinate resources among existing programs;
- Build local partnerships;
- Connect families to existing respite resources;
- Maximize existing funding and leverage new dollars;
- Recruit and train respite providers;
- Maintain a registry of respite providers;
- Implement public awareness activities; and
- Provide respite vouchers to families not eligible to receive respite services through existing programs as funding allows.

Recommendation 2 would amend the Texas Government Code to require the Texas Health and Human Services Commission (HHSC), in consultation with DADS, to conduct an evaluation study to assess the impact of the lifespan respite pilot program on access to respite care and Medicaid long-term care institutional expenditures and report the findings to the Governor and the Legislative Budget Board by November 1, 2010.

Recommendation 3 would include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $150,000 in General Revenue Funds for each fiscal year of the 2008–09 biennium to DADS for implementing a lifespan respite pilot program.

The following contingency rider could be included in the 2008–09 General Appropriations Bill to implement Recommendation 3:

> **Lifespan Respite Pilot Program.**
> Contingent upon enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation establishing a lifespan respite pilot program, in addition to amounts appropriated above, the Department of Aging and Disability Services is appropriated $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 in General Revenue Funds for the purposes of contracting with local community-based networks to develop local infrastructures for increasing access to respite care, and in addition, the Full-Time Equivalent (FTE) cap for the Department of Aging and Disability Services is hereby increased by 1 for each year of the 2008–09 biennium to administer the lifespan respite pilot program. The Department shall explore federal funding opportunities.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations would result in a cost to net General Revenue Funds of $300,000 in the 2008–09 biennium. However, implementing a lifespan respite pilot program has the potential to maximize and leverage existing funds, improve access to respite services, and avoid future Medicaid institutional spending by supporting informal caregivers. As a result, the cost to implement the recommendations may be all or partially offset by potential cost savings from these outcomes.

Recommendation 1 would amend the Texas Human Resource Code to require DADS to implement a lifespan respite pilot program. As shown in **Figure 7**, Recommendation 3 would include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 from General Revenue Funds to DADS for implementing a lifespan respite pilot program. The $150,000 in fiscal year 2008 includes $50,000 for salary, benefits, and travel for one additional full-time equivalent at DADS to administer the lifespan respite pilot program, and $100,000 for grants to local community-based networks. The $150,000 in fiscal year 2009 includes $50,000 to maintain the one full-time equivalent added in 2008 and

FIGURE 7
FISCAL IMPACT OF IMPLEMENTING A LIFESPAN RESPITE PILOT PROGRAM

FISCAL YEAR	PROBABLE SAVINGS/(COST) FROM GENERAL REVENUE FUNDS	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2006–07 BIENNIUM
2008	($150,000)	1
2009	($150,000)	1
2010	($150,000)	1
2011	($150,000)	1
2012	($150,000)	1

SOURCE: Legislative Budget Board.

$100,000 for grants to the local community-based networks.

Recommendation 2 would amend the Texas Government Code to require HHSC, in consultation with DADS, to conduct an evaluation study to assess the impact of the lifespan respite pilot program on access to respite care and Medicaid long-term care institutional expenditures. It is estimated that this recommendation would have no significant fiscal impact because the evaluation of the pilot program could be conducted by HHSC using existing resources.

The introduced 2008–09 General Appropriations Bill does not address any of the recommendations.

REDUCE BARRIERS TO USE OF CONSUMER DIRECTED SERVICES IN LONG-TERM CARE

"Consumer direction" in long-term care is a healthcare delivery model that allows consumers of certain long-term care services to directly hire, train, manage, and when necessary, terminate the workers providing their care. Originating in the disability rights and independent living movements, and strengthened by government efforts to control and rebalance Medicaid long-term care spending, consumer direction has been in development as a service delivery option for accessing home- and community-based services for more than a decade.

According to the federal Centers for Medicare and Medicaid Services, helping individuals remain in their homes and allowing them to chose their provider, increases consumer satisfaction which translates into lower utilization of less appropriate and more costly emergency room and institutional care. Some of the primary benefits of consumer direction also include: giving consumers' greater choice and control over their services; improving both the quality of services delivered and the beneficiary's satisfaction with those services; and alleviating worker shortages, expanding the pool of direct care workers, and filling gaps in service delivery.

The state of Texas has taken significant steps to implement consumer direction in several long-term care programs. However, use of the option remains low. As demonstrated in one long-term care program in Texas, use of the consumer directed services option can potentially result in future cost-avoidance because of lower utilization of less appropriate and more costly care.

CONCERNS

- Without state legislative action, the statutes establishing the consumer directed services workgroup will expire September 1, 2007.
- Despite its availability in Texas, use of consumer directed services in long-term care is low. The state and consumers are forgoing the potential benefits of consumer directed services, including the reduction of less appropriate and more costly care.
- Results of the cost-effectiveness analysis of the consumer directed services option in one long-term care program cannot be generalized to other programs in which it is available. Limitations in the data collection and reporting systems have prohibited complete and definitive analysis of relative cost-effectiveness and service utilization.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Government Code to continue the consumer directed services workgroup through September 1, 2011, so that the workgroup may continue to advise on and monitor the expansion of consumer directed services, and assist in the identification and reduction of barriers to its use and the measure of cost-effectiveness.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill that requires the Department of Aging and Disability Services, with support from the Health and Human Services Commission and direction from the consumer directed services workgroup, to report barriers identified to be obstructing the use of the consumer directed services option, and effective strategies to reduce or eliminate those barriers.
- **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill that requires the Health and Human Services Commission, with support from the Department of Aging and Disability Services and direction from the consumer directed services workgroup, to report a plan for the continuing evaluation and reporting of the cost-effectiveness of consumer directed services.

DISCUSSION

"Long-term care" refers to a wide range of supportive and health services provided on an ongoing basis for persons who have limitations in functioning because of a disability or chronic condition. A person typically needs long-term care services if they require assistance with activities of daily living that are essential to daily self-care. These activities include bathing, dressing, grooming, toileting, housekeeping, shopping, and preparing meals.

Long-term care services are delivered in a range of settings that depend on the consumer's needs and preferences, the availability of informal support, and the source of

reimbursement for those services. This range is commonly categorized into two settings: institutional settings such as nursing facilities and intermediate care facilities for persons with mental retardation, and home and community-based services (community-based services). Community-based services refers to a variety of non-institutional long-term care settings that may range from congregate living arrangements to a consumer's home.

MEDICAID'S ROLE IN FINANCING LONG-TERM CARE

Medicaid is a jointly funded state-federal entitlement program that provides, to certain eligible groups, health insurance coverage for basic healthcare needs and other insurance coverage for people with chronic or long-term care needs. Although Medicaid's long-term care services are limited to those with low incomes or who incur catastrophic expenditures, the program is the nation's major source of financing for long-term care. In 2003, Medicaid accounted for 40 percent or $61 billion of the approximately $150.8 billion in total public and private long-term care expenditures.

Medicaid finances the provision of long-term care services traditionally in institutional settings, wherein the consumers reside and receive healthcare services in a specific type of certified facility, and the provider is paid a rate for the individual's room, board, and services. In addition to institutional based care, Medicaid also finances the provision of community-based services.

Texas provides Medicaid community-based services through its Medicaid state plan and seven home and community-based service waiver programs (HCBS). Under the state plan, Texas is federally mandated to provide home health services to individuals who meet certain criteria. Home health services include nursing services or aide services, and medical supplies and equipment for use in the home. While this is a mandatory service, states have flexibility to set functional eligibility criteria for these services. States may also elect, under the state plan, to provide personal care, an optional Medicaid community-based service. Personal care services provide assistance to persons with disabilities and chronic conditions to help them perform activities that they normally would perform themselves if they did not have a disability. Whether mandatory or optional, state plan benefits (if offered) are federal entitlements and must meet certain criteria regarding access and adequacy. Texas also provides community-based services through several HCBS waiver programs. These programs allow Texas to provide long-term care services in a community-based setting to individuals who would otherwise require institutional services. Texas must ensure that the cost of care under waiver programs is no higher than the cost of institutional care.

There has been growth over the past decade in Medicaid spending on community-based services, and a shift in the distribution of Medicaid long-term care resources from institutional care to community-based care. Between 1994 and 2004, national Medicaid expenditures on community-based services increased from $8.4 billion to $31.6 billion, rising from 19 percent to 36 percent of Medicaid long-term care spending. As shown in **Figure 1**, the shift was due to the growth in HCBS waiver spending which accounts for nearly two thirds of all Medicaid community-based services spending. Forty percent of Medicaid community-based services recipients access those services through HCBS waivers.

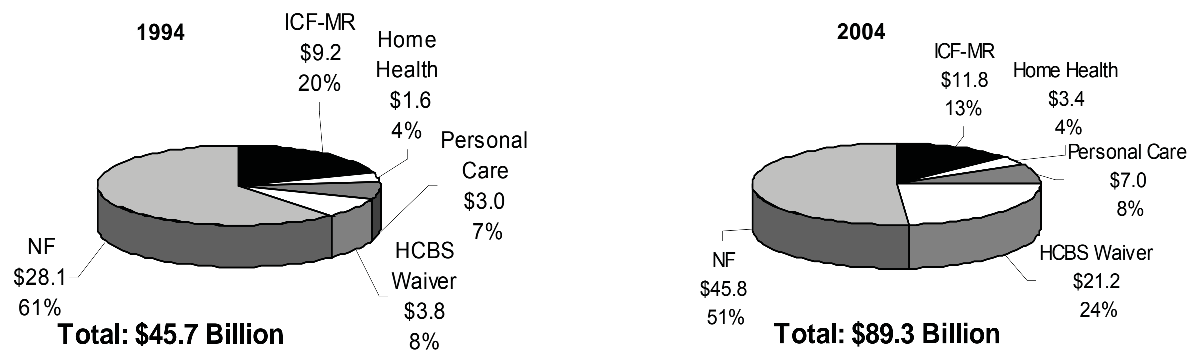
Consumer direction has been strengthened by states' efforts to control rising Medicaid long-term care costs by rebalancing public long-term care spending from expensive institutional care to community-based alternatives. It was in conjunction with the expansion of community-based services, and the use of those services, that consumer direction in long-term care was developed.

MODELS OF CONSUMER DIRECTED SERVICES

The development of consumer direction in long-term care has its roots in the disability rights and independent living movements. The tenants of these movements are based on the fundamental principles of civil rights, consumerism, self-help, de-medicalization, and de-institutionalization, as they pertain to and are defined by people who have disabilities.

According to the National Institute of Consumer-Directed Long-Term Care Services, "consumer direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumer direction ranges from the individual independently making all decisions and managing services directly, to an individual using a representative to manage needed services. The unifying force in the range of consumer directed and consumer-choice models is that individuals have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services."

FIGURE 1
NATIONAL MEDICAID EXPENDITURES FOR LONG-TERM CARE, 1994 AND 2004



NOTE: NF - Nursing Facility, ICF-MR - Intermediate Care Facility for Persons with Mental Retardation.
SOURCE: Kaiser Commission on Medicaid and the Uninsured.

While people who pay for community-based services from their own resources have always been able to direct their own services, it is only over the past decade that consumer directed services have taken shape in public programs.

Most Medicaid beneficiaries receive community-based services via an agency-based model of care. The agency-directed model provides consumers with relatively little direct control. In this model, states contract with home-care agencies that are responsible for hiring and firing home-care workers, directing services, monitoring quality of care, worker discipline, and paying workers, and applicable taxes.

Consumer direction is a model of service delivery in which consumers, guardians, or designated representatives have increased control over the delivery of their long-term care services. Consumer direction allows these persons, instead of a traditional provider agency, to directly hire, train, manage, and when necessary, terminate the workers providing their care. The use of consumer direction as a service delivery model does not preclude the use of the traditional agency-based service delivery system. There is a range of consumer directed services models, that vary according to the level at which consumers participate in managing and directing their services:

- **Direct Pay/Cash and Counseling:** The client manages both funds and services. Clients are the employer of record and handle all responsibilities associated with selected care provider, including recruiting, interviewing, screening, hiring/firing, scheduling, training, monitoring quality, paying, and maintaining records. Assistance and support may be available to clients; clients may receive an actual check or vouchers to use to pay for services.
- **Fiscal Intermediary:** The client is employer of record and manages services, but an intermediary agency (either the state or an agency designated by the state) assists clients by handling payroll, taxes and paperwork for clients. However, clients still manage their services.
- **Supportive Intermediary:** The state or designated agency offers supportive services to consumers and assistants on a limited basis, while the client remains the employer of record. These services may include recruitment assistance, criminal background checks on assistants, training, and case management.
- **Agency-with-choice:** The state or provider agency designated by the state remains the employer of record, retaining the responsibility of handling funds and much of the management of direct care workers, but the consumer is allowed to express preferences relating to the delivery of their care.

There are several key administrative and policy considerations that are fundamental to the development of consumer direction in Medicaid programs:

- **Eligibility:** Determining who will be eligible to participate in the consumer directed services program, including financial/resource standards (Medicaid eligibility), demonstrated need for that type of service based on having a given level of impairment/disability, and determining a consumer's capability to direct their services and manage the responsibilities inherent in consumer direction (many programs allow a family member or legal guardian to direct the services of a child or an individual who is unable to express his or her preferences).

- **Program related support services:** Deciding whether to include one or more of an array of services that support use of consumer direction. Those services may include that of a fiscal intermediary or a service consultant/counselor.

- **Consumer education and training:** Deciding whether to include formal training sessions, opportunities for individual discussions with service consultants, organized peer matching, and the development of written training materials to assist consumers.

- **Employer of record:** Establishing who will be the legal employer of the direct care worker(s) providing care, and thus assuming certain fiscal and legal responsibilities based on federal and state laws.

- **Provider issues:** Establishment of provider standards and qualifications, provider reimbursement methodology, policy on hiring friends and family, and the impact on the provider market (including opposition from and potential presence of conflicts of interest with traditional agency-based providers who believe that the availability of such programs will negatively affect their businesses by drawing away consumers) are all key issues to be considered.

There is no current comprehensive list of all consumer-directed programs in the nation. An inventory of both Medicaid and non-Medicaid programs conducted by the National Council on Aging in 2001 identified 139 consumer directed service programs operating in all states except Tennessee and the District of Columbia. Two-thirds of the programs inventoried were implemented since 1990. While 58 percent of consumer directed service programs served 1,000 or fewer participants, 24 percent served between 1,001 and 5,000 participants. The inventory found that nearly half a million individuals participated in consumer direction at the time.

BENEFITS OF CONSUMER DIRECTED SERVICES TO THE STATE AND CONSUMERS

States have sought to develop and implement consumer direction for a variety of reasons. Use of the consumer directed services model can:

- Better fit consumers' needs by giving them greater choice and control over their services;

- Provide, in many cases, greater flexibility in hiring workers such as relatives, friends, and neighbors, which can help alleviate worker shortages and expand the pool of direct care workers;

- Fill gaps in service delivery;

- Improve both the quality of services delivered and the beneficiary's satisfaction with those services; and

- Provide personal assistance services more cost-effectively than agency-based models due to lower administrative expenses.

According to the federal Centers for Medicare and Medicaid Services, helping individuals remain in their own homes and allowing them to choose their own providers increases consumer satisfaction which translates into lower utilization of less appropriate and more costly emergency room and institutional care. As programs progress, agency cost savings may occur due to higher utilization of lower cost services such as personal attendant care, and cost avoidance from lower utilization of high cost services such as institutionalization, as evidenced below.

The "Cash and Counseling" demonstration, first implemented in 1996 in Arkansas, Florida, and New Jersey, through a public-private partnership between the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services, evaluates the consumer-directed service delivery model for elders and younger adults with disabilities as compared to traditional agency-based model of care (control group). The demonstration studies the use of a cash benefit provided to Medicaid beneficiaries enabling them to choose who provides certain community-based services to them, and when and how they are provided. The demonstration resulted in positive client outcomes and has shown potential for Medicaid cost savings. Specifically, evaluation of the demonstration found:

- Participants in Arkansas who accessed services via consumer direction: (1) were more satisfied with the services they received; (2) reported a higher quality of life; (3) had fewer unmet needs for personal care, household activities, and transportation; (4) received more paid care; and (5) did not have more adverse events or health problems.

- Medicaid personal-care expenditures for those who directed their own care in Arkansas were higher than those in the control group, and they received more care. Medicaid expenditures on other long-term care services (nursing facilities, home health and HCBS waiver programs) were lower for the participants using

consumer direction than the control group, particularly in the second year after enrollment.

- Total Medicaid spending for those using consumer direction in Arkansas were higher in the first year than the control groups, but there was no significant difference in total Medicaid expenditures between the two groups in the second year. Total Medicaid costs in New Jersey and Florida after two years were slightly higher among those who used consumer direction.
- Recent analysis of third year data from Arkansas, however, shows that nursing home admissions among those who used consumer direction declined substantially, resulting in significant cost savings as compared to those in the control group. Nursing facility use was 18 percent lower for participants in the demonstration when compared to the control group during the 3-year follow-up period. Among those who had received personal care services before the demonstration, nursing facility savings, together with savings in other long-term care costs, fully offset the higher personal care service costs. The evaluation of the demonstration in Arkansas concluded that consumer directed personal care services reduces nursing facility use and costs more effectively than providing services in the traditional manner.

The results of the demonstration led to replicating and expanding the program into 11 additional states in 2004.

There are other initiatives, both public and private, that support the implementation of consumer direction in long-term care. The Independence Plus HCBS waiver template, the System Change Grants to States, and certain provisions in the federal Deficit Reduction Act of 2005 are all recent federal initiatives supporting consumer direction in long-term care.

IMPLEMENTATION OF CONSUMER DIRECTED SERVICES IN TEXAS

In 2001, after initial pilot project trials in state-funded programs, Texas implemented the consumer directed service (CDS) delivery model in two Medicaid HCBS 1915(c) waiver programs, the community living assistance and support services (CLASS) and deaf/blind/multiple disabilities (DB-MD) waiver programs. Since its initial implementation, application of the CDS model expanded to include four additional programs:

- Primary Home Care Services;
- Community Based Alternative;
- Client Managed Personal Assistance Services; and
- Medically-Dependent Children's Program.

Plans for continued expansion of CDS in Texas are underway. The option will be available in three additional HCBS 1915(c) waiver programs: the Consolidated Waiver Program (CWP), Home and Community Based Services (HCS) program, and Texas Home Living program. In addition to expanding CDS into more programs, there is a plan to expand the variety of services available through the option. For example, the implementation of CDS in Texas Home Living will make all of the program's services available through the CDS option. Currently, with exceptions in some programs, the CDS option can be used to access primarily personal assistance, respite, and habilitation services.

CDS in Texas is based on the fiscal intermediary model described previously. In this model, a consumer or legally authorized representative (LAR) employs their direct care workers and directs the delivery of certain program services but receives financial management services from a consumer directed services agency (CDSA) chosen by that individual. **Figure 2** shows the process whereby consumers select and implement the CDS option in Texas.

In addition, Texas implemented the Service Responsibility Option (SRO) pilot program in two regions of the state, the Texas Panhandle/South Plains region and Bexar County. The SRO program closely resembles the agency-with-choice model of consumer direction. SRO, which can be used to access primary home-care services, allows the consumer of those services to select, train, and supervise their direct care workers, but the provider agency remains the employer of record and retains the personnel and fiscal duties and the responsibility for providing substitute attendants when the consumer requests one. Currently, the Department of Aging and Disability Services (DADS) is planning to expand SRO in the primary home-care program statewide in January 2007.

CONTINUE THE CONSUMER DIRECTED SERVICES WORKGROUP

Implementation of consumer directed services (CDS) in Texas included the establishment of a stakeholder workgroup to assist the Health and Human Services Commission (HHSC) and Department of Aging and Disability Services (DADS) in the development and implementation of consumer direction. The CDS workgroup is comprised of

FIGURE 2
CONSUMER DIRECTED SERVICES PROCESS

(1) Case manager, service coordinator, or other designated person provides consumer with written and verbal information about CDS option.

(2) Consumer completes required assessments and forms.

(3) Consumer selects consumer directed services agency (CDSA).

(4) CDSA provides training on CDS.

(5) Consumer decides whether or not to enroll in CDS (there is, however, a fee assessed if the consumer does not remain with the CDSA for at least 90 days following this training.

(6) Consumer enters into service agreement with CDSA.

(7) An individual service plan and budget are developed and approved by consumer, consumer's interdisciplinary team, and CDSA.

(8) Consumer recruits and selects employee and begins to receive services (the agency previously providing the consumer's services continues to provide direct care services other than those being delivered through the CDS option and continues to be a member of the consumer's interdisciplinary team).

(9) CDSA performs payroll duties and supports consumer with financial management services.

(10) Case manager monitors consumer's service utilization.

SOURCE: Legislative Budget Board.

consumers, advocates, providers, and HHSC, DADS, and other state agency staff. The CDS workgroup has been active in assisting in the development of consumer direction in Texas, and in advising and monitoring its implementation and expansion. However, Section 531.052, Texas Government Code, the statutory provision relating to the establishment and composition of the consumer directed services workgroup, is set to expire September 1, 2007. Given the concerns highlighted in this report, continued guidance from the workgroup is merited.

Recommendation 1 would amend the Texas Government Code to continue the consumer directed services workgroup through September 1, 2011, so that the workgroup may continue to advise on and monitor the expansion of consumer directed services, and assist in the identification and reduction of barriers to its use and the measure of cost-effectiveness.

IDENTIFY AND REDUCE BARRIERS TO USE OF CONSUMER DIRECTED SERVICES IN TEXAS

While Texas has made significant strides in implementing and expanding the CDS option within the state's Medicaid community-based services, overall use of the option remains low. As shown in **Figure 3**, overall use of the CDS option is less than 0.5 percent of total enrollment of the programs in which it is available. With the exception of the CLASS and CMPAS programs, use of the option is at less than 2 percent in each program.

Barriers to use of CDS may include:

- A lack of understanding of the option and its benefits by all stakeholders—case managers, consumers and their family members, and providers. Factors may include a reluctance to accept change, a perception of risk to the consumer or liability to both the consumer as the employer of record and/or to the CDSAs acting as the fiscal intermediary, and concerns about the appropriateness of CDS for certain client populations.
- Insufficient initial and ongoing support for consumers using CDS. Factors may include high caseloads preventing case managers from spending sufficient time addressing the option with consumers, a lack of quality tools and materials to use in explaining the CDS option, and difficulty ensuring family member involvement and education due in part to scheduling constraints.
- Concern on the part of consumers and family members about managing the responsibilities of the option. Factors may include the responsibility to provide one's own service back-up plan, concern about difficulty recruiting employees, and the administrative burdens associated with enrollment and becoming an employer.
- Concern on the part of traditional agency providers relating to the potential financial impact of losing business because of the use of CDS. Factors may include the existence of conflicts-of-interest in that case managers in managing a consumer's care plan have the responsibility of introducing the consumer to the CDS option, but if the consumer elects to use the option this would in effect divert the case managers own business as a provider.

FIGURE 3
CONSUMER DIRECTED SERVICES IN TEXAS, AND RATE OF USE, FISCAL YEAR 2006

PROGRAM	ENROLLMENT*	ENROLLEES USING CONSUMER DIRECTED SERVICES*	PERCENTAGE USING CONSUMER DIRECTED SERVICES
Community Living Assistance and Support Services (CLASS)	1,790	646	36.11
Primary Home Care Services (PHC), other**	183,676	108	0.06
Community Based Alternative (CBA)	33,287	103	0.31
Deaf-Blind Multiple Disability (DB-MD)	141	2	1.50
Client Managed Personal Assistance Services (CMPAS)	449	40	8.88
Medically-Dependent Children's Program (MDCP)	1,055	0	0.00
Total, all programs	**220,398**	**899**	**0.41**

*Program enrollment: June 2006; Utilization of CDS: monthly average, September 2005 to May 2006.
**Includes Primary Home Care, Community Attendant Services, and Family Care Services.
Source: Department of Aging and Disability Services.

To evaluate consumers' experiences using the CDS option in Texas, DADS reports that it has taken the following actions:

- Added questions about barriers to use of CDS and SRO to the agency's participant experience/consumer satisfaction survey. The survey will reach both consumers that opted to use CDS, and those that did not. DADS will administer the survey to enrollees in Primary Home Care and the CBA program.
- Conducted focus groups dealing exclusively with access to and use of CDS. These focus groups were formed as a result of legislative direction concerning expansion of the CDS option and provider base as directed by legislation enacted in 2003.
- Sought grant support that may serve to support the identification of barriers to CDS use. DADS has been awarded a workforce resource center technical assistance grant that provides technical staff assistance to the state for advice and support, such as best practices on how to address growing shortages in direct care workers, which CDS can help alleviate. DADS also applied for a Systems Change Grant to support the state's effort to strengthen person-directed-planning initiatives.

While DADS is still waiting for results from these actions, DADS started to take steps that may reduce the barriers to use of the CDS option:

- Developed and distributed tools and outreach/resource materials for case managers and stakeholders for use in promoting the CDS option. DADS developed the materials based on the model used for SRO implementation, and include videos, written explanations, checklists, and a quality management plan. Distribution of the tools and materials and related training was planned for fall 2006.
- Implemented support consultation services, an optional service that is provided by a support advisor, beyond the level of assistance and training provided by a consumer's CDSA. Support consultation services are designed to help consumers meet the responsibilities associated with being an employer as required by the CDS option. Support consultation services will be made available in the Home and Community-based Services and Texas Home Living programs.

While these steps are helpful, a comprehensive effort is needed to identify specific barriers to use of CDS in Texas and to develop effective strategies to reduce those barriers. Recommendation 2 would direct Department of Aging and Disability Services, with support from Health and Human Services Commission (HHSC) and direction from the CDS workgroup, to identify barriers to use of the consumer directed services option, and to identify effective strategies for the reduction or elimination of those barriers. The Department of Aging and Disability Services should report identified barriers and the strategies to address them to the Legislative Budget Board and the Governor no later than November 1, 2007. Recommendation 2 could be implemented by including the rider found at the conclusion of this report in Article II, Special Provisions, of the 2008–09 General Appropriations Bill.

CONTINUE TO EVALUATE COST-EFFECTIVENESS OF CONSUMER DIRECTED SERVICES

According to HHSC, Texas' consumer directed services (CDS) program is cost neutral by design. Consumers' receive no additional amount of authorized benefit by opting for CDS than they would have under the traditional agency-based model. The state's potential exposure under either model is equivalent.

HHSC staff conducted a cost-effectiveness analysis, initially, in fiscal year 2004, wherein overall costs for CDS consumers in CLASS were shown to be approximately 4 percent, or $161 higher per recipient month than for non-CDS consumers. Additional analysis in 2005, however, revealed that CDS recipients received more of their authorized units of service than did those in the traditional agency-based model. HHSC staff reported that after adjustment for this difference in utilization, the cost difference was reduced to less than 2 percent per recipient month, or approximately $66. This difference can be attributed to the average cost for a CLASS waiver services per recipient month being higher for consumers who opted to use CDS than for those who did not, although utilization for those services were still within authorized levels of service hours. According to HHSC staff, the remaining difference in cost may be a result of differences in service authorization, attendant provided transportation, and higher initial expenditure rates.

HHSC's analysis found that CDS users' higher average CLASS waiver services costs were largely offset by lower average acute and pharmaceutical costs per recipient-month than non CDS users. For CDS consumers, acute care costs were an average of more than 12 percent less or $145 per recipient-month, and prescription drug costs were an average of nearly 16 percent less or $37 per recipient month than non-CDS consumers in CLASS.

There are, however, limitations to the above cost-effectiveness analysis. All analysis to date has been of one data set from March 2002 to February 2004, a period immediately following implementation of the CDS option in Texas. Furthermore, the results of the cost-effectiveness analysis cannot be generalized to other programs in which CDS is available because the analysis was conducted only within the CLASS program. Continued analysis is merited and should include analysis of other programs in which CDS is an option if utilization is of a quantity to produce statistically significant analysis, separate analyses for start-up years versus later years, and for children versus adults.

Recommendation 3 directs the Health and Human Services Commission, with support from Department of Aging and Disability Services and direction from the consumer directed services workgroup, to develop a plan for continuing evaluation of the cost-effectiveness of consumer directed services. This plan should include analysis of other programs in which consumer directed services is an option if utilization is of a quantity to produce statistically significant analysis, separate analyses for start-up years versus later years, for children versus adults, and modification of data systems or use of alternative data if necessary. Recommendations 2 and 3 could be implemented by including the following rider in Article II, Special Provisions, of the 2008–09 General Appropriations Bill.

Reporting Requirements Related to Consumer Directed Services and Service Responsibility Option. The Department of Aging and Disability Services and the Health and Human Service Commission shall report the following consumer directed services (CDS) and service responsibility option (SRO) information to the Legislative Budget Board and the Governor no later than November 1, 2007:

a) The Department of Aging and Disability Services, in coordination with the Health and Human Services Commission and the consumer directed services workgroup, shall report barriers the agency has identified to be obstructing the use of CDS and SRO, and strategies the agency will employ to reduce or eliminate those barriers.

b) The Health and Human Services Commission, in coordination with the Department of Aging and Disability Services and the consumer directed services workgroup, shall report a plan for the continuing evaluation and reporting of the cost-effectiveness of CDS and SRO. The plan should include, but is not limited to:

i. Analysis of programs other than the community living assistance and support services program in which CDS and SRO are an option, if utilization is of a quantity to produce statistically significant analysis;

ii. Comparative analysis of start-up years versus later years;

iii. Comparative analysis of different functional eligibility groups and program populations;

iv. Modification of data-systems and use of alternative data if necessary;

v. Consideration of acute and other long-term care costs, such as deferring uptake into institutional settings; and

vi. Estimates of savings

FISCAL IMPACT OF THE RECOMMENDATIONS

None of the recommendations, if implemented, would have significant direct fiscal impact during the 2008–09 biennium.

It is estimated that agencies can implement recommendations relating to identification and reduction of barriers, as well as continuing evaluation of cost-effectiveness within existing resources. Because consumers in both the CDS and traditional agency-based models of service delivery cannot utilize more services than authorized, as long as authorized services remain equal, costs associated with CDS should remain neutral. As demonstrated in CLASS, use of the CDS option can potentially result in future cost-avoidance because of lower utilization of less appropriate and more costly care.

The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendations 2 and 3. The introduced 2008–09 General Appropriations Bill does not address Recommendation 1.

UPDATE ON HEALTHCARE PROVIDER ASSESSMENTS

Under federal law, a state may impose an assessment on certain classes of healthcare providers. States may use revenues from such assessments under limited circumstances to pay the state share of Medicaid spending. Doing so allows the state to leverage the revenue generated by an assessment to "draw down" additional matching federal funds.

While there are challenges associated with the application of healthcare provider assessments, they provide an opportunity for a significant source of revenue. This report provides a summary of federal provisions governing the use of healthcare provider assessments, an update on the latest developments relating to their application, and an overview of the potential for further application in Texas.

FACTS AND FINDINGS

- ♦ Forty-one states have implemented one or more provider assessments, most commonly on nursing homes, intermediate care facilities for persons with mental retardation, hospitals, and managed care organizations.
- ♦ Texas has enacted and implemented provider assessments on intermediate care facilities for persons with mental retardation and for managed care organizations. Two other assessments, one on two long-term care waiver programs and the other on non-public hospitals in certain counties have been enacted, but not implemented due to concerns raised by the federal government. The Seventy-ninth Legislature, Regular Session, 2005, also considered enactment of an assessment on nursing homes.
- ♦ Two recent federal developments could affect states' implementation and use of provider assessments. First, the Centers for Medicare and Medicaid Services have approved 15 states' applications for waiver of the broad-based and uniformity requirements relating to provider assessments. Such waivers reduce the number of providers that might experience a net negative fiscal impact from an assessment, thereby making such assessments more widely accepted. Second, in December 2006 the U.S. House of Representatives and Senate passed legislation that includes a reduction of the provider assessment safe-harbor from 6 percent to 5.5 percent from January 1, 2008 to September 30, 2011. This reduction of the safe-harbor restricts states' use of assessments by reducing the amount of revenue that can be used to "draw down" matching federal funds.
- ♦ While legal and policy challenges persist relating to the application of provider assessments to new provider classes in Texas, such assessments provide an opportunity to generate additional revenue that can be used to support the needs of the state. For example, an assessment of 5.5 percent on gross receipts of nursing homes would generate approximately $231 million in gross additional revenue for a full fiscal year. An assessment of 1 percent on gross inpatient receipts of hospitals would generate approximately $680 million in gross additional revenue for a full fiscal year.

DISCUSSION

A healthcare provider assessment (provider assessment), such as Texas' quality assurance fee currently assessed on intermediate care facilities for persons with mental retardation (ICF-MR), is an assessment or fee required of a healthcare provider by a state. Federal regulations provide that an assessment is considered to be related to healthcare items or services if at least 85 percent of the burden of the assessment revenue falls on healthcare providers, with certain exceptions. **Figure 1** shows the regulatory distinctions among classes of

FIGURE 1
HEALTHCARE ITEMS OR SERVICES

Inpatient hospital service	Dental services
Outpatient hospital service	Podiatric services
Nursing facility services	Chiropractic services
ICF-MR services	Optometric/optician services
Physician services	Psychological services
Home health services	Therapist services
Outpatient prescription drugs	Nursing services
Health maintenance organizations and health insuring organizations	Laboratory and x-ray services
Ambulatory surgical center services	Emergency ambulance services

Source: Code of Federal Regulation.

healthcare items or services for delineating application of provider assessments.

FEDERAL PROVIDER ASSESSMENT REQUIREMENTS

States may use revenues from provider assessments, under the limited circumstances specified in federal law, to pay the state share of Medicaid spending. Doing so allows the state to leverage the revenue generated by an assessment to "draw down" additional matching federal funds. The two primary requirements for the permissible use of provider assessment revenue are as follows:

- The assessment must be "broad based," imposed on all providers in that class; and
- The assessment must be "uniform," imposed at the same rate for all providers within that class.

For example, a nursing home assessment cannot specifically exclude certain providers who have only private pay (non-Medicaid) clients or charge them a lower assessment.

Further, a provider assessment is not considered to be uniform if it provides for credits, exclusions, or deductions that in effect return any portion of the assessment to providers with the following net result: the assessment is not generally redistributive; and the amount of the assessment is directly correlated to Medicaid payments. The federal government determines whether an assessment is generally redistributive via a mathematical calculation.

Likewise, a provider assessment is not considered to be uniform if it holds providers "harmless" for the cost of the assessment. Providers are considered to be held harmless if any of the following apply:

- The state provides for a non-Medicaid payment to those providers or others paying the assessment and the amount of the payment is positively correlated to either the amount of the assessment or to the difference between the Medicaid payment and the total assessment cost;
- All or any portion of the Medicaid payment to the provider varies based only on the amount of the total assessment payment; or
- The state provides for any payment, offset, or waiver that guarantees to hold providers harmless for all or a portion of the assessment.

For example, the structure of the assessment cannot protect a sub-group of providers by ensuring that they will be compensated by either increased reimbursements or other funding methods for the full amount of their assessment. Federal regulations provide for a hold-harmless test which a state will pass if the assessment on each healthcare class produces state revenues less than or equal to 6 percent of the providers' gross receipts. The mathematically derived threshold of 6 percent is the "provider assessment safe-harbor."

Federal provisions do, however, provide for the opportunity to seek a waiver of the broad-based and/or uniformity requirements. To do so, a state must demonstrate that the net impact of the assessment is generally redistributive and the amount of the assessment is not directly correlated to Medicaid payments. States that receive waiver approval may levy assessments that are not broad based or uniform without a reduction in the state's federal funds, as described below. The provisions for the application and approval of waivers from these requirements consist of several mathematical calculations for measuring the impact of the assessment levied. If the tests applied to the proposed assessment meet the waiver calculation requirements and it is generally redistributive, the waiver application will be approved.

FEDERAL FUNDS REDUCTION FROM UNAPPROVED PROVIDER ASSESSMENTS

There are no regulations of a state's use of provider assessment revenues. However, states seeking to use funds as state Medicaid match from an assessment that fails to meet provider assessment requirements incur a reduction in the state's share of federal funds. The Social Security Act requires the federal government, for the purposes of determining a state's federal financial participation, to reduce the total amount expended as medical assistance under the state's Medicaid plan by the sum of any revenues received by the state via a provider assessment that does not meet federal requirements.

STATE ENACTMENT OF PROVIDER ASSESSMENTS

As of the end of fiscal year 2006, 41 states had one or more provider assessments in place. Among the assessments in place, the most common were on nursing homes, ICF-MRs, hospitals, and managed care organizations (MCO). In fiscal year 2005, 21 states increased or imposed one or more new assessments; 11 states did so in fiscal year 2006. Twenty-three states apply assessments to more than one category of provider. **Figure 2** shows the states that enacted provider assessments as of the end of fiscal year 2006.

FIGURE 2
STATE PROVIDER ASSESSMENTS, AUGUST 31, 2006

STATE	NURSING HOME	ICF-MR	HOSPITAL	MANAGED CARE ORG	PHARMACY	HOME HEALTH	PRACTITIONER	OTHER*
Alabama	X				X			
Alaska								
Arkansas	X							
Arizona				X				
California	X	X		X				
Colorado								
Connecticut	X							
Delaware								
Florida			X					
Georgia	X			X				
Hawaii								
Idaho								
Illinois	X	X						
Indiana	X	X						
Iowa		X						
Kansas			X					
Kentucky	X	X	X	X		X		
Louisiana	X	X			X			
Massachusetts	X		X					
Maryland				X				
Maine		X	X					X
Michigan	X		X	X				X
Minnesota	X	X	X	X				
Missouri	X		X	X	X			
Mississippi	X	X	X					X
Montana	X	X	X					
Nebraska		X						
Nevada	X							
New Hampshire								
New Jersey	X	X		X				
New Mexico				X				
New York	X		X					
North Carolina	X	X						
North Dakota		X						
Ohio	X	X	X	X				
Oklahoma	X							
Oregon	X		X	X				
Pennsylvania	X	X		X				

FIGURE 2 (CONTINUED)
STATE PROVIDER ASSESSMENTS, AUGUST 31, 2006

STATE	NURSING HOME	ICF-MR	HOSPITAL	MANAGED CARE ORG	PHARMACY	HOME HEALTH	PRACTITIONER	OTHER*
Rhode Island	X	X	X					
South Carolina		X	X					
South Dakota								
Tennessee	X	X		X				
Texas		**X**		**X**				
Utah	X	X						
Vermont	X	X	X		X			X
Virginia								
Washington	X							
West Virginia		X	X				X	X
Wisconsin	X		X					
Wyoming								
Total: 50	**29**	**23**	**18**	**15**	**4**	**1**	**1**	**5**

*Refer to Figure 1 for delineation of other healthcare items or services.
SOURCES: Legislative Budget Board; Kaiser Commission on Medicaid and the Uninsured.

POLICY ISSUES RELATING TO USE OF REVENUE GENERATED BY PROVIDER ASSESSMENTS

States use provider assessments to generate state and federal funds to support their budgets in a variety of ways. Some states devote all of the revenue generated by the assessment to support their overall Medicaid budgets. Others use the funds to finance specific provider rate increases. Still others use the funds to address overall state budget needs.

The way the assessment is levied on providers and the subsequent use of the revenue determines which providers benefit from the implementation of the provider assessment. Generally, implementation of provider assessments coupled with higher Medicaid reimbursements creates disproportionate benefits among providers within the class assessed. For example, assuming some or all of the revenue generated from an assessment is sent back to providers through increased Medicaid reimbursements, a nursing home that has little or no Medicaid clients would be required to pay the assessment, but would receive little or no financial offset via the higher Medicaid reimbursements. Conversely, a nursing home with a significant proportion of Medicaid clients may receive an increase in reimbursements that is larger than the amount of the provider assessment it paid.

This result presents the primary policy challenge relating to the implementation of provider assessments. If an assessment creates disproportionate benefits among providers, those providers who experience a net negative fiscal impact must find a way to cover the cost of the assessment, including potentially passing the cost on to non-Medicaid clients. Likewise, diverting portions of the revenue generated from the assessment away from the providers paying it can result in a greater number of providers experiencing a net negative fiscal impact. The federal broad-based and uniformity requirements limit states control over these impacts. Provider support of an assessment is typically dependent upon policy makers' commitment to allocate the funds generated to those providers paying it.

Figure 3 profiles four populous states' use of provider assessments. The profiles include: class of provider or service assessed; rate of assessment; amount of revenue generated from assessment; and general disposition of that revenue.

PROVIDER ASSESSMENTS IN TEXAS

Texas is among the states that currently impose a provider assessment. While only the insurance premium tax and the quality assurance fee (QAF) on intermediate care facilities for persons with mental retardation (ICF-MRs) have been implemented, assessments on several other classes of providers have recently been considered by the Texas Legislature. There are currently two provider assessments that have been fully implemented.

FIGURE 3
PROFILES OF STATE PROVIDER ASSESSMENTS

STATE	PROVIDER ASSESSMENT USE
California	• California currently imposes a provider assessment on intermediate care facilities for persons with developmental disabilities (ICF-DD, similar to ICF-MR), skilled nursing facilities, and MCOs. • The current rate of assessment is 6 percent of gross receipts on ICF-DDs, $7.79 per bed-day on skilled nursing facilities, and 6 percent on Medicaid MCOs. • An estimated $492 million from all three assessments in fiscal year 2007 support the Medi-Cal program, the state's Medicaid program.
Florida	• Florida currently imposes a provider assessment on inpatient and outpatient hospital services. • The current rate of assessment is 1.5 percent of net operating revenues on inpatient hospital services, and 1 percent of net operating revenues on outpatient hospital services. • An estimated $340.9 million in fiscal year 2006 generated from current assessments support the state's Medicaid program.
Illinois	• Illinois currently imposes a provider assessment on nursing facilities and ICF-MRs. • In fiscal year 2003, the rate of assessment on nursing facilities was $1.50 per licensed bed day, and 6 percent on adjusted gross revenues of ICF-MRs. • Estimated collections in fiscal year 2003 from nursing facilities were $58.7 million and from ICF-MRs were $19.8 million, for a total of $78.5 million. • All funds are returned to providers in the form of higher rates of reimbursement.
New York	• New York currently imposes a provider assessment on residential health care facilities and hospitals. • The current rate of assessment on residential health care facilities is 6 percent of cash operating receipts, and 0.35 percent on hospitals. • An estimated $727 million in fiscal year 2007 will be generated from current assessments to support the state's Medicaid program.

SOURCE: Legislative Budget Board.

Insurance Premium Tax: Enacted in 1907, the life, health, and accident insurance premium tax is levied at 1.75 percent of the taxable gross premiums of any insurer, health maintenance organization (HMO), and managed care organizations (MCO). The life, health, and accident portion of the insurance premium tax generated $446 million in tax year 2005. Seventeen percent, or $76 million, came from HMO/MCOs. Because HMO/MCOs are included in the classes of healthcare providers delineated in federal regulations relating to provider assessments, the insurance premium tax levied on HMO/MCOs in Texas would be considered a provider assessment. Seventy-five percent of the revenue collected from the insurance premium tax is allocated to the General Revenue Fund, and 25 percent is allocated to the Foundation School Account (General Revenue–Dedicated Funds).

ICF-MR Quality Assurance Fee: Enacted by the Seventy-seventh Legislature in 2001, the QAF is a provider assessment imposed on ICF-MRs. The current rate of assessment is 6 percent of gross receipts. The QAF generated $55 million in fiscal year 2006. Section 252.207, Texas Health and Safety Code, authorizes the Health and Human Services Commission (HHSC), subject to appropriation and state and federal law, to use QAF funds to:

- Administer the QAF;
- Increase reimbursement rates paid under the Medicaid program to facilities or waiver programs for persons with mental retardation; or
- For any other health and human services purpose approved by the Governor and Legislative Budget Board.

Three other assessments have recently been considered in Texas.

Home and Community Based Waiver Programs: Senate Bill 1830, enacted by the Seventy-ninth Legislature, Regular Session, 2005, requires the executive commissioner of HHSC to modify the QAF currently imposed on ICF-MRs to also apply it to the home and community-based services (HCS) and community living and support services (CLASS) waiver programs. The application to HCS and CLASS would have been at a rate not more than 6 percent of total annual gross receipts.

After enactment of Senate Bill 1830 in 2005, HHSC sought guidance from CMS on the implementation of the new assessment. HHSC reported that it received indications from CMS that the new assessment would not meet the broad-based and uniformity requirements relating to provider assessments. HHSC is, therefore, no longer pursuing implementation of the expansion of the QAF to the HCS and CLASS programs.

Health Care Funding District Pilot: House Bill 2463, enacted by the Seventy-ninth Legislature, Regular Session, 2005, created a healthcare funding district pilot program in Hidalgo, Webb, and Bexar counties wherein districts were to use revenues from a provider assessment levied on non-public hospitals in the district to support additional Medicaid upper payment limit reimbursements to those providers.

During HHSC's development of the Medicaid state plan amendments necessary to implement the program, CMS indicated it would not approve the amendments with the provider assessment component included. While CMS never gave an absolute denial of the use of these provider assessments, they expressed concern about the way it was structured. However, the piloted hospital funding districts are moving forward with plans to support UPL payments with local revenue.

Nursing Homes: Application of a provider assessment on nursing homes was considered by the Seventy-seventh Legislature in 2001 and the Seventy-ninth Legislature in 2005. Several bills considered by the Seventy-seventh Legislature proposed a provider assessment of 6 percent of gross receipts on nursing homes. While the assessment on ICF-MRs noted above was approved, an assessment on nursing homes was not enacted by the Seventy-seventh Legislature in 2001.

Several bills considered by the Seventy-ninth Legislature in 2005, also proposed a provider assessment of 6 percent of gross receipts on nursing homes. In addition, the enrolled version of the 2006–07 General Appropriations Act (GAA) included a contingency rider appropriating revenue generated from the assessment on nursing homes contemplated in those bills to the Department of Aging and Disability Services. An assessment on nursing homes was, however, not enacted by the Seventy-ninth Legislature in 2005, and the contingency rider included in the enrolled version of the GAA was vetoed.

FEDERAL DEVELOPMENTS RELATING TO PROVIDER ASSESSMENTS

Two key developments at the federal level could potentially affect state implementation of provider assessments. They include recent administrative actions taken by the Centers for Medicare and Medicaid Services (CMS) relating to provider assessments and the passage of recent federal legislation relating to the safe-harbor.

Waiver of Provider Assessment Rules: Federal regulation provides states the opportunity to apply for waiver of the broad-based and uniformity requirements relating to provider assessments. The use of such waivers can result in a reduction of the number of providers who experience a negative net fiscal impact. In structuring an assessment that includes a waiver of the broad-based and/or uniformity requirements, states must still meet the hold-harmless test in federal regulations.

Both North Carolina and California have recently received approval from CMS for waiver of both the broad-based and uniformity requirements relating to assessments on nursing homes in those states. The assessment designs in those states are very similar to the assessment considered in Texas that would have included a waiver of broad-based and uniformity requirements, thereby reducing the number of providers who might experience a negative net fiscal impact.

Approval of assessments with waivers, however, has proven to be more subjective than those with a uniform assessment model. Aside from CMS' consideration of waiver applications, states have limited ability to seek or obtain "approval" of a proposed provider assessment. CMS's authority with regard to provider assessment is, instead, applied via its ability to reduce a state's allocation of Medicaid Federal Funds by the sum of any revenues received by the state via a provider assessment that does not meet federal requirements.

Figure 4 shows the states that have received approval of provider assessment waivers from CMS and those states that have waiver applications pending approval.

Provider Assessment Safe-Harbor: The President's proposed budget for fiscal year 2007 included approximately $6 billion in reductions of Federal Funds for Medicaid funding, including a proposal to amend administrative rules to restrict states' use of provider assessments. The President's proposal would have phased down the safe-harbor from 6 percent to 3 percent, reducing Federal Funds for Medicaid to states by approximately $2.1 billion over five years.

FIGURE 4
STATE SUBMITTAL OF WAIVER APPLICATIONS TO CMS: APPROVED AND PENDING APPROVAL

STATES WITH APPROVED WAIVER APPLICATIONS			STATES WITH WAIVER APPLICATIONS PENDING		
NURSING FACILITY	INPATIENT HOSPITAL	OUTPATIENT HOSPITAL	NURSING FACILITY	PRESCRIPTION DRUGS	INPATIENT HOSPITAL
California	Kansas	Oregon	Michigan	Missouri	Illinois
Connecticut	Oregon	Vermont	Missouri		Missouri
Georgia	Vermont		Mississippi		
Indiana			Vermont		
Kentucky					
Massachusetts					
Nevada					
North Carolina					
New Jersey					
New York					
Oregon					
Pennsylvania					
Washington					

Source: Centers for Medicare and Medicaid Services, as of November 2006.

However, before the close of the One Hundred-ninth Congressional Session in December 2006, federal legislation was passed that removed the ability to implement the proposal through administrative rules. This new legislation codifies the safe-harbor limit at 6 percent through December 31, 2007, at 5.5 percent from January 1, 2008 through September 30, 2011, and back to 6 percent thereafter.

Appropriation of the current quality assurance fee (QAF) revenue has been adjusted in the 2008–09 General Appropriations Bill to reflect this recent change in federal law.

POTENTIAL FOR ADDITIONAL REVENUE FROM NEW OR MODIFIED ASSESSMENTS

New or modified assessments in Texas could generate additional revenue to support the state's needs. Below are estimates of potential revenue from an increase in the insurance premium tax on health maintenance and managed care organizations (HMO/MCO) and new assessments on nursing homes, hospitals, physicians, prescription drugs, and home health services.

Nursing Homes: Based on the model considered most recently in Texas, (a waiver model, which assumes a waiver of the federal broad-based and uniformity requirements for implementation of a two-tiered rate and excluding continuing care retirement communities, Medicare units of service, and state veterans homes), an assessment of 3 percent of gross receipts on nursing homes would generate net revenue of approximately $220.1 million, All Funds, for a full fiscal year (if all of the new revenue is used as state match for Federal Funds). An assessment of 5.5 percent of gross receipts on nursing homes would generate net revenue of approximately $403.6 million, All Funds, for a full fiscal year. **Figure 5** shows the annual fiscal impact of an assessment on nursing homes at 3 percent and 5.5 percent of gross receipts.

Assuming that a waiver model is used and that all of the revenue generated from an assessment on nursing homes is appropriated to Department of Aging and Disability Services in Strategy A.6.1, Nursing Facility Payments, and used as state match for Medicaid, the number of nursing homes that would likely experience a net negative fiscal impact resulting from the assessment would be limited to 49 out of 1,119. The waiver model of assessment and full appropriation of

FIGURE 5
ESTIMATED FISCAL IMPACT OF NURSING HOME PROVIDER ASSESSMENT, FISCAL YEAR 2008 (IN MILLIONS)

ASSESSMENT	TOTAL REVENUE GAIN/(LOSS) FROM ASSESSMENT	SAVINGS/(COST) TO STATE-MATCH (MEDICAID RATE OFFSET)	SAVINGS/(COST) TO FEDERAL FUNDS (MEDICAID RATE OFFSET)	GAIN/(LOSS) TO FEDERAL FUNDS, IF NET USED AS STATE-MATCH	NET IMPACT ALL FUNDS
3%	$126.1	($39.5)	($61.1)	$133.6	$220.1
5.5%	$231.1	($72.5)	($112.0)	$245.0	$403.6

Sources: Legislative Budget Board; Health and Human Services Commission.

generated revenues to nursing homes through Medicaid rates minimizes the number of providers that would experience a net negative fiscal impact.

Hospitals: A provider assessment on hospitals could be applied in several forms and could therefore generate a range of revenue and have a range of impact on providers. The design of an assessment and the manner in which funds are used, both policy decisions, will likely affect the estimates of impact on providers. An assessment on gross inpatient revenue would generate the following approximate amounts for a full fiscal year (gross revenue would be reduced by the cost of the assessment to the Medicaid program):

- $680 million from an assessment of 1 percent on gross impatient revenue
- $2 billion from an assessment of 3 percent on gross impatient revenue
- $3.7 billion from an assessment of 5.5 percent on gross inpatient revenue

Managed Care Organizations: An increase in the insurance premium tax assessment on HMO/MCOs from 1.75 percent to 5.5 percent would generate approximately an additional $164 million per year. Currently, 17 of the 52 active licensed HMOs in Texas are participating in the state's Medicaid or Children's Health Insurance Programs.

Every state imposes a retaliatory tax on foreign insurers based on a state-to-state comparison of the aggregate taxes, fees, and assessments imposed on a given line of insurance. However, according to the Comptroller of Public Accounts, retaliatory taxes do not apply to HMO/MCOs. An increase of the insurance premium tax on HMO/MCOs would therefore not affect other states' retaliatory taxes.

While there is less detailed information available to estimate the extent of the fiscal impact on providers, based on CMS estimates of healthcare expenditures in Texas, assessments on physicians, prescription drugs, and home healthcare could be used to generate the following revenue.

Physicians: An assessment of 1 percent on physician services would generate annual gross revenue of approximately $296 million. Gross revenue would be reduced by the cost of the assessment to the Medicaid program.

Prescription Drugs: An assessment of 1 percent on prescription drugs would generate annual gross revenue of approximately $114 million. Gross revenue would be reduced by the cost of the assessment to the Medicaid program.

Home Health Services: An assessment of 1 percent on home health services would generate annual gross revenue of approximately $36 million. Gross revenue would be reduced by the cost of the assessment to the Medicaid program.

While there are challenges in applying provider assessments and using the revenue to leverage additional Federal Funds, they could provide a significant source of revenue to support the needs of Texas.

EXPAND ACCESS TO TEXAS TOBACCO PREVENTION FUNDING AND ENHANCE ENFORCEMENT EFFORTS

The Texas Tobacco Prevention Initiative, a pilot project that studies the most effective ways to prevent tobacco use among Texans, began because of the Texas tobacco lawsuit settlement of 1998 (The State of Texas vs. The American Tobacco Company, et al.). Earnings from the Texas tobacco settlement appropriated for tobacco prevention and education have largely been used for the Texas Tobacco Prevention Initiative in Jefferson County. As a result, Texas communities outside of the Texas Tobacco Prevention Initiative area have not had access to tobacco settlement earnings and the prevention efforts it funds. Creating a competitive statewide grant program would allow city and county health departments to apply for state funding to initiate and coordinate comprehensive tobacco prevention efforts in their communities.

State legislation passed in 1997, commonly referred to as the Texas tobacco law (Texas Health and Safety Code 161), provided penalties for minors under age 18 who buy tobacco products and for retailers who allow the illegal purchase. Since its enactment, on average, about 16 percent of Texas retailers continue to sell tobacco products to minors illegally. According to federal law, this rate may not exceed 20 percent or the state will be at risk of losing 40 percent of its $135 million federal Substance Abuse Prevention and Treatment block grant funding. Increasing funding for enforcement by allocating 10 percent from the collection of fees from tobacco permits would assist local enforcement efforts, help to decrease illegal sales to minors, and help to ensure Texas' block grant funding. A grant program created by Texas Health and Safety Code §161.302 to educate youth about tobacco prevention has never been funded or implemented. Using proceeds from the tobacco advertising fee collection and tobacco product fines to fund this youth group grant program would increase awareness of the Texas tobacco law (Health and Safety Code 161) and contribute to the overall statewide tobacco prevention and enforcement efforts.

CONCERNS

- Texas communities outside of Jefferson County, the current Texas Tobacco Prevention Initiative area, do not have access to tobacco settlement money used by the Department of State Health Services for tobacco prevention and cessation efforts.
- Several state agencies offer grant assistance to prevent tobacco use to various populations in Texas. While each may have their own grant-specific requirements, the state does not have a uniform requirement regarding the funding of evidence-based practices in tobacco prevention. As a result, funds may be spent on programs that have not been proven to be effective.
- In 2005 law enforcement efforts to prohibit illegal tobacco sales to minors resulted in 15.5 percent of Texas retailers selling to minors. This rate is higher than the national average of 11.7 percent, and puts Texas at risk of losing $54 million of federal Substance Abuse Prevention and Treatment block grant funding.
- The state has not made use of tobacco product fines and advertising fees to implement the youth group grant program Texas Health and Safety Code §161.302 authorized, thereby resulting in a lost opportunity to assist state tobacco control efforts by helping local organizations educate youth to make tobacco-free choices.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill to require the Department of State Health Services (DSHS) to develop a competitive tobacco prevention grant program. The program would provide all Texas city and county health departments the opportunity to apply for funding from the earnings from the tobacco education and enforcement fund and any other funding used by DSHS for tobacco prevention activities that is not already dedicated by statute for another specific tobacco prevention activity. In addition, new tobacco prevention reporting requirements should be created.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill to require any state agency using state appropriated funds for tobacco prevention to implement only best practice tobacco prevention, cessation, and enforcement interventions recommended by the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services Substance Abuse and Mental Health

Services Administration, or activities proven through implementation and evaluation in the Texas Tobacco Prevention Initiative (TTPI) area.

- **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill to require the Department of State Health Services to publish or make available via their website a resource list identifying best practice interventions in tobacco prevention, cessation, and enforcement for use by tobacco prevention grant recipients.
- **Recommendation 4:** Include a rider in the 2008–09 General Appropriations Bill to require any state agency that funds tobacco prevention activities with state appropriated funds to report to the Department of State Health Services relevant grantee information and the grant amounts.
- **Recommendation 5:** Appropriate 10 percent of tobacco permits fee revenue to the Fiscal Programs of the Comptroller of Public Accounts in the 2008–09 General Appropriations Bill to provide additional funding for the enforcement of Texas Health and Safety Code §161.252 by the Comptroller of Public Accounts' tobacco law enforcement grant program.
- **Recommendation 6:** Appropriate funds to the Department of State Health Services from the revenue of the Tobacco Outdoor Advertising Fee and Tobacco Fines for the implementation of a statewide competitive youth group grant program authorized Health and Safety Code §161.302.

DISCUSSION

Two major events affecting tobacco use and prevention in Texas are the passage and implementation of legislation from the Seventy-fifth Legislature, Regular Session, 1997 and the Texas tobacco settlement.

SYNAR AMENDMENT

In 1992, Section 1926 of the federal Public Health Service Act now known as the "Synar Amendment" passed Congress. As **Figure 1** shows, it requires states to enforce laws against underage purchase of tobacco and to demonstrate increasing rates of retailer compliance with prohibitions on tobacco sales to minors as a condition for receiving behavioral health block grants. State non-compliance rates must be 20 percent or less to be in compliance. Failing to comply can result in a 40 percent reduction in a state's Substance Abuse Prevention and Treatment Block Grant (SAPT) award. Texas' 2005–06 SAPT block grant award totaled $135 million. With several states at risk of losing their block grant funding in 1999, Congress adopted a proposal that gave noncompliant states an alternative. They could allocate additional state appropriated funds to tobacco compliance efforts in an amount equal to 1 percent of their block grant award for each percentage point by which they missed their youth access compliance goal in the previous fiscal year.

TEXAS' COMPLIANCE WITH FEDERAL LAW

Texas complied with the Synar Amendment by enacting Texas Health and Safety Code 161 during the Seventy-fifth Legislature, Regular Session, 1997. Texas Health and Safety Code 161 penalties for minors went into effect January 1, 1998, while laws affecting merchants took effect September 1, 1997. The penalties Texas Health and Safety Code 161 set

FIGURE 1
SYNAR AMENDMENT REQUIREMENTS

IMPLEMENTATION OF THE SYNAR AMENDMENT REQUIRES STATES TO:

- Have in effect a law prohibiting the selling or distributing of tobacco products to youth under the age of 18;
- Enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18;
- Conduct annual random, unannounced inspections to ensure compliance with the law. These inspections are to be conducted in such a way as to provide a valid sample of outlets accessible to youth;
- Develop a strategy and timeframe for achieving an inspection failure rate of less than 20 percent of outlets accessible to youth; and
- Submit an annual report detailing the state's activities to enforce their law, the overall success the state has achieved during the previous fiscal year in reducing tobacco availability to youth, describing how inspections were conducted and the methods to identify outlets, and plans for enforcing the law in the coming fiscal year.

Source: U.S. Health and Human Services Substance Abuse and Mental Health Services Administration.

for youth are a fine up to $250, mandatory participation in a tobacco awareness class, community service, and up to a six-month suspension of the teen's driver's license. The tobacco awareness class is the only mandatory penalty; however, a judge may impose any of the other three penalties in conjunction with the class.

The Texas law (Health and Safety Code §161.088) gives full responsibility for enforcement of the law to the Comptroller of Public Accounts (CPA). Substance Abuse Services within the Department of State Health Services (DSHS) (formerly the Texas Commission on Drug and Alcohol Abuse) conducts the annual Synar survey to determine the rate of illegal sales to minors. CPA responsibilities include issuing tobacco permits to retailers and other entities, training employees about the law, issuing appropriate signage, conducting unannounced inspections, issuing grants to counties and municipalities for enforcement and addressing reported violations.

The CPA has an interagency contract with DSHS to manage the Texas Tobacco Hotline, to implement the Texas tobacco law public awareness campaign, and to manage the responsibilities of the youth tobacco awareness class. DSHS is also responsible for training instructors across the state in the tobacco awareness class curriculum.

TEXAS TOBACCO SETTLEMENT

In March 1996, the Texas Attorney General filed suit against the tobacco industry on behalf of the State of Texas accusing the tobacco industry of violating conspiracy, racketeering, consumer protection, and other provisions of state and federal law. The state sought to recover billions of tax dollars it had spent to treat tobacco-related illnesses. The lawsuit resulted in a settlement agreement in which the industry agreed to pay the state $15 billion. Texas received an additional $2.3 billion earmarked for Texas counties and hospital districts based on their provision of indigent healthcare. Actual payments by the industry are subject to adjustment formulas related to tobacco sales, inflation, and industry profitability. Under Texas' settlement terms, payments from the industry rise or fall in proportion to U.S. consumption of cigarettes each year as compared to consumption in 1997.

As a result of the settlement with the tobacco industry, Government Code §403.105 created four permanent funds for certain public health purposes. One fund is for health and tobacco education and enforcement (Fund 5044), which received an initial deposit of $200 million. Government Code §403.105 dedicated the earnings received from investment of permanent fund for health and tobacco education and enforcement to the Texas Department of Health (TDH), now known as the Department for State Health Services (DSHS). The earnings of the fund may be appropriated to DSHS for preventive medical and dental services to children in the medical assistance program under Chapter 32, Human Resources Code and for programs to reduce the use of cigarettes and tobacco products in this state, including:

- smoking cessation programs;
- enforcement of subchapters H (Distribution of Cigarettes or Tobacco Products), K (Prohibition of Certain Cigarette or Tobacco Product Advertising; Fee), and N (Tobacco Use by Minors) of Chapter 161, Health and Safety Code or other laws relating to the distribution of cigarettes or tobacco products to minors or use of cigarettes or tobacco products by minors;
- public awareness programs relating to use of cigarettes and tobacco products, including general educational programs and programs directed toward youth; and
- specific programs for communities traditionally targeted by advertising and other means by companies that sell cigarettes or tobacco products.

TEXAS TOBACCO PREVENTION INITIATIVE

The Texas Tobacco Prevention Initiative (TTPI) is the result of funding from the establishment of the permanent fund for health and tobacco education and enforcement (Fund 5044) in Texas Government Code §403.105. In fiscal year 2000, through the Department of State Health Services (DSHS), TTPI began as a pilot study. At that time, it encompassed 18 communities in the East Texas area and its purpose was to examine the most effective ways to prevent tobacco use and promote cessation among all Texans. According to DSHS, the East Texas area was chosen for TTPI because of its high rate of lung cancer and other tobacco-related diseases as well as its demographic diversity.

In the study, a combination of interventions in school, community, enforcement, cessation and mass media were examined in each of the 18 communities. As shown in **Figure 2**, Port Arthur, received all interventions (Intensive Media, Enforcement, Cessation, and School and Community Activities) also known as the comprehensive approach or comprehensive interventions. In other communities, expenditures ranging from $0.25 to $2.50 per capita

FIGURE 2
COMMUNITIES AND TOBACCO PREVENTION INTERVENTIONS, FISCAL YEAR 2000

COMMUNITY	LOW LEVEL MEDIA	INTENSIVE MEDIA	ENFORCEMENT	CESSATION	SCHOOL AND COMMUNITY
Tyler		X			
Lufkin			X		
Waco				X	
Texarkana					X
Longview		X	X		
Bryan-College Station		X		X	
Beaumont		X			X
Port Arthur		X	X	X	X
E. Harris County	X			X	
Galveston County	X			X	
S. Harris County	X		X		
Brazoria County	X		X		
NW Harris County	X				X
Montgomery/Waller County	X				X
Fort Bend	X		X	X	X
W. Harris County	X		X	X	X
NE Harris County	X				
Liberty County & Chambers County	X				

SOURCE: Department of State Health Services.

supported lower intensity combinations of the interventions (i.e., not comprehensive). These interventions included a less intensive media campaign, and single-focus community, school, enforcement or cessation programs. For example, Lufkin only received support to improve law enforcement efforts while Texarkana only received support to implement the school curriculum and promote community activities.

Comprehensive interventions are defined as spending $3 per capita (the maximum rate as defined by DSHS) and implementing best practices. Best practice elements of comprehensive interventions include evidence-based activities in enforcement, intensive media, cessation, and school and community. Today Jefferson County is the only area receiving comprehensive funding ($3/capita) and interventions. Jefferson County's population is approximately 250,000, according to the U.S. Census Bureau.

INCREASING LOCAL ACCESS TO STATE TOBACCO PREVENTION FUNDING

In the seven years since the creation of the Texas Tobacco Prevention Initiative (TTPI), communities outside of East Texas have not had access to tobacco settlement money used by the Department of State Health Services for tobacco prevention and cessation efforts. DSHS allocated each year's tobacco settlement appropriation for TTPI in East Texas. In fiscal years 2000 and 2001, DSHS received $10.0 million each year from the tobacco settlement to begin TTPI. In fiscal years 2002 and 2003, DSHS received $12.5 million annually to continue with TTPI. Tobacco settlement earnings decreased resulting in $5.9 million allocated for TTPI in fiscal years 2004 and 2005. Fiscal year 2006 resulted in a $5.2 million appropriation. **Figure 3** shows the funding estimates expended on statewide tobacco prevention activities versus spending on TTPI.

Areas receiving comprehensive interventions for fiscal years 2000–2006 are shown in **Figure 4**. As earnings from the tobacco settlement increased or decreased, DSHS added or reduced the TTPI intervention area, thus affecting the number of Texans impacted by comprehensive interventions.

According to DSHS, the comprehensive tobacco prevention program achieved significant results in fiscal years 2000 and 2001, including a 40 percent decline in usage among 6th and

FIGURE 3
STATEWIDE AND TEXAS TOBACCO PREVENTION INITIATIVE EXPENDITURES, FISCAL YEARS 2002 TO 2006

	2002	2003	2004	2005	2006 (BUDGETED)	TOTAL
STATEWIDE EXPENDITURES						
Regional Staff salaries	$485,167	$354,050	$458,116	$392,348	$487,159	$2,176,840
Media for TX Tobacco Law	146,183	133,436	147,293	188,095	150,000	765,007
Tobacco Prevention Hotline	25,452	25,605	15,051	17,824	25,000	108,932
Tobacco Awareness Classes	102,676	108,172	96,243	88,293	229,429	624,813
Curriculum Development/Evaluation	106,203	180,300	47,646	84,181	150,000	568,330
Statewide Total	**$865,681**	**$801,563**	**$764,349**	**$770,741**	**$1,041,588**	**$4,243,922**
TTPI EXPENDITURES						
Region (6/5) Staff salaries	$104,436	$57,717	$54,777	$76,789	$38,825	$332,544
Community contracts	4,502,898	4,224,794	2,238,247	2,029,653	1,311,261	14,306,853
Tobacco Prevention Media	5,322,357	4,718,060	2,179,535	2,244,045	1,800,000	16,263,997
Evaluation and Research	1,161,384	2,251,637	838,875	1,136,933	1,646,761	7,035,590
Smoking Quitline	499,320	499,320	177,574	254,915	236,000	1,667,129
TTPI Total	**$11,590,395**	**$11,751,528**	**$5,489,008**	**$5,742,335**	**$5,032,847**	**$39,606,113**

Source: Department of State Health Services.

FIGURE 4
TOBACCO PREVENTION COMPREHENSIVE INTERVENTION AREAS

FISCAL YEAR	AREA RECEIVING COMPREHENSIVE INTERVENTION
2000	Port Arthur
2001	Port Arthur
2002	Harris, Montgomery, Fort Bend and Jefferson Counties
2003	Harris, Montgomery, Fort Bend and Jefferson Counites
2004	Jefferson County
2005	Jefferson County
2006	Jefferson County

Source: Department of State Health Services.

7th graders and a significant increase in cessation among older youth and adults. The results from the communities with the less-intensive programs did not show measurable reductions in tobacco usage among either adults or children. **Figures 5 and 6** show Jefferson and Harris counties tobacco use rates by middle and high school students, respectively, from 2000 to 2005. Port Arthur is located in Jefferson County and is the only area in TTPI to continually receive comprehensive interventions from 2000 to 2006.

Decreasing tobacco use among Texans can reduce costs to tax payers and businesses. According to DSHS, in 1999, tobacco-related disease cost the state approximately $10 billion ($4.5 billion in direct medical costs and an additional $5.5 billion in lost worker productivity). Moreover investing in tobacco prevention and control strategies for youth could prevent a new generation of tobacco users. Research conducted by the Substance Abuse and Mental Health Administration found that "lifetime smoking and other tobacco use almost always begins by the time kids graduate from high school."

Expanding tobacco prevention activities is the goal of the first recommendation. Recommendation 1 allows all Texas communities access to tobacco settlement earnings and other funds DSHS dedicates to tobacco prevention activities through the creation of a competitive state grant program. The grant program would help local communities establish their own comprehensive tobacco prevention program. While tobacco use may not immediately be a priority to every Texas community, the grant program would allow city or county health departments to apply for funding when their area is ready to confront the health effects of tobacco use and have other local resources to supplement tobacco prevention.

Grants would be limited to local health departments because they are the public health experts in their respective communities. Local public health officials are also in the best position to coordinate tobacco prevention efforts for their community. Local officials would have access to state tobacco prevention specialists who can provide technical assistance in

FIGURE 5
JEFFERSON COUNTY AND STATEWIDE MIDDLE SCHOOL AND HIGH SCHOOL TOBACCO USE RATES, 2000 TO 2005

SCHOOL	2000	2001	2002	2003	2004	2005
Jefferson Co. MS	24.8%	20.3%	20.1%	18.2%	17.6%	15.2%
Statewide MS	No data	16.6%	No data	15.3%	17.4%	No data
Jefferson Co. HS	40.7%	No data	26.5%	23.0%	24.6%	24.3%
Statewide HS	No data*	33.0%	No data*	28.4%	No data*	29.8%

*No data due to changes in survey timeframes.
Source: Department of State Health Services.

FIGURE 6
HARRIS COUNTY AND STATEWIDE MIDDLE SCHOOL AND HIGH SCHOOL TOBACCO USE RATES, 2000 TO 2005

SCHOOL	2000	2001	2002	2003	2004	2005
Harris Co. MS	26.0%	18.0%	17.9%	16.0%	20.3%	24.7%
Statewide MS	No data	16.6%	No data	15.3%	17.4%	No data
Harris Co. HS	35.0%	No data	22.7%	25.0%	22.7%	18.7%
Statewide HS	No data*	33.0%	No data*	28.4%	No data*	29.8%

*No data due to changes in survey time frames.
Source: Department of State Health Services.

all aspects of tobacco prevention and assist communities in creating a comprehensive tobacco prevention program. A tobacco prevention specialist is located in each of the DSHS's 11 public health regions. Additionally, due to limited state funding, local communities may be required to match a percentage of grant funding. This requirement would ensure as many areas of Texas receive grants as funds allow. As a part of Recommendation 1, new reporting requirements would also be created.

Rider language could be inserted into the 2008–09 General Appropriations Bill to implement Recommendation 1 and can be found at the end of this report.

USING EVIDENCE-BASED INTERVENTIONS FOR TOBACCO PREVENTION

An important aspect of TTPI is the use of best practice comprehensive interventions. To replicate the effectiveness of TTPI, it is equally important to ensure the use of evidence-based interventions at the local level. Additionally, as state funding is limited, using evidence-based interventions ensures state dollars are used effectively.

Several state agencies (i.e. ,Texas Cancer Council, Department of State Health Services, Texas Education Agency, Comptroller of Public Accounts) offer grant assistance to prevent tobacco use to various populations in Texas. While each may have their own grant-specific requirements, the state does not have a uniform requirement regarding the funding of evidence-based practices in tobacco prevention.

The Centers for Disease Control and Prevention (CDC) define evidence-based public health "as the available body of research evidence on any given intervention's effectiveness and the use of this evidence by public health professionals, advocacy groups, providers, purchasers, and policy makers when making healthcare decisions." An evidence base is formulated by expert opinion and systematic reviews based on interventions that have been evaluated in scientific studies. Evidence-based interventions have a high degree of generalizability, in other words, the intervention results have been replicated in different settings and with different populations over time through research studies. This replication is important because the more generalizable an intervention is, the more likely it would yield the same results. The more successful an intervention is the greater the affect on the population and the more effective the program. According to the CDC, tobacco prevention programs and policies can fail because an ineffective intervention was chosen, a potentially effective approach was not fully implemented, or inadequate evaluation that limits generalizability was conducted.

Recommendation 2 requires all state agencies and all other entities using state appropriated funds for tobacco prevention to implement only best practice tobacco prevention, cessation, and enforcement interventions recommended by the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), or

activities proven through implementation and evaluation in the TTPI area.

To implement this recommendation, a rider could be inserted in the 2008–09 General Appropriations Bill. Suggested language for the rider can be found at the end of this report.

EVIDENCE-BASED INTERVENTION RESOURCES

Distinguishing what is evidence-based and what is not can be a daunting experience for those new to tobacco prevention activities. To help communities access evidence-based information related to tobacco prevention, the state could publish the information in the appropriate medium. Recommendation 3 requires DSHS to publish or make available via the Internet a resource list identifying accepted best practice interventions in tobacco prevention, cessation, and enforcement for use by grant recipients.

Figure 7 shows several federal websites related to best practice methods for use in tobacco prevention.

To implement this recommendation, a rider could be inserted into the 2008–09 General Appropriations Bill. Suggested language for the rider can be found at the end of this report.

ASSISTING LOCAL COMMUNITIES THAT USE STATE APPROPRIATED FUNDS

Along with using evidence-based interventions to ensure state money is used effectively, it is important local communities coordinate their state funded efforts to ensure state money is maximized. In addition to the grant program created by Recommendation 1, funding opportunities from several state agencies are offered to local communities to conduct tobacco prevention activities. For example, within the same city, a school district receives money from the Texas Education Agency for substance abuse education, and a community-based organization receives funding from the Texas Cancer Council for an after-school program to prevent tobacco use, while the local police department receives a grant from the CPA for conducting tobacco "stings" and educating the retail community about the Texas tobacco law. Each organization may be unaware of the other's efforts and therefore not able to coordinate or maximize their efforts and funding.

Recommendation 4 requires all state agencies that fund tobacco prevention activities with state appropriated funds to report to DSHS the pertinent grantee contact information, the purpose of the grant funding, and the amount of grant. Additionally, it requires DSHS to compile this information and publish it on their website. The benefit to listing this information in one location allows community and state leaders to see who is conducting tobacco prevention activities in an area and how to contact them to coordinate efforts and maximize the area's resources.

To implement this recommendation, a rider could be inserted into the 2008–09 General Appropriations Bill. Suggested language for the rider can be found at the end of this report.

TOBACCO ENFORCEMENT AND CONTROL: REDUCING SALES OF TOBACCO TO MINORS

Since implementation of the Texas tobacco law (Texas Health and Safety Code 161), on average 16 percent of Texas retailers continue to sell tobacco products to minors. These illegal sales put Texas at risk of losing 40 percent ($54 million) of its $135 million federal Substance Abuse Prevention and Treatment (SAPT) block grant. As mentioned previously, federal law requires states to maintain a tobacco retailer noncompliance rate of 20 percent or less to keep Substance Abuse and Treatment funding. **Figure 8** shows Texas' non-compliance Synar rate from 1998 to 2005.

Texas' average noncompliance rate, 16 percent, is higher than the national average, 11.7 percent. Texas youth are able to buy or smoke more cigarettes illegally than in any other state. **Figure 9** shows that Texas youth bought or smoked an estimated 67.2 million packs of cigarettes illegally in 2005. California, New York, and Florida, populous states Texas is

FIGURE 7
WEBSITES LISTING EVIDENCE-BASED INTERVENTION INFORMATION

AGENCY	WEBSITE
Centers for Disease Prevention and Control (CDC)	http://www.thecommunityguide.org
National Guideline Clearinghouse	http://www.guideline.gov
U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA)	http://www.modelprograms.samhsa.gov/
Center for Substance Abuse Prevention (CSAP)	http://captus.samhsa.gov

SOURCE: Legislative Budget Board.

FIGURE 8
TEXAS SYNAR RATES
FEDERAL FISCAL YEARS 1998 TO 2005

	1998	1999	2000	2001	2002	2003	2004	2005
Texas Synar Rate	24.0%	13.0%	14.6%	13.4%	12.9%	15.7%	23.8%	15.5%

SOURCE: Substance Abuse and Mental Health Services Administration.

FIGURE 9
PACKS OF CIGARETTES PURCHASED OR SMOKED BY YOUTH AND STATE SYNAR RATES

STATE	CIGARETTE PACKS BOUGHT OR SMOKED BY YOUTH (AGE 12 TO 17) YEARLY	FEDERAL FISCAL YEAR 2005 SYNAR NON-COMPLIANCE RATE
Texas	67.2 million	15.5%
California	57.0 million	14.0%
New York	34.8 million	9.5%
Florida	29.9 million	7.0%
Mississippi	7.9 million	6.0%
Nationwide	**685.4 million**	**11.7% (average)**

SOURCES: Campaign for Tobacco-free Kids; Substance Abuse and Mental Health Service Administration.

often compared with, have lower "Synar rates" and a lower number of cigarette packs bought or smoked by youth.

Funding the enforcement of access laws is a problem for many states. The Substance Abuse and Mental Health Service Administration does not allow the allocation of Federal Funds for enforcement purposes. For most states, this has proved to be a significant problem because enforcement of youth access laws is not viewed as a priority, and states are reluctant to redirect already limited funding for prevention and treatment services to law enforcement. Some states address the problem by earmarking revenue derived from licensing fees, taxes, or fines specifically for enforcement purposes.

Numerous published studies show the combination of enforcing laws that restrict tobacco sales to minors and educating merchants can reduce illegal sales of tobacco to minors. The CDC concluded that giving retailers information was less effective in reducing illegal sales than active enforcement. Research regarding the effects of active enforcement on youth smoking suggests that it is an important and essential element of a comprehensive effort to reduce underage tobacco use.

Recommendation 5 provides additional funding to the state's tobacco law enforcement grant program established by Texas Health and Safety Code §161.088 and managed by the Texas Comptroller of Public Accounts (CPA). This grant program issues grants to local law enforcement agencies that, as a condition of the grant, must conduct tobacco "stings" and educate the retail community about the Texas tobacco law in their area. Using 10 percent of tobacco permits fee collections could provide additional funding for the enforcement of the Texas tobacco law by the CPA tobacco law enforcement grant program.

A four-year average (fiscal years 2002 to 2005) of tobacco permit fees collected is $3 million. Ten percent of the fees is $300,000. The additional amount of funding will allow more law enforcement departments to qualify for grants, thereby expanding their reach to the retail community. Approximately 3,000 more retailers could be educated about the Texas tobacco law (Texas Health and Safety Code 161). In 2005, 5,400 enforcement "stings" affecting approximately 18 percent of Texas retailers took place through the CPA law enforcement grant program. With the additional funding, 12,000 more "stings" on Texas retailers could occur, adding another 10 percent of retailers directly affected by local law enforcement.

To implement this recommendation, a rider could be inserted in the 2008–09 General Appropriations Bill. Suggested language for the rider can be found at the end of this report.

CREATING YOUTH GROUP GRANT PROGRAMS

State legislation passed in 1997 (Texas Health and Safety Code §161.302) created a grant program for youth groups to promote and implement tobacco prevention activities at the local level. The youth group grant program has never been implemented. Community-wide tobacco prevention programs can strengthen school-based tobacco prevention

efforts. Although schools offer some practical advantages for prevention efforts, there are limitations to what they can accomplish. Schools are limited by time and resources for meeting routine education requirements. In addition, they are only one of the settings in which youth are exposed to social influences about smoking. In fact, lasting effects of school-based tobacco prevention programs have been shown to be short-lived. Community interventions can help change community norms or practices that are relevant to youth tobacco use.

Recommendation 6 uses funds from the collection of the Tobacco Outdoor Advertising Fee and Tobacco Product Fines for the implementation of a statewide competitive youth group grant program created by Texas Health and Safety Code §161.302 and to be administered by the Department of State Health Services.

Figure 10 shows the amount of money collected by each revenue stream since 2002.

FIGURE 10
TOBACCO FINES AND FEES COLLECTED
FISCAL YEARS 2002 TO 2004

	2002	2003	2004
Tobacco Product Fines	$47,299	$56,161	$78,389
Tobacco Outdoor Advertising Fees	$122,849	$119,356	$83,111
Total	$170,148	$175,517	$161,500

Source: Texas Comptroller of Public Accounts.

Implementing the youth group grant program would complement Recommendation 1 (statewide tobacco prevention competitive grant program) by allowing more tobacco prevention activities to occur at the local level through already established youth groups. This recommendation also strengthens Recommendation 5 (enhancing law enforcement efforts to prevent retail tobacco sales to minors) by using funds for groups wanting to conduct tobacco prevention activities and encourage youth to make tobacco-free choices. For example, retail sales of tobacco products are not a minor's only source of obtaining tobacco. Many youth turn to social sources like older friends, parents, and family members. Public health experts say it is critical that a minor's access restriction be combined with a comprehensive tobacco control program that reduces the availability of social sources and limits the appeal of tobacco products. Recommendation 6 would help to eliminate social sources as a means of obtaining tobacco and indirectly aid law enforcement efforts to prevent underage tobacco use.

To implement Recommendation 6, a Department of State Health Services rider could be included in the 2008–09 General Appropriations Bill along with increased General Revenue appropriations totalling $322,700. Suggested language for the rider can be found below. This same rider could also implement Recommendations 1 and 3.

> **Statewide Comprehensive Tobacco Prevention Community Grant Program.** The funds appropriated above in Strategy B.2.5, Reduce Use of Tobacco Products, to the Department of State Health Services shall be used to create a competitive statewide grant program allowing all Texas city and county health departments to apply for funds from the Texas tobacco settlement earnings and other funding DSHS designates for tobacco prevention activities that is not already designated for Health and Safety Code §161.302 or another statute. Matching local funding may be required by the grant program to ensure as many Texas communities receive funding as possible. Any unexpended balance of these funds remaining as of August 31, 2008 is hereby appropriated to the Department of State Health Services for the fiscal year beginning September 1, 2008 for the same purpose.
>
> **Tobacco Prevention Reporting Requirements.** The Department of State Health Services shall prepare a report on its progress in the following areas: (1) the number and amount of grants issued to communities to implement comprehensive tobacco prevention efforts, (2) the number of Texas communities implementing a comprehensive tobacco prevention program, (3) the youth and adult tobacco use rate in communities implementing comprehensive programs, (4) the statewide youth and adult tobacco use rates, (5) the number of Texans accessing cessation resources, and (6) the number of Texans exposed to tobacco prevention advertising. The report shall include an overview and evaluation of the state's tobacco prevention and enforcement progress and recommendations to improve the state's efforts. The report shall be submitted to the Governor and the Legislative Budget Board by October 1, 2008.
>
> **Evidence-based Interventions for Tobacco Prevention.** The Department of State Health Services (DSHS) shall use funds appropriated by this Act to publish or make

available via the Internet a resource list identifying best practice interventions in tobacco prevention, cessation, and enforcement for use by entities receiving state appropriated funds.

Appropriation and Unexpended Balance Authority: Tobacco Outdoor Advertising Fee and Tobacco Product Fines. Funds appropriated above in Strategy B.2.5, Reduce Use of Tobacco Products, include $161,380 in General Revenue Funds in fiscal year 2008 and $161,380 in General Revenue Funds in fiscal year 2009 from the collection of Tobacco Product Related Fines and Tobacco Product Advertising Fees. These funds shall be used for the implementation of a statewide competitive youth grant program created by Texas Health and Safety Code §161.302. Any Tobacco Product Related Fines and Tobacco Product Advertising Fees (revenue objects 3280 and 3281) collected above $161,380 in fiscal year 2008 and $161,380 in fiscal year 2009 are appropriated to the department for the same purpose. Any unexpended balance of these funds remaining as of August 31, 2008 is hereby appropriated to the department for the fiscal year beginning September 1, 2008 for the same purpose.

Recommendations 2 and 4 could be implemented with a rider included in Article IX, General Provisions, in the 2008–09 General Appropriations Bill. Suggested language for the State Tobacco Prevention Activities and Tobacco Control and Enforcement rider is below.

Funding and Implementation of Evidence-based Interventions for Tobacco Prevention. Any state agency using funds appropriated by this Act for tobacco prevention activities or interventions shall use the funds to implement only best practice tobacco prevention, cessation, and enforcement interventions recommended by the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services, and the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), or activities proven effective through study and evaluation in the communities in the Texas Tobacco Prevention Initiative areas. The Texas Tobacco Prevention Initiative areas were: (1) the City of Port Arthur during the state fiscal years 2000 and 2001; (2) Harris, Montgomery, Fort Bend, and Jefferson Counties during the state fiscal years 2002 and 2003; and (3) Jefferson County during the state fiscal years 2004, 2005, and 2006.

Statewide Tobacco Prevention Resource Coordination. Any state agency using funds appropriated by this Act to conduct tobacco prevention activities shall report to the Department of State Health Services (DSHS) relevant grant and grantee information prescribed by DSHS. DSHS shall report this information and publish it on DSHS website for the benefit of local and state leaders to coordinate and maximize their resources.

Recommendation 5 could be implemented with increased appropriations estimated to be $600,000 and a Fiscal Programs of the Comptroller of Public Accounts rider included in the 2008–09 General Appropriations Bill. Suggested language for the Fiscal Programs of the Comptroller of Public Accounts State Tobacco Control and Enforcement rider is below.

Use of Tobacco Permit Fees and Unexpended Balance Authority. Out of the funds appropriated above in Strategy A.1.9, Underage Tobacco Program, 10 percent of Tobacco Permit Fees (Revenue Object 3282) in General Revenue Funds shall be used for the Underage Tobacco Enforcement Program Grants established by Texas Health and Safety Code §161.088. The amount estimated to be $300,000 is appropriated for fiscal year 2008 and the amount estimated to be $300,000 is appropriated for fiscal year 2009. Any unexpended balance of these funds remaining as of August 31, 2008 is hereby appropriated to the Fiscal Programs of the Comptroller of Public Accounts for the fiscal year beginning September 1, 2008 for the same purpose.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 through 4 would not impact either the General Revenue Funds or the General Revenue–Dedicated Funds in the 2008–09 biennium. Recommendations 5 and 6 would result in a cost in General Revenue Funds totaling $922,760 for the 2008–09 biennium. These costs could result in long term savings to the state by reducing smoking and tobacco use rates among all Texans. Tobacco use is a major risk factor for multiple cancers, heart disease, stroke, and lung disease all of which contribute to increasing healthcare costs.

Recommendation 1 directs Department of State Health Services to create a competitive statewide grant program. Recommendation 2 requires all state agencies using state appropriated funds for tobacco prevention to implement only best practice interventions. Recommendation 3 creates

a repository of best practice intervention information and Recommendation 4 establishes reporting requirements for all state agencies using state appropriated funds for tobacco prevention, as well as creates a directory of state-funded local tobacco prevention efforts.

Recommendation 5 will cost an estimated $300,000 a year in General Revenue Funds based on a four-year average of tobacco permit fees collected. Recommendation 6 will cost an estimated $161,380 per year. The assumptions made are based on a four-year average of tobacco product fines and tobacco advertising fees collected. The fiscal impact of recommendations 5 and 6 are shown in **Figure 11**.

FIGURE 11
FIVE-YEAR FISCAL IMPACT TABLE

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUNDS
2008	($461,380)
2009	($461,380)
2010	($461,380)
2011	($461,380)
2012	($461,380)

SOURCE: Legislative Budget Board.

The introduced General Appropriations Bill for the 2008–09 biennium does not address any of the six recommendations.

EXPANSION OF FEDERALLY QUALIFIED HEALTH CENTERS IN TEXAS

As a result of the federal health centers initiative that began in federal fiscal year 2002, Texas and other states have seen an increase in the number of new or expanded health centers receiving federal grant funds. Nationally, the U.S. Department of Health and Human Services, Health Resources and Services Administration awards grant funds that go directly to the health centers and not through state treasuries. These "federally qualified health centers" also receive funds from other federal, state and local sources such as reimbursements from Medicaid, Medicare and indigent care programs, client fees, and funds from state and local grant awards and contracts.

FACTS AND FINDINGS

- ♦ The Health Resources and Services Administration indicates that in 2005 Texas federally qualified health centers provided services to 642,701 users. Almost half were adults between the ages of 25 and 64; 61 percent were female; 68 percent were Hispanic; and 64.4 percent had incomes within 100 percent of the federal poverty level.
- ♦ As of August, 31, 2006, 50 federally qualified health centers provide services at 306 sites located in 81 Texas counties.
- ♦ Texas Medicaid expenditures for fee-for-service and managed-care reimbursements, and cost settlements to federally qualified health centers were $26.8 million in All Funds in fiscal year 2000 compared to $76.2 million in All Funds in fiscal year 2005.
- ♦ According to the Health and Human Services Commission, the cost reconciliations related to the implementation of the federally required prospective payment system (PPS) methodology are reflected in the increase in cost settlement expenditures in fiscal year 2003 through fiscal years 2005. Expenditures for cost settlements in fiscal year 2002 were $4.2 million compared to $15.4 million, $22.4 million and $11.1 million in fiscal years 2003, 2004, and 2005, respectively.
- ♦ According to the Health and Human Services Commission, Medicaid payments for health center-related expenses in fiscal year 2006 and beyond may increase primarily due to the establishment of alternative prospective payment rates for new federally qualified health centers and annual adjustments in alternative prospective payment rates to account for the change in the Medical Expenditure Index.
- ♦ The Texas Department of State Health Services reports that the agency awarded over $43 million in All Funds to FQHCs in each year of the 2004–05 biennium.
- ♦ The incubator program for federally qualified health centers awarded 113 grants funded with General Revenue Funds totalling $14.6 million from fiscal years 2004 through 2006. Fifteen entities receiving incubator funding received federal status making them eligible to receive new or increased Federal Funds. These 15 entities received $5.4 million in incubator funds and were subsequently awarded $8.2 million in Federal Funds.

DISCUSSION

The federal health centers program began in 1965 when the Office of Economic Opportunity implemented a demonstration project. The project created the Neighborhood Health Centers program to address limited access to healthcare or lack of healthcare services in certain communities. The program used public funds to establish medical clinics and to provide social services in these communities by using community-based staff. In the 1970s, the federal health centers program was moved to the U.S. Department of Health, Education and Welfare, the predecessor of the Department of Health and Human Services. In 1975, the health centers program was formally adopted as a program of the federal Public Health Service and authorized as "community and migrant health centers." Subsequent authorizations included healthcare services for residents of public housing and the homeless.

The Health Centers Consolidation Act of 1996 combined these authorities under Section 330 of the Public Health Services Act (42 U.S.C. 254b) to create the Consolidated Health Centers Program. This program provides federal support to community health centers, migrant health centers, healthcare for the homeless, and public housing primary care. Recipients of federal funds under this program are

referred to as 330-grantees. The Health Care Safety Net Amendment of 2002 reauthorized the program through federal fiscal year 2006.

Eligible 330-grantees must meet the following criteria:

- be public entities or private non-profit organizations;
- be located in a "medically underserved area" or serve a "medically underserved population" (as determined by the Secretary of U.S. Department of Health and Human Services);
- provide comprehensive primary care services as well as supportive services that promote access such as translation and transportation services;
- make services available to all residents of their service areas and offer a sliding fee scale based on patients' ability to pay;
- be governed by a community board with a majority of members health center patients; and
- meet all federal performance and accountability requirements.

According to the Centers for Medicare and Medicaid Services (CMS), Congress set limitations on Medicaid reimbursement for services provided by federally qualified health centers (FQHCs). FQHC services are defined similarly under Medicaid and Medicare. These services are provided by a physician, a physician assistant or nurse practitioner, a clinical psychologist or clinical social worker, and include such services and supplies that are incidental to the services provided. According to CMS, Medicaid will pay FQHCs for behavioral health services furnished by clinical psychologists, clinical social workers and nurse practitioners to individuals who are categorically eligible for Medicaid or who are eligible as medically needy if a state Medicaid program provides FQHC services to the medically needy. However, CMS indicates that it is not intended that any FQHC service, without qualification, would be paid by the Medicaid program.

Federal provisions enacted in 1992 and 1995 granted medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to Health Resources and Services Administration (HRSA) funded health centers. The health centers must apply and be "deemed" eligible for FTCA coverage and deemed health centers must reapply each year for the malpractice protection.

As FQHCs, 330-grantees are eligible to participate in the federal 340B Drug Pricing Program, along with other healthcare providers such as family planning clinics, AIDS clinics and disproportionate share hospitals. Drug makers are required to charge at or below statutorily defined price ceilings.

EXPANSION OF FEDERALLY QUALIFIED HEALTH CENTERS

In 2002, the federal health centers initiative began a national expansion to add 1,200 new and expanded health center sites in five years and to increase the number of patients served annually from approximately 10.3 million in 2001 to 16 million in 2006. With increased access due to the expansion, the federal government expects to increase the provision of comprehensive primary and preventive health care services in areas of high need, as well as improve the health status of and decrease health disparities in the medically underserved populations targeted. In 2006, the goals expanded to include locating a health center in every poor county in the nation. The President's 2007 budget proposes 300 new and expanded community health centers; 80 of the new sites would be in counties with a high prevalence of poverty.

The National Association of Community Health Centers and George Washington University report that 30 percent of the nation's counties are poor and lack a health center. Similarly, 70 percent of counties in Oklahoma and 50 percent of counties in Kentucky, Louisiana, Montana and Texas are poor and lack a health center. The study also indicates that Texas is included among nine other states with 20 to 50 percent of the state's residents living in the poorest counties. Texas, along with seven other states, has 10 to 19 percent of the state's uninsured population residing in counties identified as poor and without a federally funded health center.

To accomplish the community health center expansion goals, the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care administers three grant competitions: (1) new access points, (2) expanded medical capacity, and (3) service capacity. The new access points-grants are awarded to new 330-grantees or existing 330-grantees opening new sites. The expanded medical capacity grants are awarded to existing health centers to increase the number of persons served at the existing sites. The service capacity grants are awarded to existing 330-grantees to add new or expanded mental health, substance abuse, or oral health services, and to fund continued participation in certain health disparities projects. According to HRSA, 330-grant awards are not based on statutory formula. The amounts

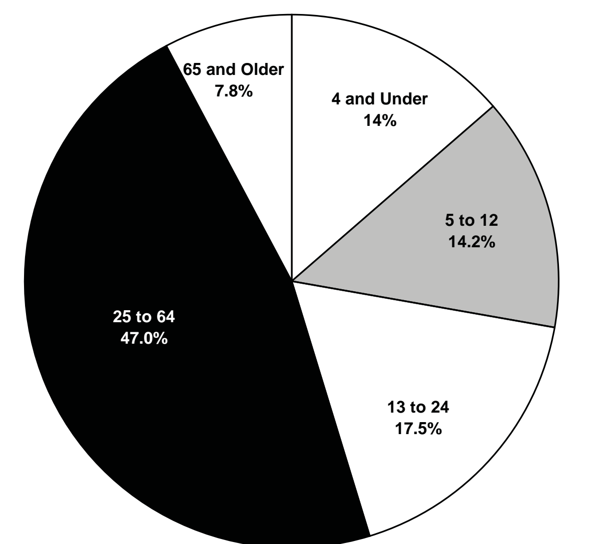
are negotiated based on costs associated with the proposed grant activities. The initial period of grant support may be up to 5 years. Grant recipients may receive federal funding for additional years based on their progress and need for additional support. The 330-grant funds cannot be used for inpatient services, or to make cash payments to intended recipients of services.

FEDERALLY QUALIFIED HEALTH CENTERS IN TEXAS

All federally funded health centers in Texas are designated by the federal government as federally qualified health centers (FQHCs). As FQHCs, they are certified Medicaid providers and eligible for Medicaid reimbursements. HRSA reports that FQHCs in Texas receiving federal 330-grant funds in 2005 provided services to 642,701 users. Almost half (47 percent) of the users were adults between the ages of 25 and 64. Approximately 61 percent of the users were female; 68 percent were Hispanic; and 64.4 percent had incomes within 100 percent of the FPL (**Figures 1 through 3**). Medical services accounted for 74 percent of encounters at FQHCs in 2005; dental services accounted for 11 percent and substance abuse, mental health and other services accounted for the remaining services.

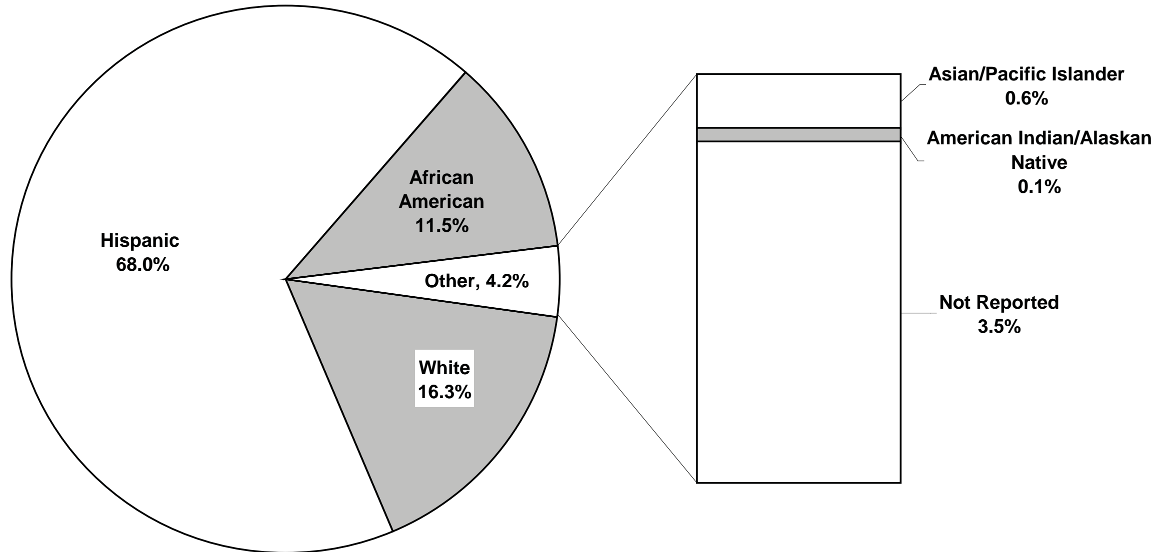
According to the Texas Department of State Health Services (DSHS) and the Texas Association of Community Health Centers, 50 FQHCs in Texas received federal 330-grant funds in fiscal year 2006. The health centers provide services at 306 sites located in 81 counties. By site type, they include 258 service delivery sites, 25 sites offering Special Supplemental Nutrition Program for Women, Infants and Children services only, 12 mobile units offering medical and/or dental service, 10 developmental sites under federal review for service expansion and 1 interim FQHC site. **Figure 4** shows the number of Texas FQHC sites by county, as of August 31, 2006.

FIGURE 1
CLIENTS OF TEXAS FEDERALLY QUALIFIED HEALTH CENTERS BY AGE, 2005



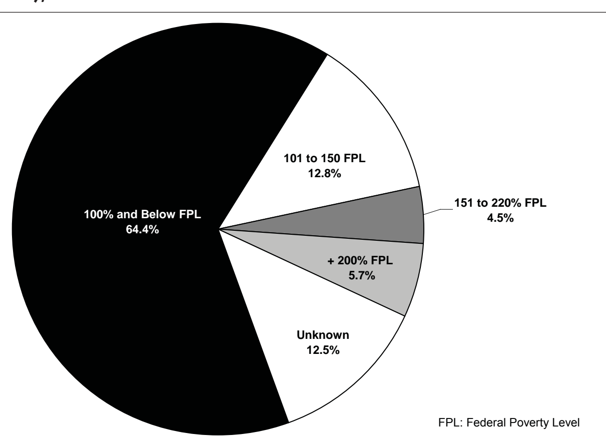
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration.

FIGURE 2
RACE/ETHNICITY OF CLIENTS OF TEXAS FEDERALLY QUALIFIED HEALTH CENTERS, CALENDAR YEAR 2005



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration.

FIGURE 3
CLIENT INCOME OF TEXAS FEDERALLY QUALIFIED HEALTH CENTERS BY PERCENTAGE OF FEDERAL POVERTY LEVEL (FPL), 2005

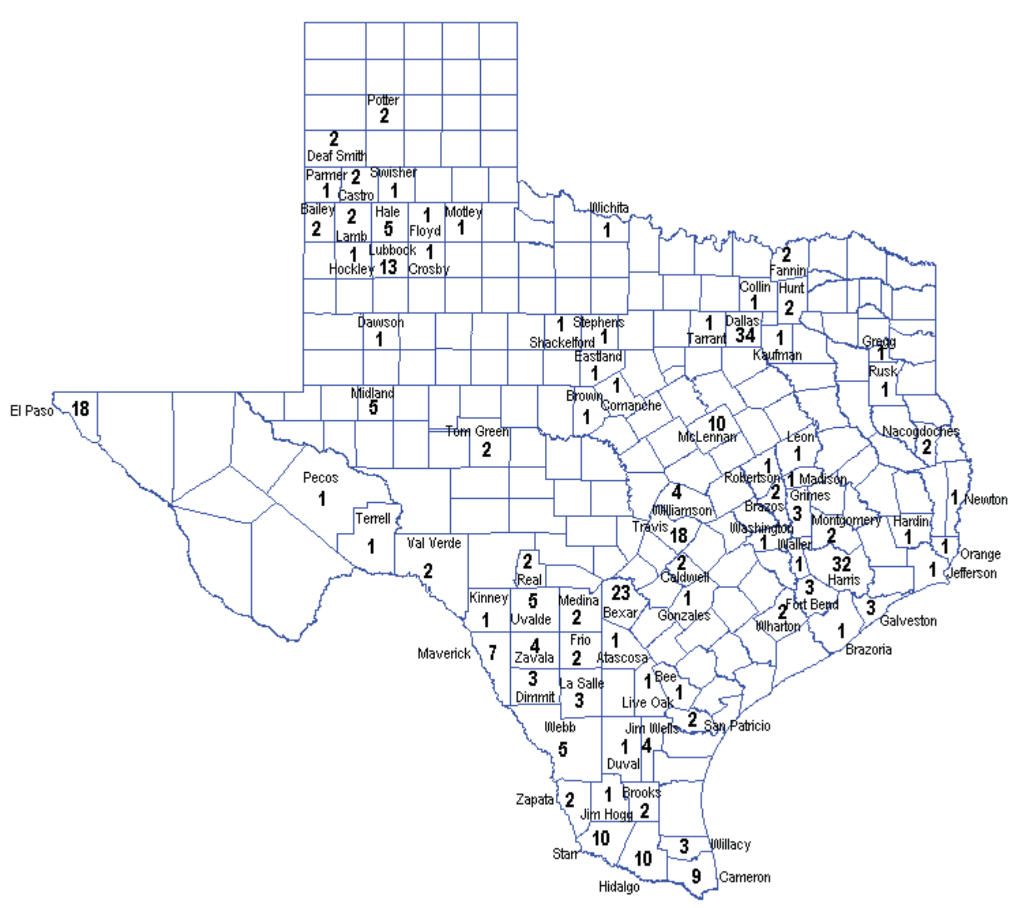


Source: U.S. Department of Health and Human Services, Health Resources and Services Administration.

FEDERALLY QUALIFIED HEALTH CENTERS FUNDING RESOURCES

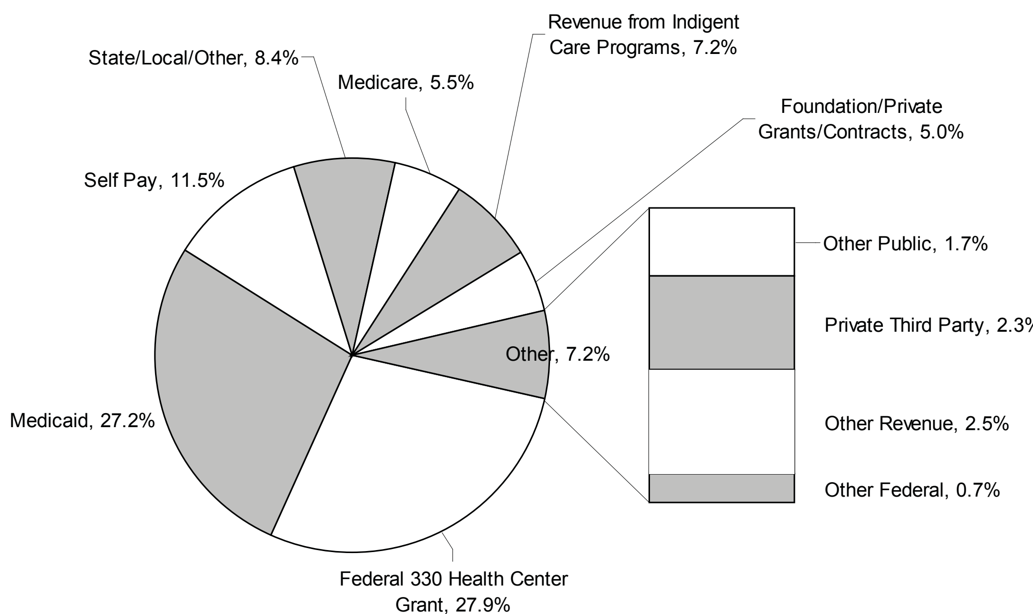
As **Figure 5** shows, a variety of sources fund Texas' FQHCs. Federal 330-grants and Medicaid accounted for similar shares of funding in 2005 (27.9 percent and 27.2 percent respectively). In Texas, the proportion attributable to Medicaid has grown in the past five years. In 2000, the federal 330-grant funds were the largest source of funding for federally fund FQHCs in Texas providing $57.7 million or 38 percent of approximately $152 million in total funds. Medicaid was the second largest source of funding and provided approximately $29.7 million or 29.5 percent of total funds. In 2005, the federal 330-grant funds were approximately $89.9 million or 27.9 percent of approximately $321.9 million in total funds. Medicaid was the second largest source of funds providing approximately $87.5 million or 27.2 percent. HRSA reports that FQHC Medicaid

FIGURE 4
TEXAS FEDERALLY QUALIFIED HEALTH CENTER DELIVERY SITES AS OF AUGUST 31, 2006



Sources: Legislative Budget Board; U.S. Department of Health and Human Services, Health Resource and Services Administration; Department of State Health Services; Texas Association of Community Health Centers.

FIGURE 5
SOURCES OF FUNDING FOR TEXAS FEDERALLY QUALIFIED HEALTH CENTERS, 2005



SOURCE: U.S. Department of Health and Human Services, Health Resources and Services Administration.

collections in Texas rose from $27.7 million in 2000 to $87.5 million in 2005.

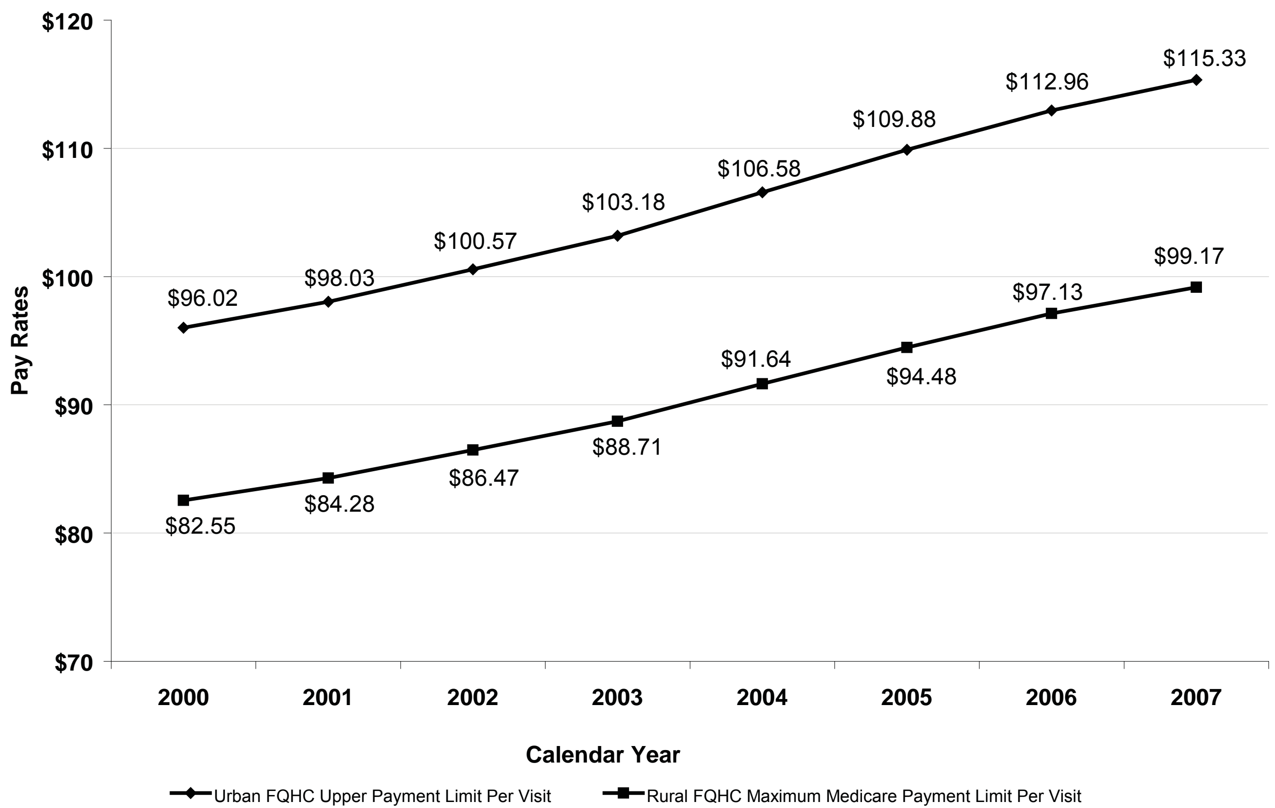
Under contract with the Centers for Medicare and Medicaid Services (CMS), FQHCs receive reimbursement for outpatient services to Medicare beneficiaries. CMS sets the payment limit per visit for urban and rural FQHCs annually. According to CMS, an FQHC is designated as an urban or rural entity based on the urban and rural definitions in the Social Security Act that defines urban and rural for hospital payment purposes. The urban payment limit applies to FQHCs located within a Metropolitan Statistical Area or New England County Metropolitan area. The rural payment limit applies to an FQHC if it is not located in either of the areas mentioned above and cannot be classified as a large or other urban area. The specific definition of urban and rural is based upon recent census data and issued by the Office of Management and Budget (OMB).

Figure 6 shows the FQHC upper payment limit per visit for urban FQHCs and rural FQHCs for 2000 through 2007 in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by §1833 (f) of the Social Security Act. In 2005, CMS announced proposed rules that would provide supplemental payment to FQHCs that contract with Medicare Advantage Plans. The supplemental payment would cover the difference, if any, between the payments received by a health center for services provided to Medicare Advantage plan enrollees and the normal Medicare payment rate for the health center.

In 1989, the U.S. Congress enacted the Federally Qualified Health Centers Act. Under the Act, states were required to pay the full cost of care that the health centers incurred in providing services to Medicaid clients. The cost was not to exceed the reasonable costs determined by the Medicare cost reimbursement principles set forth in federal regulation. States required FQHCs to submit costs reports that were reviewed to determine cost-based payments, and federal regulations allowed states to define what constituted "reasonable costs." The underlying policy intent was to provide adequate reimbursement for FQHCs serving Medicaid and Medicare beneficiaries so that federal 330-grant funds and other funds that FQHCs received would be used to provide care to the uninsured.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a new prospective payment system methodology for the reimbursement of services provided by FQHCs and Rural Health Centers on or after January 1, 2001. In states where Medicaid Managed Care organizations (MCOs) subcontract

FIGURE 6
MEDICARE MAXIMUM TEXAS FEDERALLY QUALIFIED HEALTH CENTERS PAYMENT RATES FOR 2000–2006



Sources: Legislative Budget Board; U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

with FQHCs to provide covered services to Medicaid enrollees, the BIPA requires the state to make a supplemental payment to FQHCs covering the difference between the MCO amounts and what the FQHC would have received from the state under cost-based Medicaid reimbursement.

The provisions of the BIPA were included in the Consolidated Appropriations Act of 2000 and established Medicaid per visit rates for FQHCs using a prospective payment systems methodology (PPS). States were required to amend their Medicaid State Plans to provide for payment of services to FQHCs using the PPS. The 2001 base rate was calculated based on the average of each FQHC's fiscal year 1999 and fiscal year 2000 reasonable costs per visit. States were allowed to determine the base rate using their prior definition for reasonable costs. Beginning fiscal year 2002, the PPS rates were to be adjusted annually for inflation using the MEI as required in statute. The statute required that payment adjustments would also be made based on increases or decreases in the scope of services provided.

The federal statute allows a state to use an alternative payment methodology to calculate an FQHC payment rate if the methodology results in payment that is at least equal to what the FQHC would have received under the PPS and if the FQHC agrees to use the alternative methodology. The alternative methodology must be included in a state's Medicaid state plan.

A June 2005 report by the U.S. Government Accountability Office indicated that using the MEI index to adjust the PPS rates for inflation may not be appropriate. The index was designed to estimate the increase in the total costs of the average physician to operate a medical practice, which is different from the costs associated with providing FQHC services. An FQHC can include enabling services such as transportation and language translation services. Some stakeholders believe that the MEI index may increase costs at a lower rate than actual FQHC costs. However, it is argued that the objective of the PPS is to encourage efficiency; therefore equivalent increases in payments to compensate for increasing cost trends may not be desirable.

Section 1905 of the Social Security Act also addresses the FQHC-Look Alikes (FQHC-LAs). These provider entities are identified by HRSA as meeting the requirements of a Section 330-grantee but are not recipients of the federal grant. They are certified by CMS. FQHC-LAs are eligible for the FQHC Medicare and Medicaid reimbursement rates, and can participate in the 340(b) Federal Drug Pricing program. There are five FQHC-LAs in Texas, as of September 2006.They include 3 sites in Harris County, and one site each in Rusk and Gregg counties. The FQHC-LAs are also included in **Figure 4**.

TEXAS' IMPLEMENTATION OF THE MEDICAID PPS

The Texas Administrative Code provides for the PPS methodology or an alternative to the PPS methodology to reimburse FQHCs for Medicaid-covered services provided in Texas. An FQHC chooses whether to have its reimbursement rate based on the PPS methodology or the alternative to the PPS methodology. FQHCs receive Medicaid reimbursement based on provider-specific encounter rates. Subject to state approval, FQHCs can also be reimbursed for case management services for children and pregnant women.

The Health and Human Services Commission (HHSC) is required to set a PPS rate or alternate prospective payment (APP) rate for each FQHC. Upon final HHSC approval, the PPS or APP rate is applied prospectively. According to HHSC, all FQHCs in Texas agreed to the APP rate calculated as follows:

APP = (Initial base payment amount X MEI)
+ 1.5 percent

(If costs increase more than the inflation factor, an FQHC can request an adjustment equal to 100 percent of costs, if the entity can demonstrate operational efficiency or an increase is due to change in scope.)

According to the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid administration contractor, the initial APP rates were calculated based on the greater of the average of the 1999 and 2000 costs per visit or the 2001 cost per visit.

The fiscal year 2005 Medicaid reimbursement rates for FQHCs and FQHC-LAs in Texas ranged for $91.16 to $231.31. On average, the Medicaid reimbursement rate for FQHCs and FQHC-LAs was $151.60.

Figure 7 shows Medicaid expenditures for FQHC-related expenses in fiscal years 2000 through 2005 including reimbursement for services and cost settlements. TMHP indicates that Texas FQHCs and FQHC-LAs received approximately $76.2 million (All Funds) in fiscal year 2005. This includes approximately $65.5 million in fee-for-service and $10.7 million, in managed care.

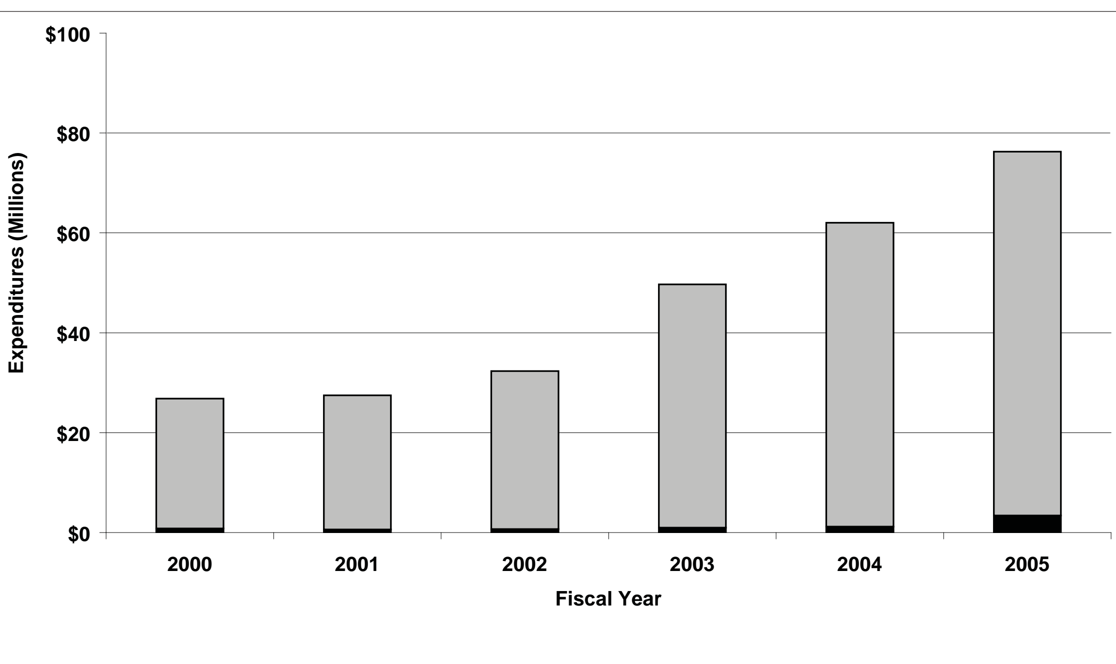
Implementation of the federally required prospective payment system resulted in Medicaid expenditures for FQHC cost reconciliations. The agency anticipates fewer but continuing Medicaid cost reconciliations in fiscal year 2006 and beyond because the APP rates for new FQHCs will need to be determined. Total Medicaid reimbursements to FQHCs may increase as annual adjustments are calculated due to changes in the MEI. The rate formula also includes an additional 1.5 percent applied each year.

Federal requirements provide for supplemental payments to FQHCs and FQHC-LAs that contract with MCOs. The supplemental payments cover the difference between the FQHC rate and the MCO capitated rate. TMHP makes quarterly supplemental payments to FQHCs and FQHC-LAs. According to TMHP, Medicaid MCO supplemental payments to FQHCs were $3.2 million in fiscal year 2002 compared to $8.9 million in fiscal year 2005.

FUNDING AWARDED BY THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES

The DSHS awards numerous grants and contracts to FQHCs in Texas. The grants and contracts awarded are funded with federal and state dollars appropriated to the agency. DSHS reports that the agency awarded approximately $43.3 million in All Funds to FQHCs in Texas in fiscal year 2005. This amount included $32.6 million in Federal Funds and $10.7 million in General Revenue Funds and General Revenue–Dedicated Funds. For instance, DSHS awarded approximately $20 million in federal Special Supplemental Nutrition Program for Women, Infants and Children funds to 18 Texas FQHCs, which accounts for about 58 percent of the Federal Funds awarded. Of the $10.7 million in General Revenue Funds and General Revenue–Dedicated Funds, DSHS awarded approximately $5.6 million in General Revenue Funds appropriated for Strategy B.1.5, Community Primary Care Services to 24 FQHCs and $2.2 million in General Revenue Funds appropriated for Strategy B.3.2, FQHC Infrastructure Grants to 16 FQHCs in fiscal year 2005. The remaining $2.9 million were appropriated for various strategies. **Figure 8** shows the amount of General Revenue Funds and General Revenue–Dedicated Funds, combined,

FIGURE 7
MEDICAID EXPENDITURES FOR TEXAS FEDERALLY QUALIFIED HEALTH CENTERS
FISCAL YEARS 2000 TO 2005



Sources: Legislative Budget Board; Health and Human Services Commission; Texas Medicaid and Healthcare Partnership.

and Federal Funds awarded by DSHS to FQHCs in Texas for fiscal years 1998 through 2005.

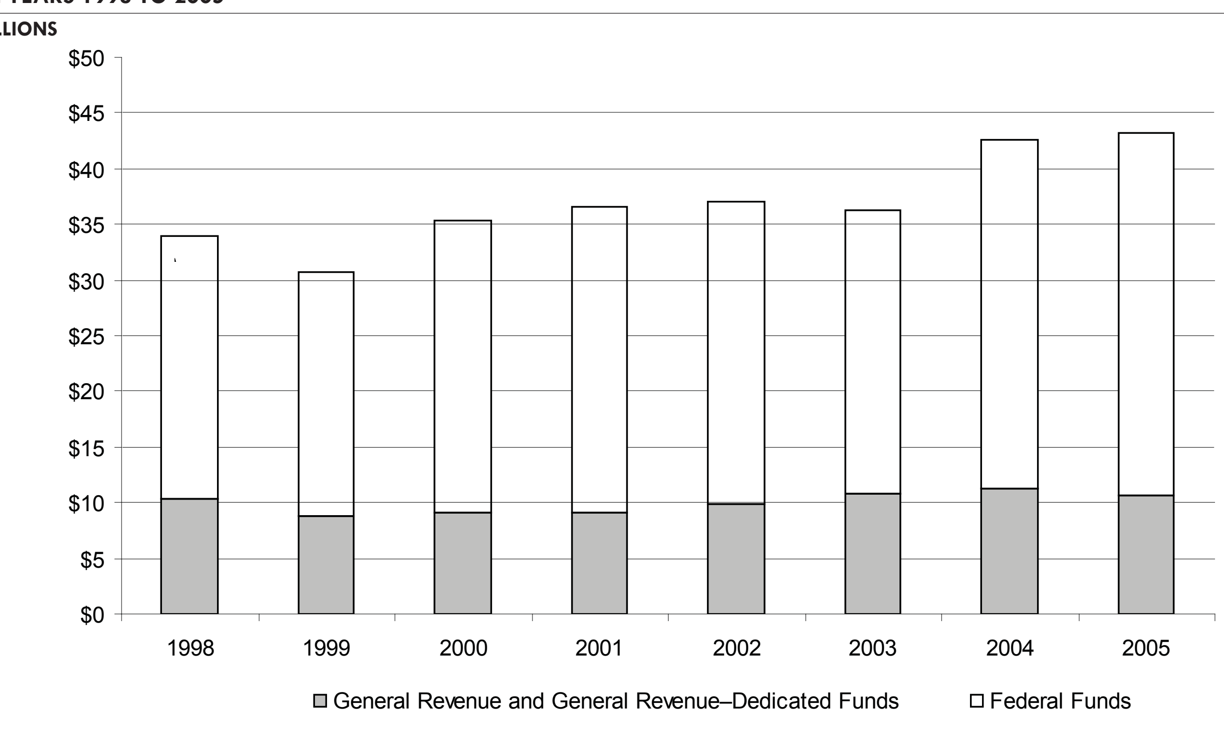
STATE FQHC INCUBATOR PROGRAM

Riders contained in the 2004–05 and 2006–07 General Appropriations Acts allowed the DSHS to expend up to $5 million in General Revenue Funds in each year of the 2004–05 and 2006–07 biennia, respectively, to sustain existing FQHCs and to aid existing FQHCs and new institutions seeking to become FQHCs through grant awards. The funds awarded should be used for planning, grant writing, initial operating costs and initial capital costs. These funds are included in the amounts mentioned above regarding grants awarded to FQHCs by DSHS.

DSHS' Texas Primary Care Office administers the FQHC Incubator Program. The program awards Planning, Development/Technical Assistance, Transitional Operating Support and Capital Improvement grants to eligible applicants through a competitive bid process. Eligible applicants include currently designated FQHCs and FQHC-LAs, Internal Revenue Service-designated non-profit 501(s) (3) organizations, and public entities such as county, city or local public health departments, hospitals, or health districts; and local governments. The funds awarded may only be used for a specifically defined purpose and can be used to support the sustainable development or expansion of an FQHC or FQHC-LA. FQHC Incubator Program award recipients are not allowed to use the funds to replace local or state funds. The funds awarded are not intended as sole source or permanent funding.

According to DSHS, the FQHC Incubator Program awarded 113 grants totalling $14.6 million in General Revenue Funds to eligible organizations in fiscal years 2004 through 2006. Fifteen of the organizations receiving incubator funds received federal FQHC status as new access or expanded medical capacity sites and are eligible for new or increased Federal Funds. These 15 entities received $5.4 million in incubator funds and were subsequently awarded $8.2 million in Federal Funds over this period.

FIGURE 8
FUNDS AWARDED TO TEXAS FEDERALLY QUALIFIED HEALTH CENTERS BY DSHS
FISCAL YEARS 1998 TO 2005



SOURCES: Legislative Budget Board; Department of State Health Services.

SOCIO-DEMOGRAPHIC OVERVIEW OF TEXAS' UNINSURED POPULATION

The growing population of Americans without health insurance affects nearly every state in the country. In 2004, the number of uninsured Americans rose to 45.8 million, which is 15.7 percent of the U.S. population. In the same year nearly 5.6 million Texans, or 25 percent of the state population, lacked health insurance. Although the percentage of Texans without health insurance has been consistently high in the last decade, the rising amount of uncompensated care contributes to increased healthcare costs to the state. To create effective public policy to reduce the number of uninsured Texans, the state needs an accurate count and understanding of the uninsured population's demographics. This report and others in this publication related to the uninsured population serve as a resource for policy deliberations.

FACTS AND FINDINGS

- ♦ In 2004, 25 percent of the Texas population was uninsured, although the national uninsured rate was less than 16 percent.
- ♦ In 2005, Texas had the highest uninsured rate in the nation among people age 18 to 64.
- ♦ Aproximately 66 percent of uninsured working-age Texans were employed in 2004.
- ♦ In 2004, nearly 30 percent of uninsured Texans earned less than 100 percent of the federal poverty level, and about 60 percent earned less than 200 percent of the federal poverty level.
- ♦ Approximately 21 percent of Texans younger than age 18 were uninsured in 2004.
- ♦ Although about 52 percent of working uninsured Texans work for employers with fewer than 10 or more than 1,000 employees, a higher percentage of working uninsured Texans work for businesses with between 10 and 499 employees than in national rates.

DISCUSSION

The costs associated with the growing population of uninsured individuals affect every state in the nation. Texas, however, has the highest percentage of uninsured people of any state. In 2004, the number of uninsured Americans rose to 45.8 million, or 15.7 percent of the U.S. population, but the number of uninsured Texans was 5.6 million, or 25 percent of the population. From 1996 to 2004, the portion of the Texas population that was uninsured remained between 21 percent and 26 percent. However, as the amount of uncompensated care rose, state costs of healthcare also grew.

Providers of uncompensated care receive both direct and indirect reimbursement, which partially cover their costs, through government subsidies and cost-shifting to purchasers of healthcare. In 2004, the Kaiser Commission estimated the nationwide cost of uncompensated care at $41 billion. In the same year, the 482 non-state-owned hospitals in Texas reported $4.1 billion in uncompensated care costs, rising to $4.7 billion in 2005. Uncompensated care includes the cost of bad debt, which is uncollectible hospital charges resulting from the extension of credit, and charity care, which is health services provided free of charge to individuals meeting certain financial criteria. These reported figures have been adjusted to reflect the difference between hospital charges and the amounts received in negotiated payments (i.e., the cost-to-charges ratio). During the 2006–07 biennium, the Health and Human Services Commission (HHSC) studied the components and assumptions used to calculate uncompensated care amounts in Texas hospitals. In this study, HHSC found that the cost of bad debt and charity care can be further reduced by accounting for other offsetting payments, such as the federal portion of disproportionate share hospital funds and upper payment limit funds, charitable contributions, and tax revenue.

Tax deductions and government subsidies for public healthcare reduce funds available to governments for non-healthcare budget priorities. Hospitals charge insured patients higher rates to cover uncompensated care, and the ensuing cost-shifting to purchasers of healthcare leads to higher healthcare premiums for employers, employees, and other policyholders. According to the Texas Department of Insurance, higher insurance premiums are one of the leading causes of dropped healthcare insurance coverage in recent years. Dropped coverage leads to more uninsured Texans, thus starting the cycle over again.

Expenditures on personal healthcare services totaled $106.8 billion from all payers in Texas in 2004, or 12.1 percent of the Texas gross state product. According to the U.S. Centers

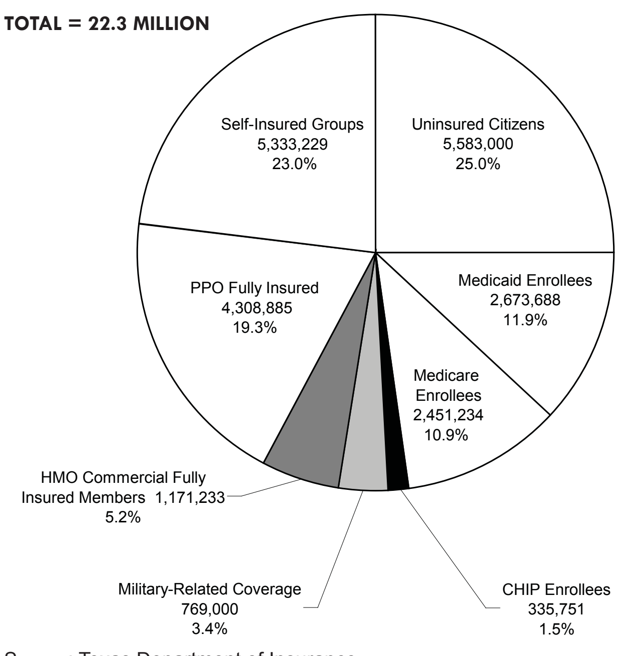
for Disease Control and Prevention, health insurance coverage is an important determinant of access to healthcare services. Policy considerations relating to health insurance coverage are among the range of critical issues affecting Texans' access to healthcare services and the associated costs.

The Texas population can be divided into three broad categories relating to health insurance coverage:

- Privately insured, which is approximately 50.9 percent of the Texas population and includes consumers who access healthcare services through the private insurance market, as provided by their employer or purchased individually;
- Publicly insured, which is approximately 24.3 percent of the Texas population and includes consumers who access services through public programs such as Medicaid, the Children's Health Insurance Program, and Medicare; and
- Uninsured, which is approximately 25 percent of the Texas population and includes all of those who have no health insurance.

Figure 1 shows the distribution of the Texas population by type of insurance coverage.

FIGURE 1
INSURANCE COVERAGE IN THE TEXAS POPULATION, 2004



SOURCE: Texas Department of Insurance.

Policy changes directed at any one of the above segments can affect access to healthcare services and the associated costs, but because there is a complex relationship between the segments, changing any one segment may affect others. For example, expansion of public health insurance coverage sometimes leads to privately insured people dropping that insurance in favor of public insurance, which is called crowd-out. Nearly one-third of the insured population in Texas access healthcare services through public insurance.

To create effective public policy to reduce the number of uninsured Texans, the state needs an accurate count and understanding of the uninsured population's demographics. The following charts demonstrate various demographic factors about the uninsured population in Texas and, when possible, compare these factors to the national rates. Some of the charts include a table showing the percentage that Texas is either higher or lower than the national rates. The charts consider several different population groups as of 2004, including:

- the total population in Texas (22.3 million) and in the U.S. (291.2 million, dropping to 290.2 million when discussing poverty levels);
- the total uninsured population in Texas (5.6 million) and in the U.S. (45.8 million, dropping to 45.6 million when discussing poverty levels);
- the portion of the total population age 18 to 64 in Texas (13.8 million) and in the U.S. (182.1 million);
- the total working-age population, excluding children under age 18 and retirees, which differs from the last population by adding retirees over 64 and subtracting retirees below 64, in Texas (13.9 million) and in the U.S. (181.5 million);
- the working-age uninsured population, excluding children under age 18 and retirees, in Texas (4.1 million) and in the U.S. (36.2 million);
- the portion of the working-age uninsured population that was employed in the previous year in Texas (2.7 million) and in the U.S. (24.5 million); and
- the total working population, which includes only those people age 18 and older who were employed at some point in the prior year, in Texas (10.3 million) and in the U.S. (137.1 million).

THE UNINSURED IN TEXAS

Figure 2 compares the percentage of the uninsured in the total Texas population (22.3 million) with the national rates (out of 291.2 million) for the most recent years for which data was available. As the chart shows, the Texas percentages were significantly higher than the national rates. The Texas uninsured population grew at a slightly greater proportion than the nation as a whole.

Figure 3 narrows the focus to the population age 18 to 64 (13.8 million in Texas and 182.1 million in the U.S.), which shows an increased percentage of uninsured both in Texas and in the nation. Although the differences between the Texas rates and national rates are slightly less than in the total population as shown in **Figure 2**, Texas again has higher uninsured rates than the national figures.

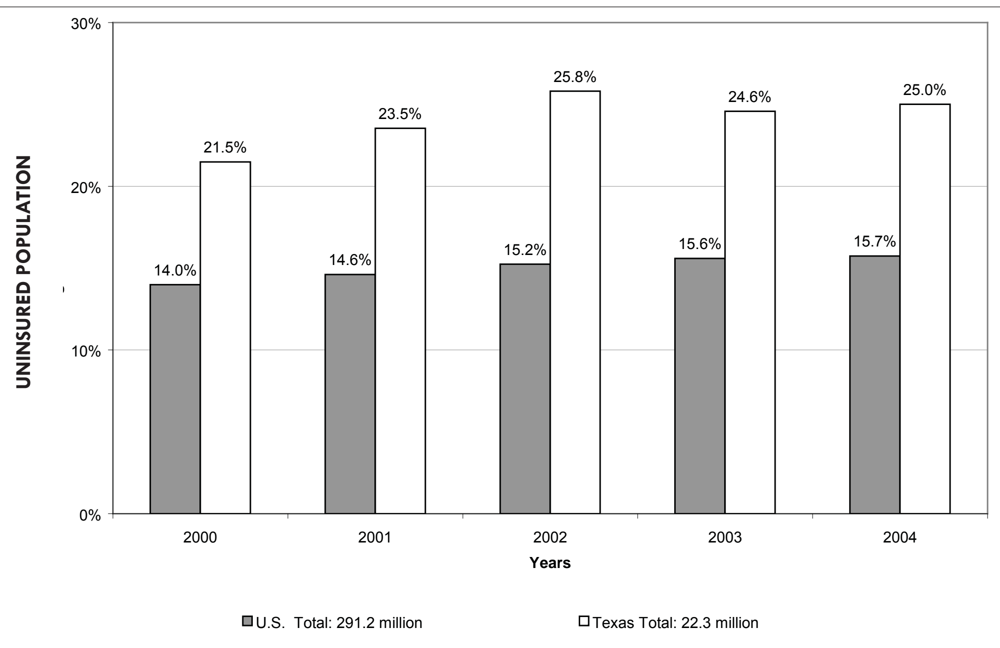
As **Figure 4** shows, Texas had the highest uninsured rate among people age 18 to 64 of any state in the nation in 2005.

WORK STATUS OF UNINSURED TEXANS

The percentage of working uninsured Texans is also higher than the national rate. **Figure 5** shows that the portion of the total Texas working-age population (13.9 million) that was uninsured and had a full- or part-time job at any point in 2004 was 26.7 percent, higher than the 17.9 percent national rate (out of 181.5 million). The portion of this population that was uninsured and unemployed in that year was 46.0 percent in Texas, above the national rate of 39.2 percent. Texas's percentage of uninsured people outside of the labor force was 37.0 percent while the national rate was 23.5 percent.

When considering the demographics of Texas' uninsured working-age population (4.1 million) rather than the uninsured percentage of the total population, Texas was comparable to the national rates (out of 36.2 million) in employment status of the uninsured. As **Figure 6** shows, 66.3 percent of all working-age uninsured people in Texas in 2004 were employed within the previous year, slightly less than the national rate of 67.8 percent. Within the same uninsured population in Texas, 6.4 percent were unemployed for the entire year, again comparable to the national rate of 8.3 percent. The remaining 27.2 percent in Texas were not in the labor pool, while the national percentage of uninsured people not in the labor pool was 23.9 percent.

FIGURE 2
PERCENTAGE OF UNINSURED IN TOTAL POPULATION, 2000 TO 2004

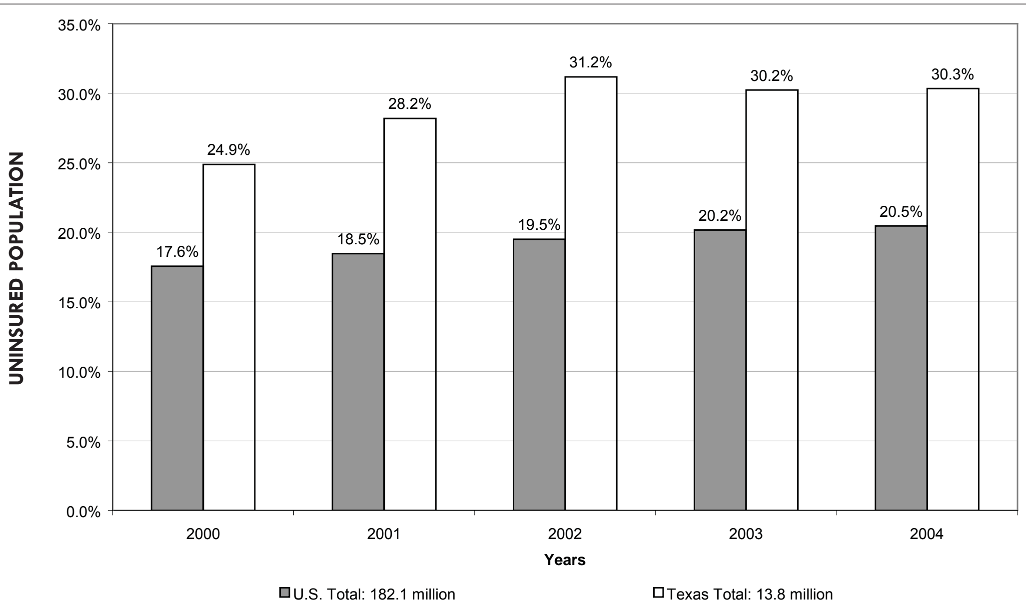


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

2000	2001	2002	2003	2004
53.6%	61.0%	69.7%	57.7%	59.2%

SOURCE: U.S. Census Bureau.

FIGURE 3
PERCENTAGE OF UNINSURED IN POPULATION AGE 18 TO 64, 2000 TO 2004

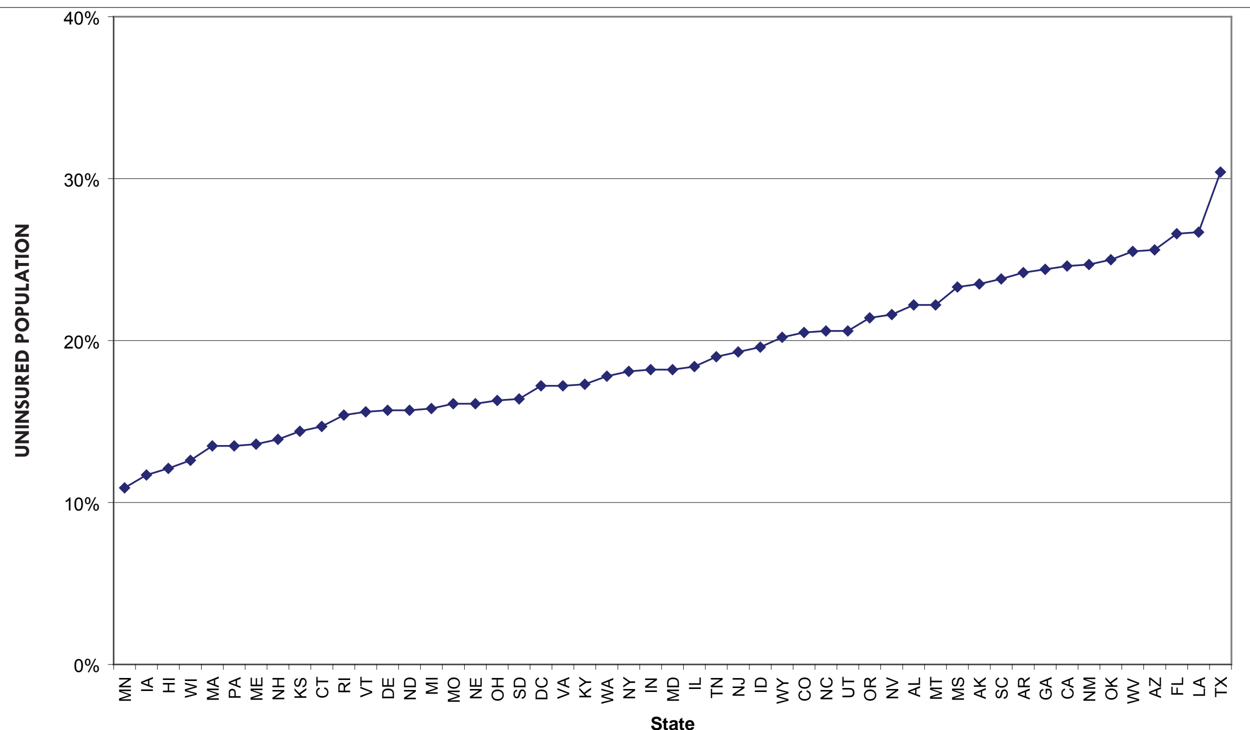


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

2000	2001	2002	2003	2004
41.5%	52.4%	60.0%	49.5%	47.8%

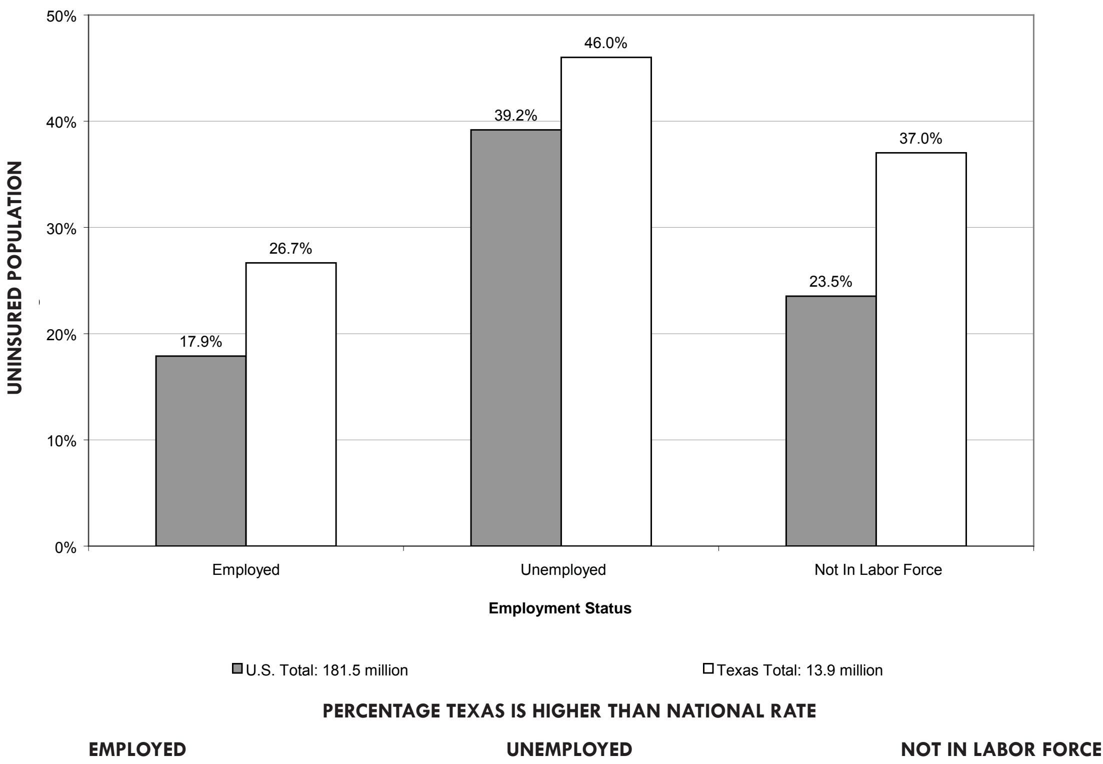
SOURCE: U.S. Census Bureau.

FIGURE 4
UNINSURED RATES FOR ADULTS AGE 18 TO 64 IN ALL U.S. STATES, 2005



SOURCE. U.S. Census Bureau.

FIGURE 5
PERCENTAGE OF UNINSURED TEXANS WITHIN LABOR FORCE CATEGORIES COMPARED TO U.S. WORKING AGE POPULATION, 2004



PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

EMPLOYED	UNEMPLOYED	NOT IN LABOR FORCE
49.2%	17.3%	57.4%

SOURCE: U.S. Census Bureau.

Therefore, when considering just the working-age uninsured population, **Figure 6** shows that both in Texas and in the nation, roughly two-thirds were employed at some point in the prior year. However, Figure 5 shows that when considering the total working-age population (13.9 million in Texas and 181.5 million in the U.S.), 26.7 percent of employed Texans were without insurance in 2004, which is higher than the national rate of 17.9 percent.

INCOME OF UNINSURED TEXANS

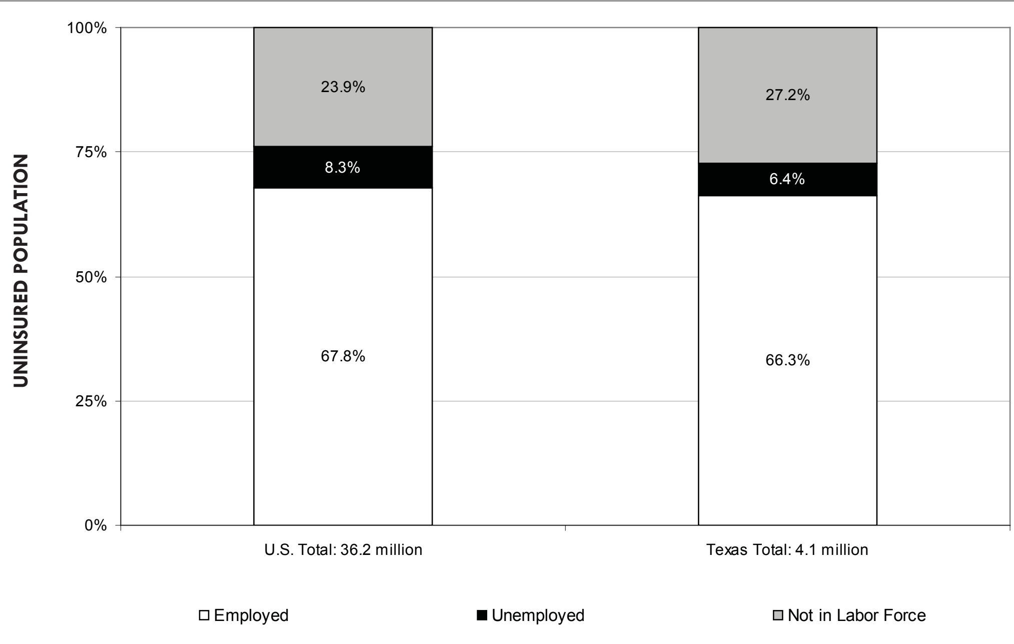
Nearly half, 47 percent, of Texans with an income below 50 percent of Federal Poverty Level (FPL) were uninsured in 2004. As **Figure 7** shows, the percentage of uninsured Texans out of the total Texas population (22.3 million) was consistently around 50 percent higher than the national rate (out of 290.6 million, because poverty levels could not be determined for the entire population), even though the percentages consistently dropped in the greater income brackets. In 2006, FPL for an individual is $9,800 and for a family of four is $20,000.

Figure 8 shows that the Texas uninsured population (5.6 million) tends to be poorer than the national uninsured population (45.6 million). On the lower end of the income distribution, more than 60 percent of uninsured Texans earned less than 200 percent of FPL in 2004, while nationally 53 percent of the uninsured population earned less than 200 percent of FPL.

AGE OF UNINSURED TEXANS

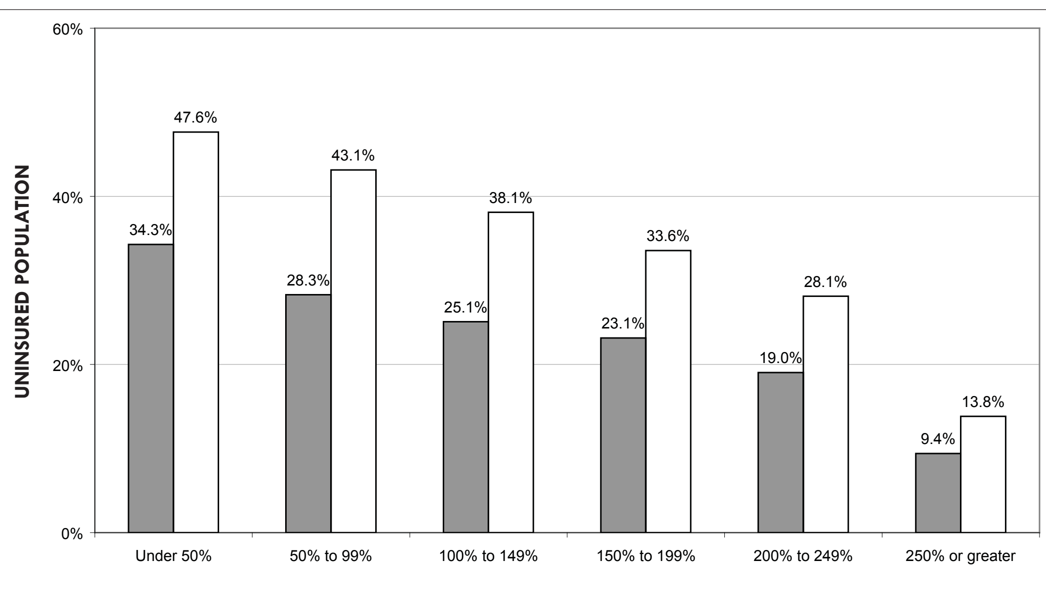
The total Texas uninsured population (5.6 million) also trends younger than the national rate (45.8 million), as **Figure 9** shows in its breakdown of the distribution of the uninsured by age. In 2004, 24 percent of all uninsured Texans were younger than age 18, while nationally, only 18 percent of the uninsured were younger than age 18. **Figure 10** shows the percentage of uninsured Texans within each age group (22.3 million in Texas and 291.2 million in the U.S.). Although Texas has a higher percentage of uninsured people in every age group, **Figure 10** shows that Texas has a rate nearly twice the national rate in the two under-18 categories.

FIGURE 6
WORK STATUS DISTRIBUTION OF UNINSURED WORKING-AGE TEXANS COMPARED TO UNINSURED U.S. WORKING-AGE POPULATION, 2004



SOURCE: U.S. Census Bureau.

FIGURE 7
PERCENTAGE OF UNINSURED TEXANS WITHIN FEDERAL POVERTY LEVEL BRACKETS COMPARED TO U.S. UNINSURED POPULATION, 2004

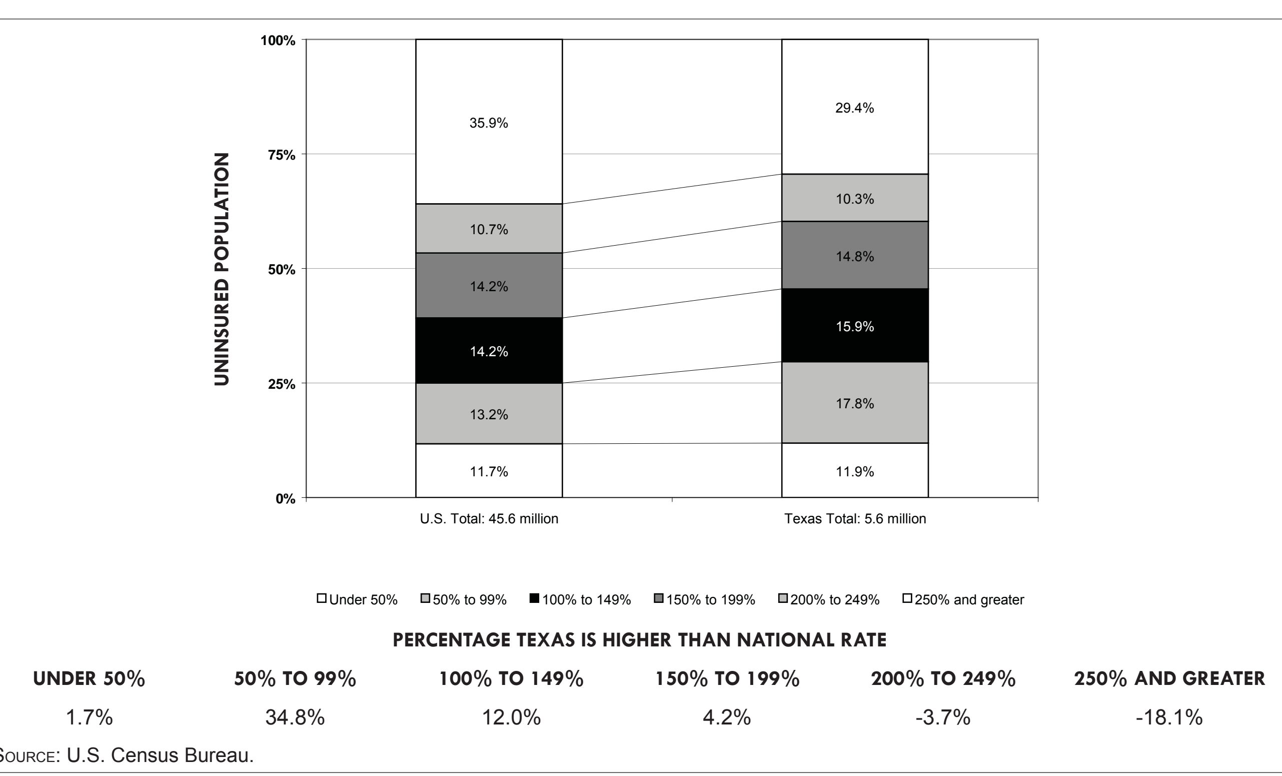


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

LESS THAN 50%	50% TO 99%	100% TO 149%	150% TO 199%	200% TO 249%	250% AND GREATER
38.8%	52.3%	51.8%	45.5%	47.9%	46.8%

SOURCE: U.S. Census Bureau.

FIGURE 8
POVERTY LEVEL DISTRIBUTION OF UNINSURED TEXANS COMPARED TO U.S. UNINSURED POPULATION 2004.

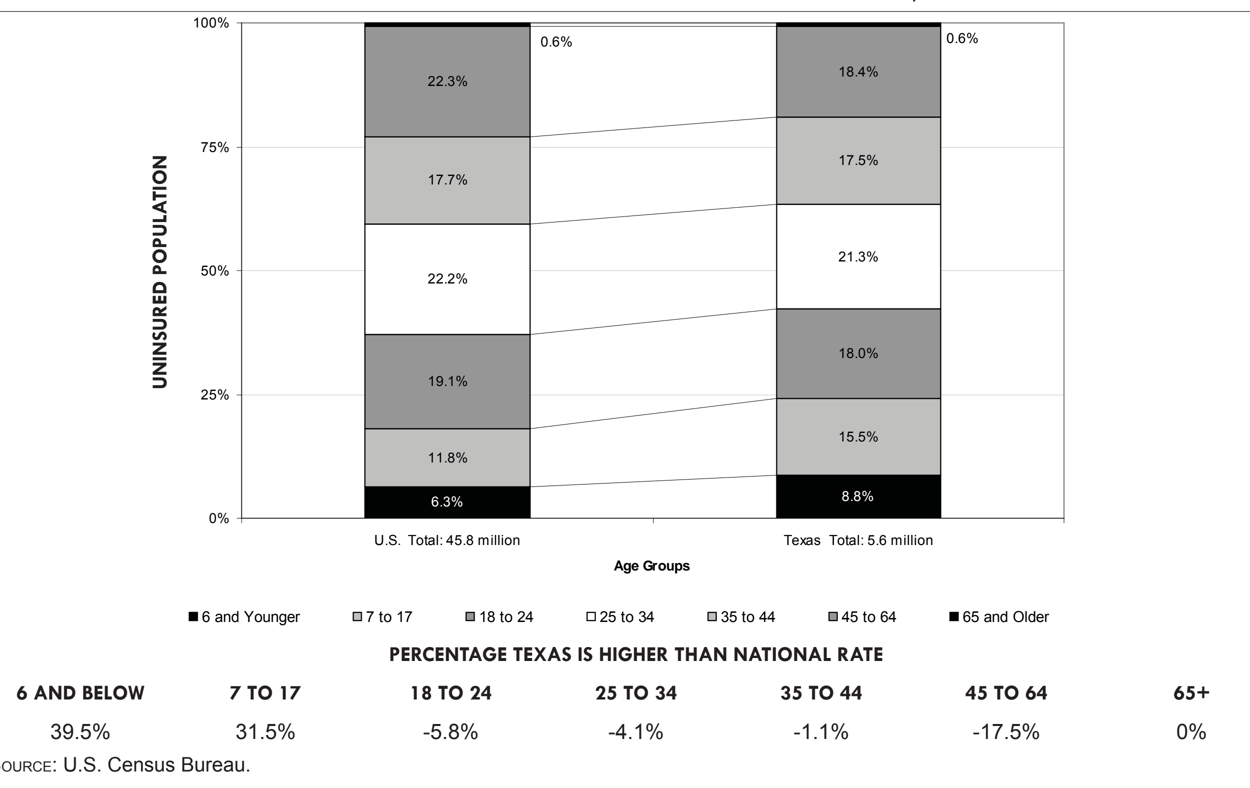


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

UNDER 50%	50% TO 99%	100% TO 149%	150% TO 199%	200% TO 249%	250% AND GREATER
1.7%	34.8%	12.0%	4.2%	-3.7%	-18.1%

SOURCE: U.S. Census Bureau.

FIGURE 9
AGE DISTRIBUTION OF UNINSURED TEXANS COMPARED TO U.S. UNINSURED POPULATION, 2004

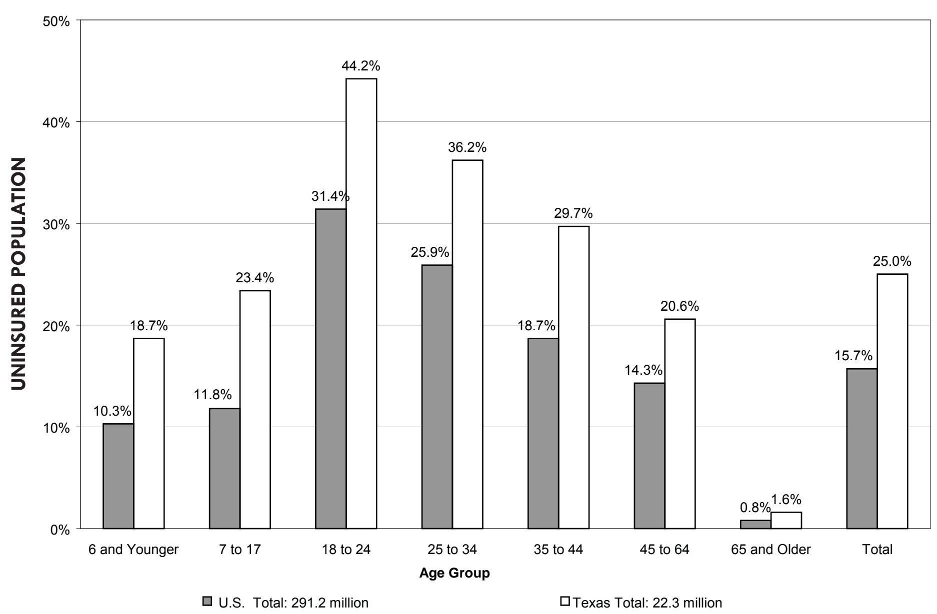


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

6 AND BELOW	7 TO 17	18 TO 24	25 TO 34	35 TO 44	45 TO 64	65+
39.5%	31.5%	-5.8%	-4.1%	-1.1%	-17.5%	0%

SOURCE: U.S. Census Bureau.

FIGURE 10
PERCENTAGE OF UNINSURED TEXANS WITHIN AGE GROUPS COMPARED TO U.S. UNINSURED POPULATION, 2004



PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

UP TO 6	7 TO 17	18 TO 24	25 TO 34	35 TO 44	45 TO 64	65+	TOTAL
81.9%	98.3%	41.0%	39.8%	58.8%	44.1%	100.0%	59.2%

SOURCE: U.S. Census Bureau.

This is significant because Texas puts most of its Medicaid efforts into assistance for children. Despite this resource allocation, Texas children have a greater tendency to be uninsured than the national rate.

RACE OF UNINSURED TEXANS

Approximately 60 percent of the total Texas uninsured population (5.6 million) is Hispanic, about twice the frequency of the national rate (out of 45.8 million), as shown in the distributions in **Figure 11**. **Figure 11** also shows the racial categories for the entire populations of Texas (22.3 million) and the U.S. (291.2 million), demonstrating that the percentage of the Texas population that is Hispanic is more than twice the percentage of the U.S. population that is Hispanic. **Figure 12** shows that the percentage of uninsured Texans within racial groupings are similar to national rates for the entire population.

CITIZENSHIP STATUS OF UNINSURED TEXANS

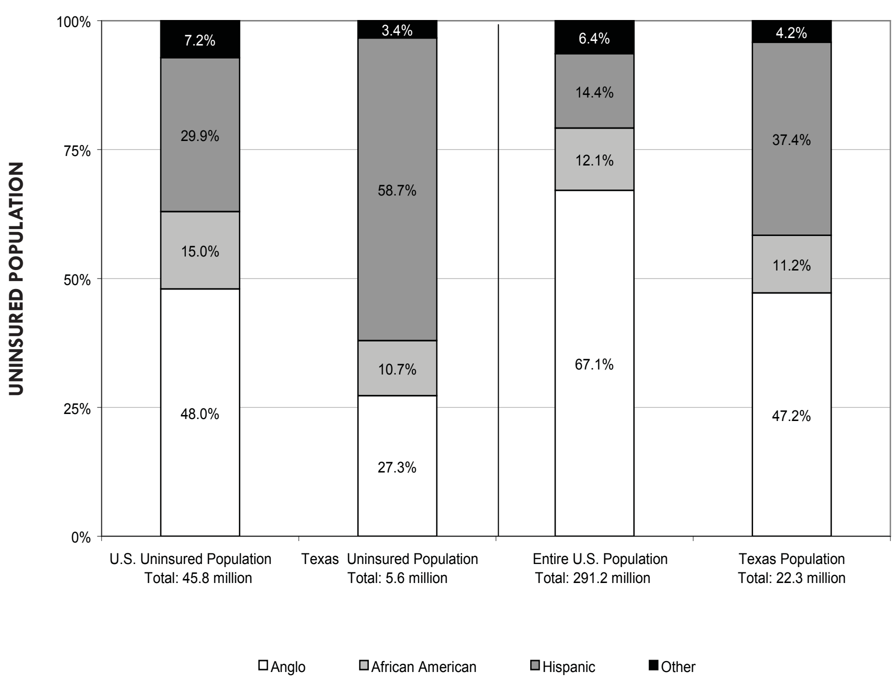
In Texas, naturalized U.S. citizens are nearly twice as likely to be uninsured than in the nation as a whole and more than 50 percent more likely to be uninsured than native U.S. citizens in Texas. **Figure 13** shows that nearly 58 percent of non-citizens in the entire Texas population (22.3 million) are uninsured, compared to 44 percent of non-citizens in the U.S. (291.2 million).

WORKING UNINSURED AND EMPLOYER SIZE

As **Figure 14** shows, the distribution of working uninsured Texans by employer size (2.7 million) is similar to the national distribution (out of 24.5 million). **Figure 15**, however, reveals discrepancies between Texas and the U.S. in the percentage of uninsured workers within employer size categories for the entire working population in Texas (10.3 million and 137.1 million in the U.S.), especially for businesses with 10 to 499 employees. Although most of the uninsured workers are employed by businesses with fewer than 10 employees or more than 1,000 employees as shown in **Figure 14**, Texas has a greater percentage of uninsured workers than in the national percentages in mid-sized businesses.

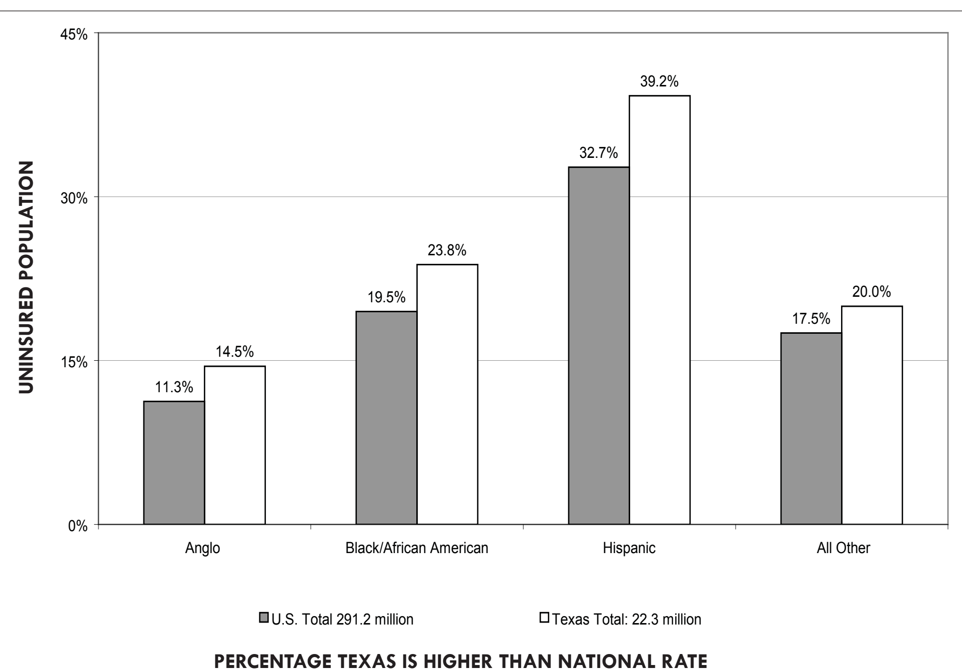
The growing costs of uncompensated care in Texas are related to the growing population of uninsured people in the state. If the state is to create effective public policy, Texas needs an accurate count and understanding of the uninsured population's demographic information.

FIGURE 11
RACE DISTRIBUTION OF UNINSURED TEXANS COMPARED TO THE U.S. UNINSURED POPULATION AND THE ENTIRE POPULATIONS OF TEXAS AND THE U.S., 2004



SOURCE: U.S. Census Bureau.

FIGURE 12
PERCENTAGE OF UNINSURED TEXANS WITHIN RACE CATEGORIES COMPARED TO U.S. POPULATION, 2004

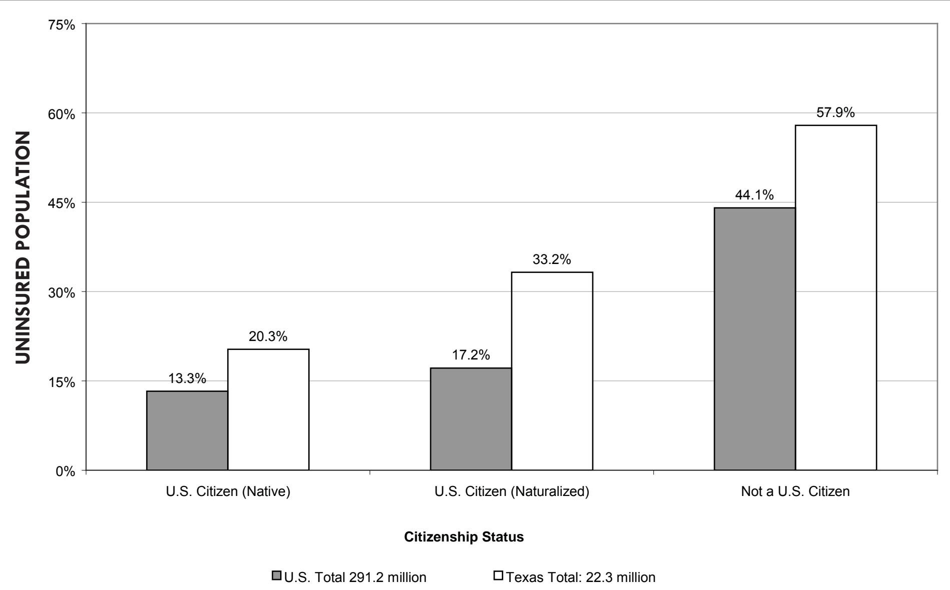


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

ANGLO	AFRICAN-AMERICAN	HISPANIC	ALL OTHER
28.3%	22.1%	19.9%	14.3%

SOURCE: U.S. Census Bureau.

FIGURE 13
PERCENTAGE OF UNINSURED TEXANS WITHIN CITIZENSHIP CATEGORIES COMPARED TO U.S. POPULATION, 2004

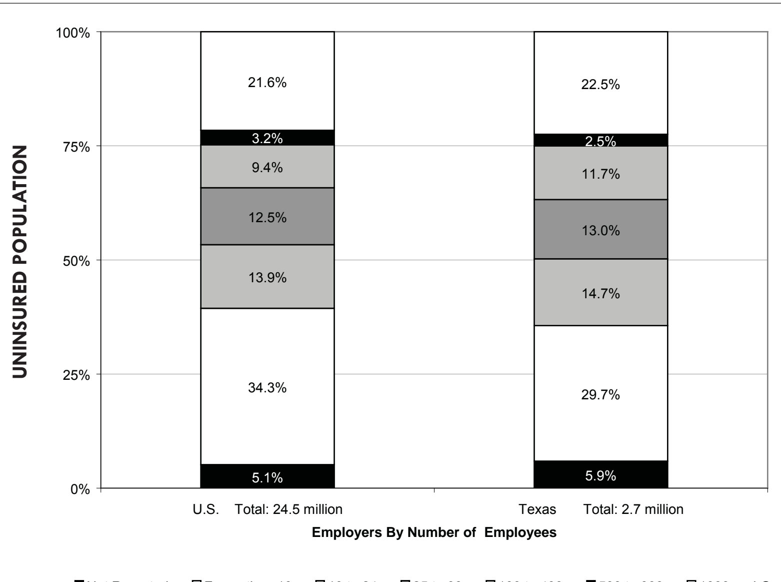


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

U.S. CITIZEN (NATIVE)	U.S. CITIZEN (NATURALIZED)	NOT A U.S. CITIZEN
52.6%	93.0%	31.1%

SOURCE: U.S. Census Bureau.

FIGURE 14
EMPLOYER SIZE DISTRIBUTION OF WORKING UNINSURED TEXANS COMPARED TO WORKING UNINSURED U.S. POPULATION, 2004

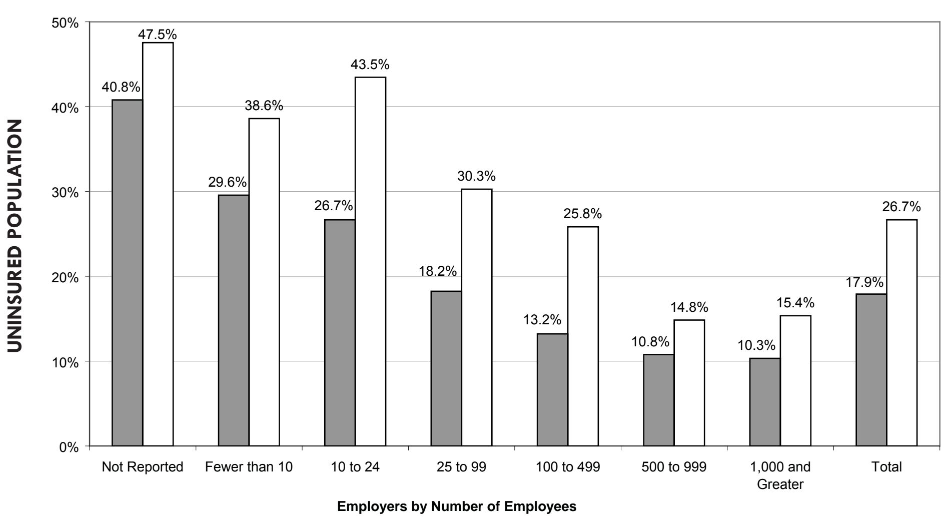


PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

NOT REPORTED	UP TO 10	10 – 24	25 TO 99	100 TO 499	500 TO 999	1,000+
15.7%	-13.4%	5.8%	4.0%	24.5%	-21.9%	4.2%

SOURCE: U.S. Census Bureau.

FIGURE 15
PERCENTAGE OF TEXAS UNINSURED WITHIN EMPLOYER SIZE CATEGORIES COMPARED TO U.S. POPULATION, 2004



PERCENTAGE TEXAS IS HIGHER THAN NATIONAL RATE

NOT REPORTED	UP TO 10 EMPLOYEES	10 TO 24 EMPLOYEES	25 TO 99 EMPLOYEES	100 TO 499 EMPLOYEES	500 TO 999 EMPLOYEES	1,000+ EMPLOYEES	TOTAL
16.4%	30.4%	62.9%	66.5%	95.5%	37.0%	49.5%	49.2%

SOURCE: U.S. Census Bureau.

STATE EFFORTS TO INCREASE ACCESS TO PRIVATE HEALTH INSURANCE

Since 1993, Texas implemented three programs to increase access to private health insurance coverage: (1) Consumer Choice Plans; (2) purchasing cooperatives and coalitions; and (3) the Texas Health Insurance Risk Pool. Consumer Choice Plans, also called limited-benefit plans, permit insurers to offer health insurance plans that eliminate certain state mandated benefits and allow new flexibility on higher deductible and coinsurance requirements. Purchasing cooperatives and coalitions allow businesses to aggregate their risk and thus negotiate more favorable rates from health insurance providers. The Texas Health Insurance Risk Pool is a high-risk pool for eligible Texas residents who cannot obtain health insurance because of pre-existing medical conditions. Twenty-five percent of Texans, approximately 5.6 million people, did not have health insurance coverage in 2004. As of 2005, approximately 125,000 Texans have coverage under these programs.

FACTS AND FINDINGS

- ♦ In 2004, almost 5.6 million Texans, or 25 percent of the population, did not have health insurance, while about 5.5 million Texans, or 24 percent of the population, had health insurance coverage through public sources and 11.6 million Texans, or 51 percent of the population, had private health insurance coverage.
- ♦ In 2005, 87,675 Texans were insured under group or individual Consumer Choice Plans, including 7,325 previously uninsured Texans.
- ♦ In 2005, there were between 5,000 and 10,000 Texans covered by purchasing cooperatives and coalitions in 2005.
- ♦ At the end of 2005, the Texas Health Insurance Risk Pool covered 28,132 Texans.

DISCUSSION

In 2004, 50.9 percent of Texans had private health insurance coverage, out of the total Texas population of 22.3 million people. Another 24.3 percent of Texans had health insurance coverage through public insurance and 25 percent of Texans were uninsured. These figures exceed 100 percent because some individuals or families have more than one type of coverage and are counted more than once. Of the uninsured Texans age 18 and older, 66.3 percent, or 2.7 million, were employed.

HEALTH INSURANCE COVERAGE IN TEXAS

Figure 1 shows the three broad health insurance coverage categories for the population of Texas:

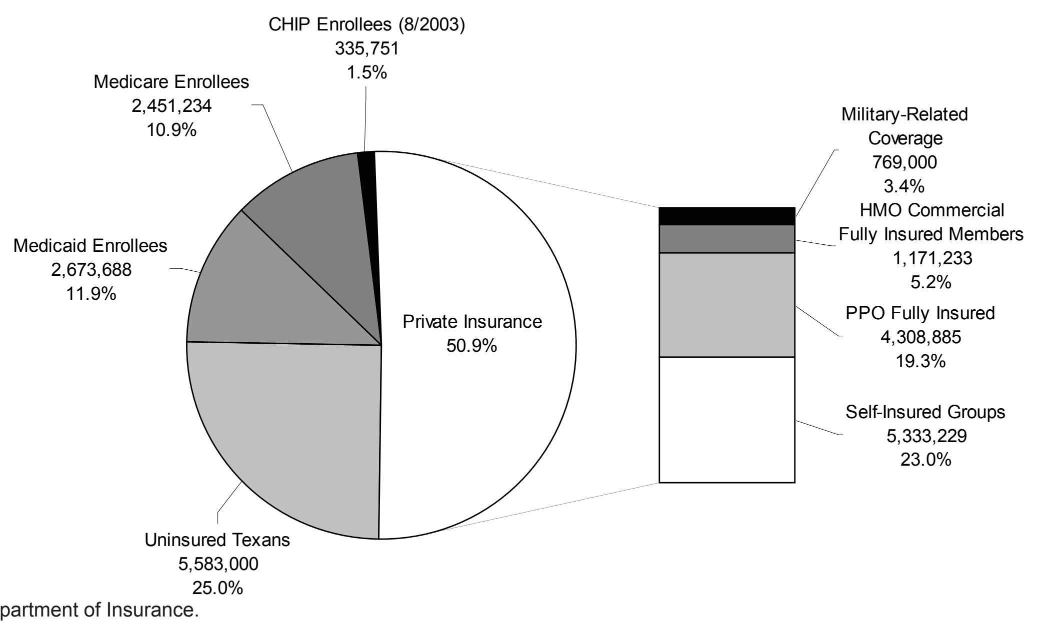
- Privately insured include approximately 50.9 percent of the Texas population, including consumers who access healthcare services through the private insurance market as provided by their employer or purchased individually;
- Publicly insured include approximately 24.3 percent of the Texas population, including consumers who access services through public programs such as Medicaid, the Children's Health Insurance Program, and Medicare; and
- Uninsured include approximately 25 percent of the Texas population, including all of those who have no health insurance.

HEALTH INSURANCE PREMIUMS

Figure 2 demonstrates how average annual health insurance premiums for employee-only (single) coverage in Texas rose 45.5 percent for all businesses between 1999 and 2003. **Figure 3** shows that average annual premiums for family coverage (for employees and dependents) rose 54.2 percent in the same period. The average rates do not consider policy differentials, such as deductibles and coinsurance requirements, which may affect the overall value of the plan. Additionally, the variation in premium amounts around the average rates can be significant. Some of the reported maximum premiums are more than 10 times greater than the average rates, and many groups, especially small businesses, do not qualify for average rates. In 2003, the highest maximum annual premium cost per person reported by a small business was $21,132. The maximum premium costs reported by small employer groups averaged $14,532, but the maximum premium costs reported by large employer groups averaged $5,330.

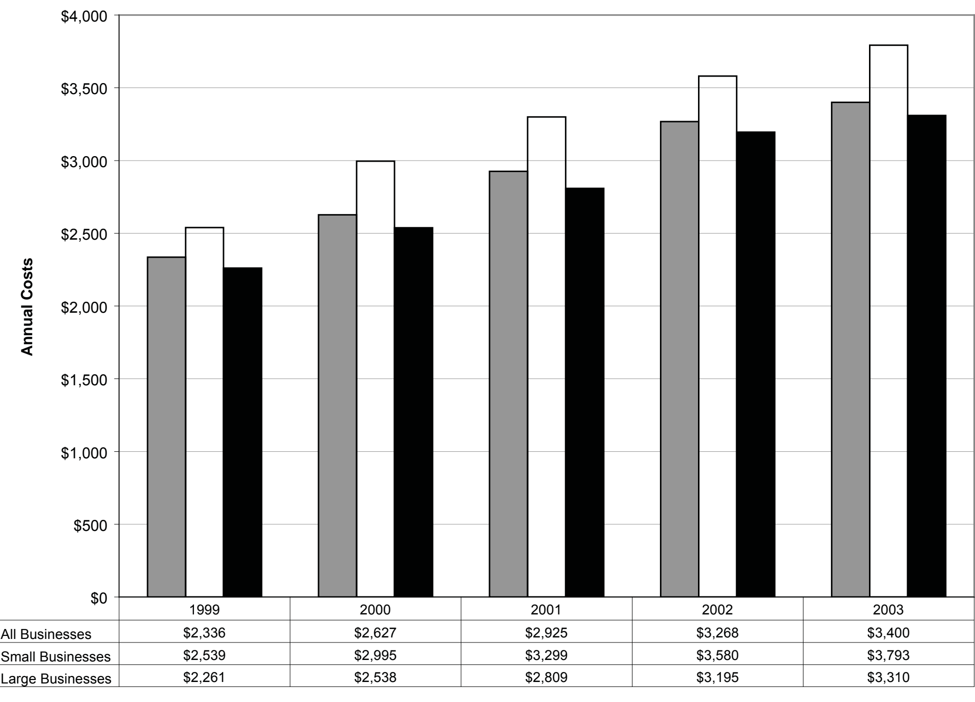
The consulting firm Price Waterhouse Coopers (PWC) estimated that, nationally, premiums increased 8.8 percent between 2004 and 2005. The factors contributing to this increase include general inflation, increased utilization, and

FIGURE 1
INSURANCE COVERAGE OF TEXAS POPULATION, 2004



SOURCE: Texas Department of Insurance.

FIGURE 2
AVERAGE ANNUAL SINGLE PREMIUMS IN TEXAS, 1999 TO 2003

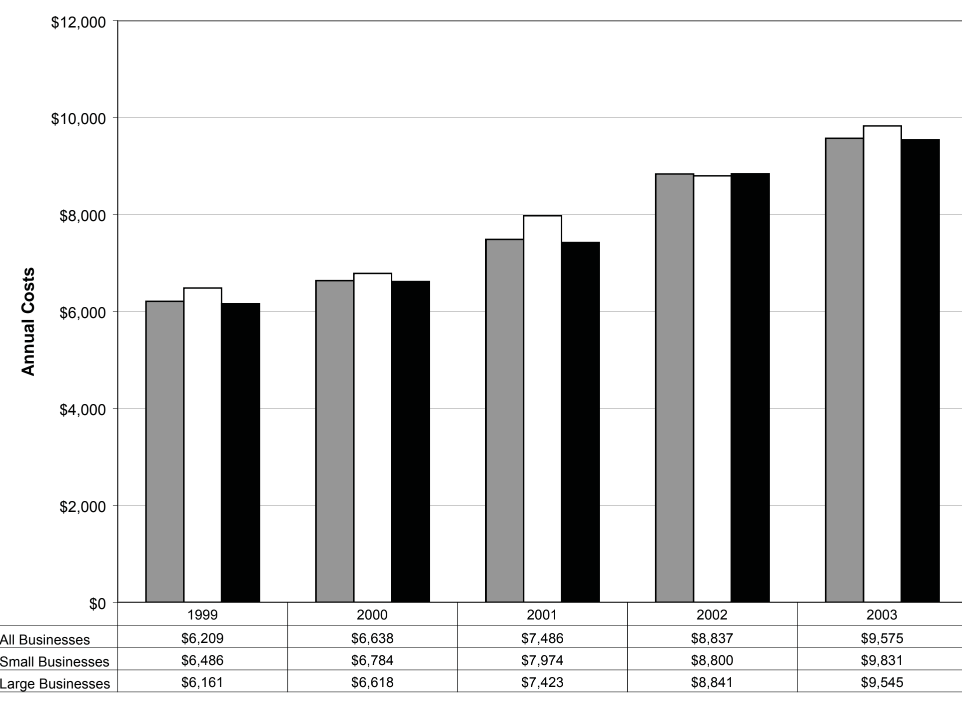


	1999	2000	2001	2002	2003
All Businesses	$2,336	$2,627	$2,925	$3,268	$3,400
Small Businesses	$2,539	$2,995	$3,299	$3,580	$3,793
Large Businesses	$2,261	$2,538	$2,809	$3,195	$3,310

SOURCE: Texas Department of Insurance.

price increases in excess of inflation (e.g., cost shifting). PWC estimated that 0.5 percentage points of this increase were the result of cost shifting from public providers and the uninsured to private payers. This estimate is based on the 0.1 percentage point increase in the number of uninsured Americans between 2003 and 2004. The number of uninsured Texans rose 0.4 percentage points during the same period.

FIGURE 3
AVERAGE ANNUAL FAMILY PREMIUMS IN TEXAS, 1999 TO 2003



	1999	2000	2001	2002	2003
All Businesses	$6,209	$6,638	$7,486	$8,837	$9,575
Small Businesses	$6,486	$6,784	$7,974	$8,800	$9,831
Large Businesses	$6,161	$6,618	$7,423	$8,841	$9,545

SOURCE: Texas Department of Insurance.

As **Figure 4** and **Figure 5** show, on average, employers paid a greater percentage of premium costs than employees did during 1999 to 2003. While the cost of single coverage rose 45.5 percent overall, the employer-paid portion rose from 80.8 percent to 83.9 percent of total cost. For family coverage, rates rose overall 54.2 percent, but the employer-paid portion rose from 71.0 percent to 73.2 percent of total cost. During that same period, the percentage of the Texas workforce that was both insured and employed decreased from 58.9 percent to 54.3 percent.

In 2003, 24.9 percent of the Texas private sector workforce was employed by small businesses, of which about half (47.9 percent) work in firms that offer insurance. Of that group, 83.4 percent are eligible for insurance, and 80.2 percent of eligible employees enrolled in the offered health plan. This means that 32 percent of all small business employees were enrolled in employer-sponsored insurance, compared to 61.5 percent of mid-sized and large business employees.

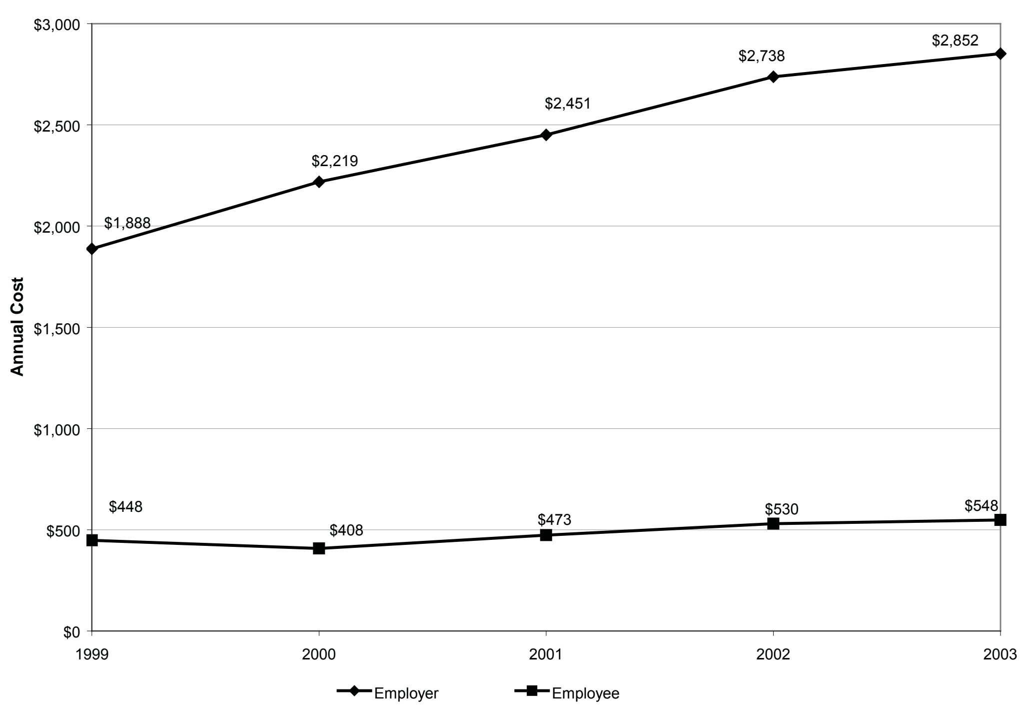
In 2003, 78.1 percent of full-time workers in Texas in businesses of all sizes were eligible for insurance and 66.5 percent were enrolled. However, only 18.8 percent of all part-time workers were eligible for insurance and only 7.4 percent were enrolled in the same period. In small businesses, part-time workers comprise 26 percent of the total workforce, but only 1.6 percent were enrolled in their employers' insurance plans in 2003.

According to TDI's Small Employer Health Insurance Survey, 54 percent of small business employers stated that they could afford $100 or less per employee every month for health insurance premiums. Thirty-four percent could afford $50 or less and 14 percent would not purchase insurance at any cost. Of those small businesses currently offering insurance, 17.7 percent stated that they were "very likely" or "almost certain" to discontinue that coverage within the next five years. Another 23.9 percent stated that they were "somewhat likely" to discontinue coverage, while 56.2 percent stated that they were "very unlikely" or "absolutely not likely" to do so. Cost is the primary reason why employers choose not to offer health insurance. Cost is also the primary reason why employees decline coverage when they do not have insurance elsewhere.

SUBSTITUTION OF PUBLIC INSURANCE

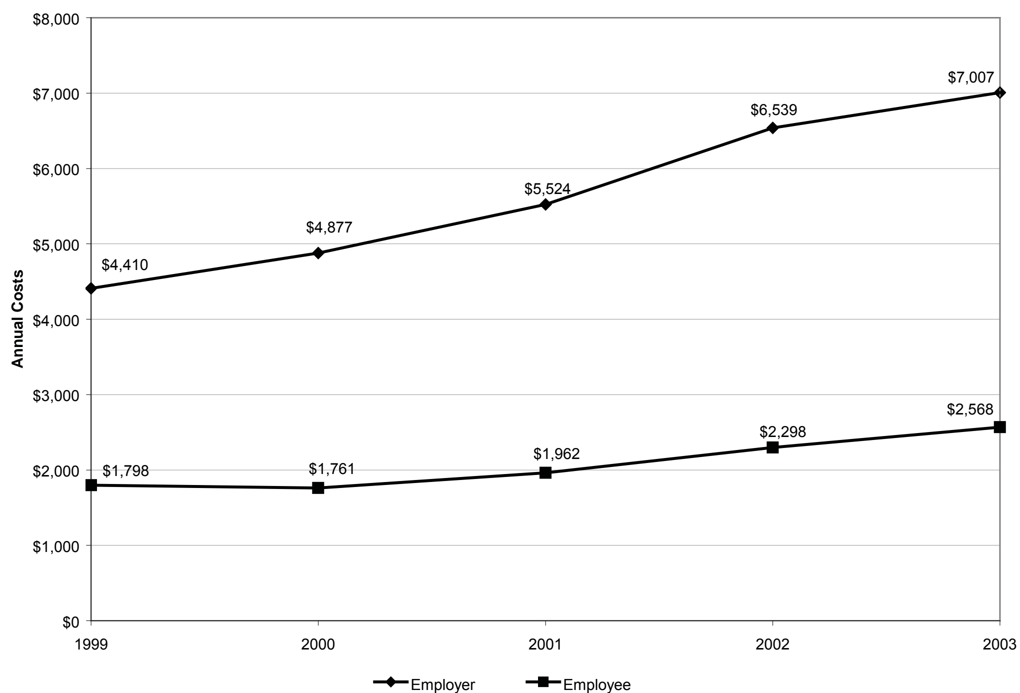
Sometimes privately insured people substitute public insurance coverage for their private insurance coverage, which is called "crowd-out." Crowd-out does not include situations where people dropping private insurance would have become uninsured without public insurance offerings.

FIGURE 4
AVERAGE SINGLE COVERAGE EMPLOYER AND EMPLOYEE CONTRIBUTIONS IN TEXAS, 1999 TO 2003



SOURCE: Texas Department of Insurance.

FIGURE 5
AVERAGE FAMILY COVERAGE EMPLOYER AND EMPLOYEE CONTRIBUTIONS IN TEXAS, 1999 TO 2003



SOURCE: Texas Department of Insurance.

The Robert Wood Johnson (RWJ) Foundation identified three types of crowd-out:

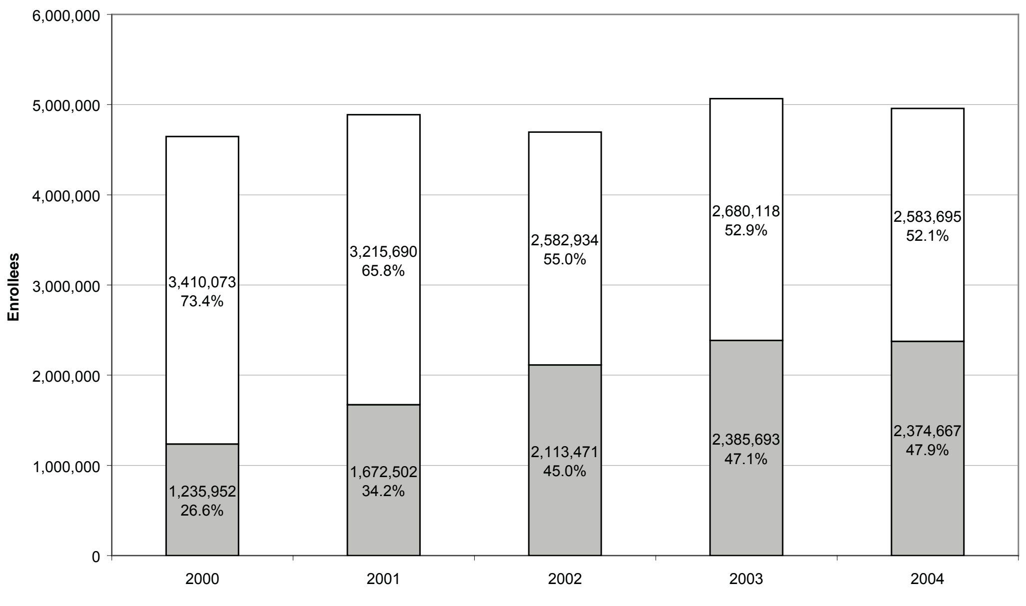
1) individuals or families drop private coverage for public coverage when they would have purchased or accepted private insurance if the public insurance were not available;
2) enrollees in a public program refuse private coverage when they would have purchased or accepted it if the public insurance were not available; and
3) employers force or encourage employees to drop private coverage in favor of public coverage when they would have offered private insurance if the public insurance were not available.

Because of the uncertainty regarding actions in the absence of available public coverage, crowd-out is difficult to measure. However, the RWJ Foundation found the following:

- higher rates of substitution of public insurance for private insurance, although not necessarily crowd-out, are more likely among families experiencing a large drop in income;
- some employers may drop coverage in response to expansions of public programs;
- allowing whole families to enroll in public programs may increase crowd-out; and
- dual coverage may reflect a desire for benefits that private insurance does not cover as well or at all.

Texas puts much of its public insurance efforts into assistance for children. Between 2000 and 2005, the percentage of Medicaid enrollees who were age 18 or younger has steadily grown from 60 percent to 70 percent. **Figure 6** shows public and private insurance coverage for the under-18 population from 2000 to 2004. Even though the total number of insured Texans age 18 or younger grew between 2000 and 2004, the percentage within both the total population and the under-18 population remained mostly constant. The percentage of this population insured through public insurance grew from 26.6 percent in 2000 to 45 percent in 2002, but it only grew another 2.9 percent between 2002 and 2004. The percentage insured through private insurance inversely decreased between 2000 and 2002, but has similarly slowed its rate of decrease between 2002 and 2004.

FIGURE 6
PUBLIC AND PRIVATE INSURANCE COVERAGE IN TEXAS, UNDER-18 POPULATION, 2000 TO 2004



Sources: Health and Human Services Commission; U.S. Census Bureau.

STRATEGIES TO INCREASE COVERAGE THROUGH EMPLOYER-SPONSORED INSURANCE

Texas began using new strategies to increase coverage through employer-sponsored insurance in 1993 when it instituted limited-benefit plans and purchasing cooperatives. The state attempted to expand insurers' ability to employ each of these strategies through legislation in 2003. The Texas Health Insurance Risk Pool, operational since 1997, is a safety net for high-risk Texans who cannot get coverage due to pre-existing medical conditions. **Figure 7**, provided by AcademyHealth, a professional society for health research and policy, shows the extent to which other states have implemented similar strategies.

FIGURE 7
STATE COVERAGE MATRIX, NOVEMBER 2005

STATE	HIGH-RISK POOL	LIMITED BENEFIT PLANS	PURCHASING COOPERATIVES AND COALITIONS	STATE	HIGH-RISK POOLS	LIMTED BENEFIT PLANS	PURCHASING COOPERATIVES AND COALITIONS
Alabama	✓			Montana		✓	✓
Alaska	✓			Nebraska	✓		
Arizona				Nevada			
Arkansas	✓	✓	✓	New Hampshire	✓		
California	✓		✓	New Jersey		✓	
Colorado	✓	✓		New Mexico	✓		✓
Connecticut	✓			New York			✓
Delaware				North Carolina			
District of Columbia				North Dakota	✓	✓	
Florida	✓	✓		Ohio			✓
Georgia		✓		Oklahoma	✓		
Hawaii				Oregon	✓		
Idaho	✓			Pennsylvania			
Illinois	✓			Rhode Island			
Indiana	✓			South Carolina	✓		
Iowa	✓			South Dakota	✓		
Kansas	✓		✓	Tennessee			
Kentucky	✓	✓		Texas	✓	✓	✓
Louisiana	✓			Utah	✓	✓	
Maine				Vermont			
Maryland	✓	✓		Virginia			
Massachusetts				Washington	✓	✓	
Michigan				West Virginia	✓		✓
Minnesota	✓	✓		Wisconsin	✓		✓
Mississippi	✓			Wyoming	✓		
Missouri	✓						

SOURCE: AcademyHealth.

CONSUMER CHOICE PLANS IN TEXAS

Consumer Choice Plans (CCPs), also called limited-benefit plans, permit insurers and health maintenance organizations (HMOs) to offer health insurance plans that eliminate certain state mandated benefits and allow new flexibility on higher deductible and coinsurance requirements. The rationale for CCPs is that mandated benefits create higher premiums, which makes insurance less affordable for employers and employees. By eliminating certain state-mandated benefits, CCPs would lower the cost of premiums, thus increasing employer-sponsored insurance and decreasing the number of uninsured Texans. As shown in **Figure 7**, 13 states use limited-benefit plans. In 2005, 87,675 Texans were insured under group or individual CCPs, up from 17,445 in 2004, including 7,325 previously uninsured Texans. As of June 1, 2006, the Texas Department of Insurance (TDI) had approved 73 CCPs.

The Texas Legislature initially gave TDI the authority to institute limited-benefit plans in 1993. The original limited-benefit plans had three tiers of coverage, each with mandates set by TDI in rule. After these plans sold poorly, the Texas Legislature modified the statute to establish two tiers of limited-benefit plans in 1995: Basic and Catastrophic. Both plans had various levels of benefits associated with them, but the Basic Plan had lower deductibles and out-of-pocket limits than the Catastrophic Plan, which had deductibles of $2,500 to $5,000 and annual out-of-pocket limits between $5,000 and $10,000. Even as the number of small employers with health plans rose between 1993 and 1997, the percentage buying limited-benefit plans dropped from 7.6 percent in 1993 to 6.1 percent in 1997.

Legislation enacted in 2003 abolished the prior limited-benefit plans and established CCPs, which provided for more flexibility in benefit coverage. The legislation became effective on September 1, 2003, and insurers and HMOs were authorized to begin selling CCPs on January 1, 2004. The mandated benefits CCPs are authorized to reduce or eliminate include, but are not limited to, contraceptive drugs and devices, coverage of AIDS/HIV, home healthcare services, and treatment for chemical dependency. CCPs could not reduce or eliminate certain other state-mandated benefits or federally mandated benefits. This legislation also allows insurers and HMOs offering CCPs to offer higher deductibles and coinsurance requirements than those already permitted. Insurers and HMOs must continue to offer full coverage plans with all mandated benefits alongside CCPs.

According to TDI, an actuarial firm found that the benefits most often excluded in approved CCPs were contraceptive drugs and devices, chemical dependency treatment, and coverage for acquired brain injury treatment and services. The firm further found that although providers offering CCPs reported cost savings ranging from less than one percent to over 35 percent, less than 3 percent of the savings was due to changes in mandated benefit provisions. The majority of the savings came from higher deductibles and co-insurance requirements, which were permitted under the statute, and exclusions of material benefits and changes in non-mandated but commonly included benefits.

PURCHASING COOPERATIVES AND COALITIONS IN TEXAS

Purchasing cooperatives and coalitions (PCCs) allow businesses to aggregate their risk and thus negotiate more favorable rates from health insurance providers. As of November 2006, Texas had 38 registered PCCs. The number of Texans covered by PCCs is unknown, but TDI estimated that between 5,000 and 10,000 Texans were covered by PCCs in 2005. Texas permits four types of PCCs: private purchasing cooperatives, health group cooperatives, sub (p) health group cooperatives, and small employer health coalitions. All PCCs must be nonprofit.

Legislation enacted in 1993 created private purchasing cooperatives to allow two or more small employers to act as a single employer when purchasing health insurance plans. As shown in Figure 8, these cooperatives only cover the purchase of benefits, and insurers may rate and issue coverage to cooperative members separately.

Legislation enacted in 1997 extended the statute to allow large employers to form private purchasing cooperatives under the same rules.

Legislation enacted 2003 created health group cooperatives. Health group cooperatives can be formed by any person other than an insurer or health maintenance organization (HMO) and must have at least 10 participating employers. As shown in **Figure 8**, health group cooperatives must be composed of either large employers or small employers. Employers that join one must commit to purchasing coverage through the cooperative for two years, but if they demonstrate financial hardship, may quit the cooperative. Health group cooperatives are not limited in size, but insurers must consider these cooperatives as single large employers for rating and issuance of coverage. Insurers and HMOs cannot offer coverage to two health group cooperatives in the same county, but they can offer limited-benefit plans similar to CCPs

FIGURE 8
PURCHASING COOPERATIVES AND COALITIONS

FEATURE	PRIVATE PURCHASING COOPERATIVES	HEALTH GROUP COOPERATIVE	SUB (P) HEALTH GROUP COOPERATIVE	SMALL EMPLOYER HEALTH COALITION
Minimum number of employers	2	10	10	2
Maximum number of employers	Unlimited	Unlimited	25	25
Maximum Group Size	NA	NA	50	50
Guaranteed Issuance of Coverage	No	No	Yes	Yes
Minimum employee commitment	None	2 years	2 years	None
Tax exemption	None	2 year exemption from certain taxes for each uninsured employee or dependent	2 year exemption from certain taxes for each uninsured employee or dependent	None
Size of Employers	Either small or large	Either small or large	Small only	Small only
Treated as single employer	Only for benefit elections	Yes, large employer	Yes, small employer	Yes, small employer
Issuance limits	None	1 per carrier per county, but expanded areas are permitted	1 per carrier per county, but expanded areas are permitted	None

Source: Texas Department of Insurance.

although governed under different statute. Legislation enacted in 2005 created a special category called sub (p) health group cooperatives, which can restrict membership to small employers, unlike regular health group cooperatives. The number of employees covered by a sub (p) health group cooperative must be between two and 50 to meet the statutory definition of a small employer.

Small employer health coalitions were created by legislation enacted in 2003. As shown in **Figure 8**, insurers must treat these coalitions as single small employers, meaning that issuance of coverage is guaranteed and all employers will be rated the same. As with a sub (p) health group cooperative, the number of employees covered by the coalition must be between two and 50 to meet the statutory definition of a small employer.

Public awareness of these options in Texas is low. For example, 72 percent of small businesses surveyed by TDI in 2004 were unaware that statute permits small businesses to create PCCs. However, 77 percent of the small businesses surveyed said they strongly support the idea of PCCs and 95 percent stated they wanted to participate in a PCC. TDI has information about PCCs on its website, but no statewide outreach or education campaign about PCCs has been done. A 2005 study by the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin recommended that the state help finance a public education campaign to increase awareness of existing PCCs. The study further recommended that the state offer incentives to insurers to work with PCCs in the form of rebates on premium taxes on all policies written for members of PCCs.

The legislation enacted in 1993 created the Texas Insurance Purchasing Alliance (TIPA), a statewide purchasing alliance governed by a state-appointed board of trustees. TIPA covered about 1,000 employers and 13,000 people at its greatest level of participation, but in 2000, the board of trustees decided that TIPA was unviable and voted to cease operations. As shown in **Figure 9**, TDI identified certain steps to reduce the difficulties faced by TIPA and other states' alliances. In the Texas State Planning Grant report of September 2006, TDI included the creation of a statewide PCC in its options to expand coverage.

THE TEXAS HEALTH INSURANCE RISK POOL

The Texas Health Insurance Risk Pool (THIRP) became operational in 1997 to comply with the federal Health Insurance Portability and Accountability Act (HIPAA), which requires states to guarantee access to health insurance in the individual market for certain eligible individuals. THIRP covers state residents under age 65 who, because of

FIGURE 9
COMPONENTS OF A SUCCESSFUL STATEWIDE PURCHASING ALLIANCE

- Involve agents and brokers from the beginning to assure effective marketing of the alliance.
- Limit the number of carriers allowed to participate in the alliance.
- Limit the number of health plan choices offered to a reasonable level that will allow for adequate enrollment and maximum administrative cost savings.
- Negotiate competitive rates with carriers.
- Implement strategies to reduce the risk of excessive adverse selection compared to the regular commercial market.
- Invest in a strong marketing and advertising program in the initial phase of the program to assure employers are aware of the availability of the alliance.

SOURCE: Texas Department of Insurance.

pre-existing medical conditions, cannot obtain health insurance substantially similar to THIRP's offering or can only obtain insurance that excludes coverage of their condition. Eligible Texans will also have had 18 months of previous health insuarnce coverage through an employer, church, or government plan, with no gap in coverage greater than 63 days, or have been diagnosed with a medical condition as established by THIRP's Board of Directors. As **Figure 7** shows, 32 states have high-risk pools. At the end of 2005, THIRP covered 28,132 Texans.

THIRP premiums cannot exceed 200 percent of the standard rate for comparable individual health insurance. THIRP has three plans with increasing deductibles: Plan One has a $1,000 deductible, Plan Two has a $2,500 deductible, and Plan Three has a $5,000 deductible. THIRP is financed with assessments on insurance companies, HMOs, and member premiums. In 2005, THIRP received $97.6 million in insurance company assessments and paid out $230 million in benefits. The remainder was collected from member premiums.

Legislation enacted in 2003 directed TDI to identify options to expand THIRP to include uninsured individuals without shifting costs from employers to the pool. In January 2005, TDI released a report on "Texas Health Insurance Risk Pool Expansion Options," which listed the following as options:

- Small employer buy-in, in which small employers could either join THIRP or shift an unhealthy employee out of their plans and into THIRP. TDI found significant legal obstacles to this option and TDI's actuarial consultant found this option beneficial only in limited cases.
- Risk pool eligibility revisions, in which individuals eligible for continued benefits under the Congressional Omnibus Budget Reconciliation Act could immediately enroll in THIRP if advantageous or individuals with limited-benefit plans who need more comprehensive coverage could purchase additional coverage from THIRP.
- Changes in operations and funding that would allow THIRP to qualify for Federal Funds, which would require legislation limiting THIRP premiums to 150 percent of the standard rate.
- Modifying insurance company assessments to spread excess loss over a wider group, in which THIRP would collect insurance company assessments based on lives covered rather than premium volume, which TDI stated would offset some of the revenue loss if THIRP premiums were limited to 150 percent of the standard rate.
- Reducing premium costs, in which THIRP could reduce benefits, which TDI stated would be counter-productive to the program, increase cost sharing provisions, such as higher deductibles and coinsurance, or provide premium subsidies or discounts to low-income individuals.

None of these options have been implemented.

Other states have used these programs and others, such as reinsurance and Medicaid waivers, to increase health insurance coverage rates. Texas implemented these three programs, but needs to do more to reduce the state's uninsurance rate. Developing a long-term strategic plan to accomplish this goal is the first step towards higher insurance rates in Texas, and these programs may play a role in producing that result.

UPDATE ON FEDERAL AND STATE EMPLOYER HEALTH INSURANCE MANDATES

Obtaining health insurance through the workplace is how many Americans aged 18 to 64 receive health coverage. In Texas, 47.5 percent of the population is covered through a health maintenance organization, a preferred provider organization, or a self-insured group. Most uninsured Texans are either employed or live in families with an employed adult. In 2004, according to the Texas Department of Insurance, 2.6 million Texans were employed and uninsured. Identifying employers who do not offer health insurance and whose employees and their dependents qualify for public health insurance programs is a growing concern as Medicaid budgets and uninsured rates increase.

Presently, 28 states are pursuing or pursued legislation commonly referred to as "Pay or Play." With this approach, employers either provide healthcare coverage for their employees, thereby "playing," or pay a tax allowing the government to provide health insurance coverage. A major obstacle to states enacting "Pay or Play" laws is the federal pension reform law, the federal Employee Retirement Income Security Act of 1974. The act includes broad preemption language providing that the federal law supersedes all state laws that "relate to" employee benefit plans sponsored by private-sector employers or unions. Two states, Maryland and Massachusetts, passed "Pay or Play" laws but none is implemented. Maryland's law is currently tied up on appeal in federal court, while Massachusetts' law is part of a larger statewide healthcare reform package and is not yet implemented.

FACTS AND FINDINGS

- Congress enacted the federal Employee Retirement Income Security Act of 1974 to prevent fraud and mismanagement in private-sector employer pension plans. The Act has broad preemption language stating that federal law supersedes all state laws that "relate to" employee benefit plans sponsored by private-sector employers or unions.
- Hawaii is the only state allowed to require employers to provide a minimum level of healthcare benefits to their workers, including employers that self-insure. Hawaii was granted a special exemption by Congress.
- Two states, Maryland and Massachusetts, have passed "Pay or Play" laws to expand health insurance coverage but neither has been implemented.

DISCUSSION

Employer mandates were an important component of previous efforts to create universal health insurance throughout the United States in the 1970s and 1990s. Employer mandates come in two forms. One requires employers to provide their employees with health insurance by paying a portion of the premium, while the second form allows employers to either provide health insurance to employees or pay a tax. Hawaii is the only state using the first form.

"Pay or Play" laws are a type of employer mandate used to expand health insurance coverage. According to the National Academy for State Health Policy, a state "Pay or Play" program would impose a tax on all employers (public and private) as one source of revenue to finance a public health coverage program but give employers credit against the tax for current costs of any coverage provided to employees and dependents.

ERISA'S EFFECT ON EMPLOYER MANDATES

Congress enacted the federal Employee Retirement Income Security Act of 1974 (ERISA) to prevent fraud and mismanagement in private-sector employer pension plans. ERISA provisions also apply to other types of employee benefit plans including health insurance coverage. The ERISA statute has broad preemption language stating that federal law supersedes all state laws that "relate to" employee benefit plans sponsored by private-sector employers or unions. In other words, it prohibits states' attempts to mandate that employers offer health insurance and preempts other state laws directed at employer-sponsored health plans. For example, a state law requiring that employer-sponsored health insurance plans cover a minimum set of benefits or that employers contribute at least a minimum percentage of the premium would raise ERISA preemption issues. Conversely, ERISA does include exceptions to preemption, one of which allows states to regulate insurance.

According to the National Academy of State Health Policy, "Congress' purpose in enacting the preemption clause was to

minimize the administrative and financial burdens of conflicting state laws facing interstate employers that wished to develop uniform national plans." Under ERISA, states retain the authority to regulate insurance. However, ERISA prohibits a state from considering a self insured employer plan to be an insurer. ERISA's preemption language creates a distinction between self-insured health coverage plans (that states cannot regulate) and insured plans (that states can affect by regulating insurance products they buy).

No courts have considered a state employer "Pay or Play" law until now. Maryland's "Pay or Play" law is the first to undergo court scrutiny. The Retail Industry Leaders Association challenged the law in federal court in February 2006. Policymakers and employers across the country are watching to see the final outcome of this case. **Figure 1** shows the timeline of major events associated with Maryland's "Pay or Play" law.

OTHER STATES AND EMPLOYER MANDATES

Twenty-eight states are pursuing or pursued legislation known as "Pay or Play". While Hawaii is the only state with an exemption to ERISA, **Figure 2** shows two states, Maryland and Massachusetts, passed "Pay or Play" legislation. California's most recent attempt at a "Pay or Play" law failed in September 2006 when the governor vetoed a bill. This bill would have required employers with 10,000 or more employees to contribute to a special fund to help pay for the difference between health insurance coverage provided by the employer and the state's Medicaid program. Other states such as Oregon and Washington attempted "Pay or Play" laws as early as 1989.

Hawaii is the only state allowed to require employers to provide a minimum level of healthcare benefits to their workers, including employers that self-insure. Hawaii was granted a special ERISA exemption by Congress. Hawaii's Prepaid Health Care Act, implemented in 1975, requires that employers must provide health insurance for all employees working 20 or more hours a week. Those not covered by the law are "employees working fewer than 20 hours a week, government employees, small family businesses, the unemployed, seasonal workers, and Medicaid beneficiaries" and are covered by a program established in 1989 known as the State Health Insurance Plan.

Employers in Hawaii can choose one of the following three ways to provide mandated coverage to their employees:

1. Purchase an approved health plan that is required to have certain benefits. Employers can decide which of two health plans (comprehensive or less comprehensive) to offer their employees. In addition, employers must pay at least 50 percent of the premium cost but can require the employee to contribute an amount up to 1.5 percent of wages.
2. Purchase an insured plan of the employers' choice. Employers' must submit their health plan choice for the Hawaii Department of Labor to review and approve.

FIGURE 1
MARYLAND PAY OR PLAY LAW TIMELINE

April 2005—Maryland lawmakers approve the Fair Share Health Care Fund Act (Pay or Play). It requires companies with more than 10,000 employees to spend at least 8 percent of their payroll on health benefits or pay the difference to a state fund for health insurance for the poor.

May 2005—Maryland governor vetoes Pay or Play law.

January 2006—Maryland lawmakers vote to override their governor's veto of the Pay or Play law.

February 2006—The Retail Industry Leaders Association (RILA) files suit seeking to invalidate Maryland's Fair Share Health Fund Act.

July 2006—Federal judge rules the Maryland Fair Share Health Fund Act is preempted by ERISA because a state law is unable to impose health or welfare mandates on employers. In addition the judge rules that the Maryland law would have hurt Wal-Mart by requiring it to track and allocate benefits for its Maryland employees in a different way from how it keeps track of employee benefits in other states.

August 2006—Maryland Attorney General has said that the state expects to appeal the decision to the 4th Circuit Court of Appeals in Richmond, Virginia. In addition, the legislative leaders said that they would modify the bill and reintroduce it to respond to the court's objections. An expedited proceeding to the Federal Court of Appeals for the Fourth Circuit is expected so the court could rule on the case before the January, 1, 2007 effective date of the Fair Share law.

November 2006—Maryland state attorneys argue before a federal appeals court to appeal ruling against Fair Share Health Care Fund Act.

Source: Legislative Budget Board.

FIGURE 2
STATES PURSUING PAY OR PLAY LEGISLATION (AS OF AUGUST 2006)

1.	Alaska – Failed	15.	Minnesota – Pending
2.	Arizona – Failed	16.	Mississippi – Failed
3.	California – Failed	17.	Missouri – Failed
4.	Colorado – Failed	18.	New Hampshire – Failed
5.	Connecticut – Failed	19.	New Jersey – Pending
6.	Florida – Failed	20.	New York – Pending
7.	Georgia – Failed	21.	Ohio – Pending
8.	Iowa – Failed	22.	Oklahoma – Failed
9.	Kansas – Failed	23.	Rhode Island – Failed
10.	Kentucky – One failed; one pending	24.	Tennessee – Failed
11.	Louisiana – Failed	25.	Virginia – Failed
12.	Maryland – Passed; Challenged in court	26.	Washington – Failed
13.	Massachusetts – Passed	27.	West Virginia – Failed
14.	Michigan – Pending	28.	Wisconsin – Failed

Source: National Conference of State Legislatures.

3. Provide a healthcare plan that is funded by the employer. To do this, employers must show proof of financial solvency and an ability to pay benefits.

In 1988, the Massachusetts Legislature passed the Health Security Act. This legislation required employers with more than five employees to pay a payroll tax to finance a public health coverage program while providing a credit for the costs of any employee health benefits the employer actually funded (up to the limit of the tax liability). Specifically, the law required employers to pay a 12 percent tax on the first $14,000 of wages or $1,680 or provide health insurance to their employees. The employer mandate would have gone into effect in 1992 but was postponed by the legislature in 1991, 1994 and 1995. The first postponement was due to a downturn in economic conditions statewide. Subsequent postponements were to gain time to develop alternative plans. Finally, the law was repealed in 1996 because no alternative plan could be identified for universal coverage and the state instead pursued a major expansion of Medicaid.

In April 2006, the Massachusetts governor signed into law legislation creating a system to provide nearly universal healthcare coverage for state residents. One component of the healthcare reform plan is to require both individuals and employers to purchase health insurance. For employers, this means those with more than 10 employees must provide health insurance or pay a "Fair Share" contribution of up to $295 annually per employee. More detailed information regarding Massachusetts' approach to near universal health coverage can be found in *Develop a Long-term Strategic Plan to Reduce the State's Uninsured Population* in this publication.

In 1989, Oregon enacted a law imposing a payroll tax on employers who did not provide employee and dependent health insurance coverage. The tax was to equal 75 percent of the cost of a basic benefits package (to be defined by the state agency) for employee coverage and 50 percent of this cost for dependent coverage. Small employers who voluntarily purchased insurance coverage would have received tax credits. Implementation was to be effective in 1995 but 1993 legislation delayed the mandate until 1997 for businesses with more than 25 employees. In 1995 a repeal of the employer mandate was passed by the legislature but vetoed by the governor. Finally, in 1996 the authority for the employer mandate expired because an ERISA exemption was not obtained from Congress by January 1996 as was required by the legislation.

In 1993, the Washington Legislature passed the Washington Health Services Act. It required large employers (more than 500 employees) to provide health insurance to employees by 1995 and their dependents by 1996. Employers choosing not to provide coverage would be assessed a percentage of their gross annual payroll based on the number of employees in the firm. The employer mandate was repealed in 1995 after the governor and key legislators left office. The mandate was never implemented.

The California Health Insurance Act was signed into law in 2003. The legislation extended coverage to workers while shielding small companies from the burden of paying for health coverage. Specifically, businesses with 50 or more workers would provide health coverage for workers and businesses with 200 or more workers would provide health coverage for workers and their dependents. The purpose of the bill was to make funding health coverage obligatory for medium and large-size businesses beginning in 2006.

According to the California Healthcare Foundation, firms that elected not to offer health coverage would be required to pay a fee to a state fund for each eligible worker. Employers that preferred to offer coverage or "play" could apply to the Employment Development Department for a credit against the fee. Firms offering coverage that met the minimum requirements of the bill would receive a credit against the fee.

Sharing costs of health insurance coverage would be borne by the employer and employee. The legislation required employers to contribute at least 80 percent to the premium and workers to contribute the remaining 20 percent. However, worker contributions were capped at 5 percent of wages for low income workers (defined as up to 200 percent of the Federal Poverty Level).

In November 2004, the legislation was put on a ballot under a referendum and narrowly defeated. It is no longer planned for implementation.

The California Healthcare Foundation conducted an in-depth implementation study and analysis of the state's 2003 "Pay or Play" legislation. Calculating the number of uninsured affected by the legislation was researched because it was one of the primary drivers for trying to expand employer-sponsored insurance.

The research estimated about two-thirds of California's uninsured are in working families. The California Health Insurance Act applied only to employers with 50 or more employees and would have required these businesses to contribute toward coverage for their workers. However for businesses with 200 or more workers, these employers would have been required to contribute toward coverage for their workers and their workers' dependents.

However, because almost all California businesses with 50 or more employees already provide health benefits (to at least some of their workers), the increase in coverage under this legislation would have come mostly from requiring employers that already offered coverage to cover more of their workers rather than requiring employers to begin offering coverage for the first time.

Moreover, the research indicates that of workers subject to the new legislation, only 1 percent work for an employer that does not offer coverage. Researchers theorize that if the legislation requirements applied to smaller businesses, then a larger share of the uninsured could have been covered.

As of this writing, California has not conducted any new analysis to assess the affect the state's latest attempt at ""Pay or Play"" legislation might have had. The California Governor vetoed the bill in September 2006.

STATUS OF EMPLOYER-SPONSORED INSURANCE IN U.S.

According to the Robert Wood Johnson Foundation, in 2003 the percentage of U.S. employees eligible for employer-sponsored health insurance who decided to enroll decreased from 85.3 percent to 80.3 percent. This percentage translates into 3 million fewer employees enrolled in optional employer-sponsored health insurance in 2003 than in 1998, in part because the of 42 percent increase in the cost of premiums. According to the report, the annual cost of health insurance premiums for an individual employee increased from an average of about $2,445 in 1998 dollars adjusted for inflation to about $3,481 in 2003.

Whether "Pay or Play" laws affect employer-sponsored insurance coverage is a frequently asked policy question. Since no "Pay or Play" laws have actually passed and been implemented, it is difficult to say. However, business groups generally oppose employer mandates for the reasons below.

Groups opposing employer health insurance mandates point to two studies that they say demonstrate "Pay or Play" laws negative effects on wages, job creation, and general economic growth. One study issued by the Employment Policies Institute in January 2006 indicates that employer mandates would not significantly help the number of uninsured because "those who experience loss of coverage over time are unemployed, employed part-time, employed at firms with fewer than 10 employees, or newly employed and have yet to accrue the tenure required for eligibility."

The second study also issued by the Employment Policies Institute found that "if a typical employer mandate proposal was broadened to apply nationwide, 45 percent of employees without insurance would see no increase in coverage." Moreover, the report says that a mandate would cause job loss for over 315,000 Americans and it would affect mainly

low-skilled employees, because employers would be forced to cut jobs to control higher labor costs.

EMPLOYER DISCLOSURE AND REPORTING REQUIREMENTS

Employer-sponsored insurance (ESI) is the backbone of the American healthcare system. The Kaiser Commission reports the numbers of uninsured people is increasing primarily due to a decline in employer-sponsored insurance. Additionally, the Kaiser Commission attributes part of the increase to jobs shifting from larger firms to businesses with less than 25 employees and self employment, and to industries that have been less likely to offer health benefits.

With ESI coverage declining and increasing concerns over the growing Medicaid budget, policymakers from across the country are interested in learning if Medicaid and State Children's Health Insurance Plan (S-CHIP) beneficiaries have the option of employer-sponsored insurance. If they do have access to ESI, enrolling them in Medicaid's Health Insurance Premium Payment (HIPP) program could reduce costs to the Medicaid program (see the Health Insurance Premium Payment Report in this publication) and if they do not have access to ESI, then policymakers want to know which employers are not offering health insurance and why. To determine this information, at least five states, Hawaii, Illinois, Maine, Massachusetts, and New Jersey have laws to report to state legislatures the number of employees on public health insurance. Sixteen other states are considering similar legislation. Establishing reporting requirements may be a first step to get policymakers the necessary information regarding the status of employer-sponsored insurance. **Figure 3** shows a summary of the reporting requirements enacted in five states.

TEXAS EMPLOYER REPORTING REQUIREMENT

A provision in House Bill 3, Seventy-ninth Legislature, Third Called Session, 2006, created a reporting provision for large employers to report the number of employees or their dependents who are enrolled in CHIP or Medicaid. Specifically the provision says, "A taxable entity that has more than 100,000 employees in this state shall file a report with the comptroller stating the number of the taxable entity's employees in this state that receive assistance for that employee or the employee's family under CHIP or the Medicaid program. A taxable entity described by subsection (a) shall file the report once a year on a form prescribed by the comptroller."

Texas' law differs from other states in that it places the responsibility of reporting workers enrolled in Medicaid and CHIP on employers instead of on the applicants to name their employers when applying for medical assistance. Requiring employers to report this information may cause inaccuracies in the reporting due to confidentiality and privacy issues for enrollees of medical assistance programs. Other states have their health and human services department prepare a report identifying employers with a specified number of employees on public assistance, while the Texas requirement has the Texas Comptroller of Public Accounts collecting this information. Lastly, Texas' reporting requirement is limited to employers with 100,000 or more employees in the state. According to the Texas Workforce Commission, there is one employer in Texas that currently meets this requirement and an additional 33 employers with 10,000 or more Texas employees. The reporting requirement takes effect January 1, 2008.

FIGURE 3
EMPLOYER DISCLOSURE AND REPORTING REQUIREMENTS

STATE	LAW
Hawaii	Requires applicants for medical assistance to disclose their employers. Dept. of Human Services must report to legislature employers with 25 or more employees on medical assistance. (SB 1772)
Illinois	Requires applicants for public health programs or uncompensated care in a hospital must report their employer. If unemployed, then most recent employer. Report naming employers with 25 or more employees on public assistance is prepared for legislature. (Known as the Public Health Program Beneficiary Employer Disclosure Act)
Maine	Requires applicants for Medicaid benefits to name their employer. Report naming employers with 50 or more employees on Medicaid is prepared and made public. Report also includes cost to state for providing Medicaid benefits per employer.
Massachusetts	Requires health and human service office to prepare report naming employers with 50 or more employees receiving uncompensated care or public assistance.
New Jersey	Requires the Commissioner of Human Services to report annually to the legislature those employers that have 50 or more employees enrolled in the NJ FamilyCare program. The report must include the cost to the state for providing for those beneficiaries and their dependents.

SOURCE: National Conference of State Legislatures.

APPLICATION OF "PAY OR PLAY" IN TEXAS

Putting aside the ERISA debate with "Pay or Play" laws, consideration should be given to the potential affect of "Pay or Play" on Texas' uninsured population. California's research regarding the affect of their "Pay or Play" legislation (had it not been overturned) offers Texas valuable information about the possible affect such a law would have on reducing the number of uninsured.

Like California, the largest group of Texas workers who are uninsured work for small businesses. Nearly 30 percent of the working uninsured in Texas are employed by a business with fewer than 10 employees and nearly 15 percent are employed by a business with 10 to 24 employees. This is the population most "Pay or Play" laws will not have any effect on because the legislation is usually aimed at getting large employers, not small, to provide health insurance for their workers.

In California, the legislation would have affected businesses already offering insurance and would have required them to cover more of their employees instead of increasing the number of businesses offering insurance that previously did not. According to the Texas Department of Insurance, in 2003, 97 percent of employees working for a large employer in Texas worked for an employer already offering insurance. And 76 percent of employees in large businesses where insurance is offered are already eligible for it.

Enactment of "Pay or Play" laws in other states is typically preceded by other efforts to ensure that the uninsured have access to health insurance. Maryland and Massachusetts, where the "Pay or Play" legislation has passed, but not yet been implemented, have already established programs such as premium assistance, pools, and expanded Medicaid populations. Texas does not have such programs and may consider pursuing intermediate steps, and establishing a long term strategic plan, before pursuing "Pay or Play" legislation.

INCREASE ACCESS TO HEALTHCARE BY EXPANDING "3-SHARE" PROGRAMS

With 25 percent of its population without health insurance, Texas has the highest percentage of uninsured residents in the nation. Two-thirds of uninsured Texans are working adults who either do not have access to health insurance or find it unaffordable. During the last several years, state and local programs known as "3-share" programs have emerged to expand access to healthcare and reduce number of working uninsured. In 3-share programs, three parties pay the healthcare premium: (1) employers, (2) employees, and (3) the public. Several states are now implementing these programs on a statewide level, but most 3-share programs are initiated on the local level. In Texas, the Health and Human Services Commission applied for a 3-share Medicaid waiver on behalf of Galveston County. Several other counties, including Harris, Bexar and Travis, have indicated an interest in 3-share programs.

Establishing more 3-share programs in Texas could have an affect on access to affordable healthcare, quality of care received by uninsured individuals and reduce the burden on state and local governments and healthcare providers.

FACTS AND FINDINGS

- ♦ Approximately 5.6 million or 25 percent of Texans do not have healthcare coverage.
- ♦ The majority of uninsured Texans are either employed or live in a family where at least one person is employed full-time.
- ♦ Approximately 2 million uninsured Texans have income above 200 percent of the federal poverty level and could contribute to the cost of health coverage if it were offered at an affordable rate.
- ♦ Though the number of people receiving access to healthcare through various governmental programs is rising, many uninsured working adults in Texas do not qualify for these programs because of eligibility requirements.

CONCERN

- ♦ Texas has only one 3-share program under development, even though these programs can be successful in providing access to healthcare services for working uninsured.

RECOMMENDATION

- ♦ **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill to appropriate $300,000 in fiscal year 2008 and $450,000 in fiscal year 2009 in General Revenue Funds (i.e., Insurance Maintenance Tax Funds) to establish an incentive fund at the Texas Department of Insurance, which will provide technical assistance and grants to areas with the highest number of uninsured residents or counties interested in developing and expanding 3-share programs to provide access to private healthcare coverage in the 2008–09 biennium.

DISCUSSION

States use various approaches to assist working uninsured citizens to access health coverage. Some states have effectively used premium assistance to enable uninsured individuals to obtain insurance through their workplace, since many uninsured individuals are employed. According to the Texas Department of Insurance (TDI), almost 67 percent of 4 million non-retired uninsured Texans over age 18 are employed. Several states including Texas implemented premium assistance programs that are based on Medicaid or Children Health Insurance Program (CHIP) funding. Even though the number of these programs is increasing, there are some barriers that hinder their expansion. Since funding for premium assistance is often tied to Medicaid or CHIP, states have to meet certain federal requirements, such as ensuring it is more cost-effective for the states to insure individuals through employer-sponsored insurance (ESI) and providing all benefits that individuals are eligible for under Medicaid. In addition, access to ESI may present an additional barrier for families and states to boost these programs.

During recent years, states have also started assessing opportunities to implement premium assistance programs under Medicaid Research and Demonstration Projects—Section 1115 (1115 waivers) that allow states to expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

While premium assistance can be a successful method to insure working adults who have access to ESI, many of the working uninsured do not have access to this type of coverage. In 2004, approximately 44 percent of all working uninsured

in Texas worked for companies with fewer than 25 employees. According to TDI statistics, during the same year about 75 percent of companies with less than 50 employees did not offer health insurance. This group requires a different approach in solving the access barrier. Many of the working uninsured are employed by small businesses that do not offer health insurance primarily because it is not affordable. Small businesses struggle to stay competitive with the added costs of the health insurance because they are often charged more for the same type of product compared to larger entities. Based on TDI data, in 2003, the aggregate average cost of a single person premium was almost more than 20 percent higher for small businesses than for large businesses.

Many small businesses indicate that they would offer health insurance if the price were more affordable. One-third of small businesses in Texas indicated that they would be able to contribute a monthly amount under $50 to healthcare coverage. Employees of small businesses are also in a less advantageous position than their counterparts in larger companies because many have to pay at least 50 percent of the premium amount. To address all of these issues and offer a more affordable product, some states and local governments introduced 3-share programs.

3-SHARE PROGRAMS IN OTHER STATES

A 3-share program is a healthcare coverage obtained with funding from three participating sides: (1) employers, (2) employees and (3) a so-called "community share". State and federal sources often fund the community share. However, local funding can pay for a portion of the community share and so can various funding streams including grants from philanthropic foundations. A 3-share program can encourage small businesses that have not offered health insurance before to provide their employees with such a benefit. Addressing access to health coverage for this population would significantly decrease the uninsurance rate.

Having three payers finance the health insurance premium makes the coverage more affordable, and therefore, more attractive to businesses and employees. As a result, in many cases, businesses are involved in developing the program and designing the benefits they offer. Based on the states' experience, an employer and employee share ranges up to $75 per month. A 3-share program is often not insurance, but rather a coverage of many healthcare services. If the program elects to use an insurance model, it then must meet state and federal requirements regarding benefits and financial reserves. Medical coverage models are not subject to the same requirements and may not be regulated by states' departments of insurance.

The original 3-share model started in 1999 in Muskegon County, Michigan with a financing pool from three sides including employer and employee contributions and community share financed by Local Funds and Federal Funds. During the seven years of its existence, it showed that the program can achieve its primary goal of establishing access to healthcare and remain economically sustainable. Founders of the model are helping other states, including Texas, by providing information about the necessary steps to establish 3-share programs.

Approaches to 3-share programs differ among program administrators. Some replicate the Muskegon County model and establish local programs, while others have implemented the program statewide. Those with locally based programs advocate for such design stating that it is the communities that know their needs and the communities are in touch with local businesses and are willing to research and identify sources of financial assistance to address their needs. According to the founder of the 3-share program in Michigan, in 1999 more than 1,600 communities applied for $20 million in grant funding from federal Health Resources and Services Administration, the agency responsible for improving access to healthcare services for "uninsured, isolated or medically vulnerable" individuals. Communities can also find assistance from various foundations that fund local programs addressing uninsurance.

Authors of the book published in 2002 *Out of the Box and Over the Barriers*, one of whom is the founder of the first 3-share model in Muskegon County, advocate for some degree of local funding, which makes ownership of the program stronger, brings awareness about healthcare costs, avoids entitlement stigma, and effectively integrates local businesses.

The specifics of 3-share programs vary among states and counties. **Figure 1** shows a summary of seven 3-share programs, two of which are implemented on a statewide basis. This summary includes information about monthly contributions from three sides, and program eligibility and benefit description. This list does not cover all 3-share programs that currently exist or are being developed in other states.

As **Figure 1** shows, every 3-share program is unique. A comparison of their attributes shows:

FIGURE 1
DESCRIPTION OF THE 3-SHARE OR SIMILAR PROGRAMS IN VARIOUS STATES

SOURCE OF THE COMMUNITY FUNDING	DESCRIPTION	ELIGIBILITY	TYPE OF BENEFITS
Muskegon County, Michigan: Employer 31 percent; Employee 31 percent; Community Share 38 percent. Implementation date: 1999 State's uninsurance rate: 11.3 percent.			
Access Health's community share is paid from Local Funds, which includes employer contributions, and Medicaid Disproportionate-Share Hospital (DSH) funds. At the time of the program's establishment, the state had available DSH allotments. State's share is contributed through intergovernmental transfers of county funds.	Access Health was created in 1999 and currently provides health coverage to 1,500 individuals from 400 businesses. The program is limited to providers in the county only. Almost 97 percent of all physicians in the county participate in the program. The program's budget in 2006 was $2.5 million, out of which $900,000 were DSH funds. About 64 percent of funds go to hospitals through a fee-for-service arrangement. The program is administered by a non-profit entity, which also provides case management. On average, monthly expenditures per person were in the range of $130. The plan is not regulated by the Department of Insurance and is not required to meet solvency requirements. The county used funding from the W.K. Kellogg Foundation to start the program.	Employers: • Small and medium size firms located in Muskegon County; • That have not provided health insurance within the last 12 months; • Full- and part-time employees with median wage not to exceed $11.50 per hour. Employees: • Retirees and temporary employees are not eligible; • Sole proprietors not eligible.	Covered services must be provided within the County: • Primary care and preventive services; • Inpatient and outpatient; • Emergency room care; • Prescription drugs; • Lab and x-ray; and • Hospice care. Covered individuals are required to pay co-payments for services. Individuals who do not follow the recommendations on treatments and lifestyle can be denied coverage for certain services.
Wayne County, Michigan: Employer 33.3 percent; Employee 33.3 percent; Community Share 33.3 percent State's uninsurance rate: 11.3 percent.			
Community share consists of county's hospital funds contributed through intergovernmental transfers and federal DSH funds. At the time of program implementation state still had available DSH allotment.	Four Star (services are provided by four major health systems) plans to cover up to 11,000 of the 250,000 county's uninsured individuals. Care is provided from participating physicians and 11 hospitals.	Employers: • Small businesses with 2 to 100 employees located in the county with 50 percent of their employees residing in Wayne county; • That have not provided health insurance within the last 12 months; • Half of the business employees should make less than $14 per hour. Employees: • Full- and part-time employees are eligible; • Seasonal employees are not eligible; • Spouses of the employees are eligible for coverage, but dependents are not.	Four Stars covers the following services, which are capped at $35,000 annually: • Primary care and specialty services; • Inpatient (up to 20 days/year) and outpatient (including behavior) care; • Emergency care – up to $1,000 per visit; • Lab and x-ray; • Prescription drugs ($2,500 annual limit); • Home care visits. Cost-sharing is required. Lifetime maximum benefit is capped at $200,000. Pre-existing conditions are covered with certain limitations.

FIGURE 1 (CONTINUED)
DESCRIPTION OF THE 3-SHARE OR SIMILAR PROGRAMS IN VARIOUS STATES

SOURCE OF THE COMMUNITY FUNDING	DESCRIPTION	ELIGIBILITY	TYPE OF BENEFITS
Winnebago County, Illinois: Employer 33.3 percent; Employee 33.3 percent; Community Share 33.3 percent (Total premium is $150 per month) State's uninsurance rate: 14.2 percent.			
Financing of the community share is done through changes in state's financing. Local units of government use "certified public expenditures" (CPE) mechanism to certify clinics' losses from treating Medicaid patients at below cost. The state matches CPEs and draws down Federal Funds that were not previously available. Additional Federal Funds allow the states to free up Local Funds that are used for the community share of the program.	Enrollment in the program is low (50 enrollees) even though the program has been in existence for several years. The program used funding from Health Resources and Services Administration to start the program.	Employers: • Small businesses with 3 to 25 employees and located in the county; • That have not provided health insurance within the last 6 months; and • Median wage of the employees cannot exceed $12 per hour. Employees: • Full- and part-time employees are eligible; • Seasonal and temporary employees are not eligible.	Covered services must be provided within the County: • Physicians office visits; • Emergency department visits; • Inpatient hospital stay; • Intensive care; • Skilled nursing facilities; • Inpatient mental healthcare; • Wellness care; • Lab and x-ray; • Prescription drugs; and • Discounted vision and dental care. Pre-existing conditions are covered. Cost-sharing is required.
Cabell County, West Virginia: Employer 14.4 percent; Employee 14.4 percent; Community Share up to 71.2 percent (Total monthly premium is $250) Implementation date: 2002 State's uninsurance rate: 16.9 percent.			
Community share consists of county funds and grants from federal Health Resources and Services Administration.	Offering the Uninsured of Cabell County Health care program started in 2002 and had 18 businesses enrolled in 2003. More than 250 providers and both local hospitals participate in the program. As of December 2006, about 90 individuals were enrolled in the program. The program negotiates discounted rates with the providers to serve more people. The program is exempt from insurance laws.	Employers: • Companies located in the Cabell County that meet income guidelines; • That have not provided health insurance within the last 12 months. Employees: • Working adults between the ages of 19 and 64 with income up to 200 percent of Federal Poverty Level; • Full- and part-time workers are eligible.	Covered services must be provided within the County: • Various medical services – primary care, hospital stay; • Lab and x -ray; • Prescription drugs; and • Vision and dental care. Pre-existing conditions are covered. There an annual cap of $3,000 per person. Each individual can decide what services he wants to receive with this amount.

FIGURE 1 (CONTINUED)
DESCRIPTION OF THE 3-SHARE OR SIMILAR PROGRAMS IN VARIOUS STATES

SOURCE OF THE COMMUNITY FUNDING	DESCRIPTION	ELIGIBILITY	TYPE OF BENEFITS
Arkansas: Employer is not required to contribute, but can choose to pay employee's share; Employee 10% to 25% (depends on income); Community Share up to 90 percent (Total monthly premium is $250). Implementation date: 2006 State's uninsurance rate: 17.2 percent.			
Arkansas Safety Net Benefit Program, which is a Medicaid Section 1115 HIFA waiver, will provide funding for adults with children with CHIP funds and use Medicaid funds for covering childless adults and providing wellness activities. The state will use tobacco settlements funds (which are used only healthcare expansions) as a state portion. The state planned to use employer share as part of a state share, but it was not approved by the Centers for Medicare and Medicaid Services. Phase I is planned to be rolled out in January 2007.	Anticipated number of individuals enrolled: Phase 1 (1 and 2nd year) – 15,000 Phase I and II – 80,000 individuals. Initial targeted monthly premium amount was $150. Currently, premium amount is estimated to be $250. The state assumes full risk for the program. The state's goal is to reduce the uninsured rate by four percent in Phase 1.	Employers: • Companies with full time employees between 2 and 500; • With Arkansas and/or federal tax ID number; • That have not provided health insurance within the last 12 months; • Willing to insure 100 percent of employees regardless of income. Employees: • Parents of Medicaid and CHIP children; • Childless adults between age 19 to 64 with income up to 200 percent of FPL; • Childless adults with income above 200 of FPL can buy in the program. The program provides single coverage to employees and their spouses.	The following benefits are provided on an annual basis: • Six physician visits; • Seven inpatient hospital days; • Two outpatient hospital services (surgery, radiology and emergency room visits); • Two prescription drugs (based on tiered formulary). Additional services including smoking cessation, preventive and wellness services will be included in the benefit package. Pre-existing conditions are covered by the program. Out-of-pocket coinsurance and deductible amount is limited to $1,000.
New Mexico: Employer 21 percent; Employee 0–10 percent (depends on the income); Community Share between 70 percent and 79 percent (Total monthly premium is $355). Implementation date: July 2005 State's uninsurance rate: 21.1 percent.			
State Coverage Insurance (SCI) Program, which is a Medicaid Section 1115 HIFA waiver, provides coverage to uninsured adults with the help of state and Federal Funds. State's share is $7 million in General Revenue Funds. Federal portion is funded with CHIP funds. Total budget of the program is approximately $20 million.	As of May 2006, SCI provided coverage to 4,500 adults. Benefits are provided through MCOs that are participating in Medicaid. Average capitated premium rate was $355, which was close to the Medicaid rate, even though fewer services are provided under SCI.	Employers: • Companies with fewer than 50 employees; • With New Mexico business license and state tax ID number; • That have not voluntarily cancelled health insurance within the last 12 months. Employees: • Uninsured adults (including childless) age between 19 and 64; • With income up to 200 percent of FPL; • That have not voluntarily cancelled health insurance within the last 6 months. Self-employed individuals can enroll if they pay employer and employee shares.	Benefits are capped annually at $100,000 and are similar to a basic commercial plan: • Primary and specialty care; • Inpatient and outpatient services; • Prescription drugs; • Lab and x-ray; • Physical, occupational and speech therapies; • Behavioral health and substance abuse services. Out–of-pocket maximum is 5 percent of employee's annual household income. Benefits are not conditioned on healthy behavior agreements.

FIGURE 1 (CONTINUED)
DESCRIPTION OF THE 3-SHARE OR SIMILAR PROGRAMS IN VARIOUS STATES

SOURCE OF THE COMMUNITY FUNDING	DESCRIPTION	ELIGIBILITY	TYPE OF BENEFITS
Galveston County, Texas: Employer 33.3 percent; Employee 33.3 percent; Community Share 33.3 percent (Total premium is $180 per month) Implementation date: Under development State's uninsurance rate: 25 percent.			
State Medicaid office applied for a Medicaid section 1115 HIFA waiver to cover this population. Community match will consist of General Revenue Funds already appropriated to the University of Texas Medical Branch (UTMB) and CHIP Federal Funds, local funds and federal grants. Assistance from Kempner Fund was used for the planning of the program.	The program estimates monthly rates of $180 per person. Over 5 years it is expected that 3,525 individuals will be enrolled in the program. Since federal regulation, excludes coverage of childless adults with CHIP funds, UTMB will provide community share for the affected 20 percent of the population with Local Funds or federal grants if approved. In federal fiscal year 2007, UTMB plans to expend almost $630,000 for the program (parents and childless adults combined), and in 2008, $1.7 million. The plan will be administered by UTMB's Choice One HMO, and is excluded from Texas Department of Insurance regulation.	Employers: • Small businesses with at least two employees that have been working for a company for one year (does not have to be the same individuals); • That have not provided health insurance within the last 12 months. Employees: • Parents of Medicaid and CHIP eligible children at or below 200 percent of FPL; • Childless adults with similar income; • It is a business' decision whether to include part-time employees; • If an employer does not want to participate, an employee can pay both shares.	The program will cover: • Primary care and specialty services – 12 visits a year; • Inpatient (maximum of 30 days/year) and outpatient services; • Emergency care – up to $1,000 per visit; • Lab and x-ray; • Prescription drugs ($1,200 annual limit); and • Mental health; • 10 percent coinsurance/with $1,000 annual maximum. Annual maximum benefit is capped at $50,000.

SOURCES: Legislative Budget Board.

- Employer eligibility: Some programs limit eligibility to companies with 25 employees, while others allow businesses with 100 employees to participate in the program. Statewide programs also differ significantly. Arkansas' program allows businesses with up to 500 employees to join the program, while New Mexico's program limits that number to 50. All programs established a requirement for a minimum amount of time a company has not been providing coverage to its employees prior to joining a 3-share program, which is between six and 12 months.
- Employee eligibility: Statewide programs cover individuals with income up to 200 percent of Federal Poverty Level, while county-based programs allow employers with employees' hourly wage up to $11.50 and $14 to participate in the program. Based on 2004 Texas Small Employer Survey, almost 1,500 companies out of 2,242 that do not offer health insurance employ individuals with hourly rates up to $15. Programs also differ in regard to allowing sole proprietors and employee's family members to participate in the programs.
- Premium contribution: County-based programs, with the exception of West Virginia's program, tend to equally divide monthly contributions among three payers. The community portion in statewide programs represents a larger portion of the premium amount. Overall, premiums costs at county level programs are less costly (between $150 and $180), while statewide programs appear to be more expensive. This might explain the need for a bigger subsidy on the community side to keep employee and employer contribution at a more affordable level.
- Benefits: All programs provide various health services with the emphasis on preventive care. Programs also do not deny coverage to the individuals due to pre-existing conditions. This is an important distinction from many commercial products that do limit coverage of such conditions.

Some programs also require participants to adopt healthy lifestyles in order to receive coverage for services. For example, Access Health, Muskegon County's program, implemented a coordinated care approach to ensure that individuals follow prescribed treatments. Since Access Health relies just on revenue it brings in and does not have reserves, even one case of extremely high claims could financially destroy the program. This is especially true due to high-risk populations that participate in the program:

- approximately 66 percent of program participants were smokers compared to 27 percent of county residents; and
- the occurrence of chronic diseases was twice as high as the county rate.

Taking all of these factors into consideration, program administrators implemented a strong case management program, which allows Access Health to help individuals manage their needs. Reimbursement, which is above the Medicare level by 12 percent, allowed the program to ensure that providers consistently communicate treatment and action plans with the program administrators. The program's nurse receives updates from the physicians about treatment plans and follows up with the consumers to make sure these treatment plans are followed. Even though the program can decline reimbursement for the services if a participant does not follow recommended actions, it does not deny services, and instead, encourages program participants to take corrective actions prior to approving services.

Figure 1 also shows that states with higher uninsurance rates have established 3-share programs on a statewide basis.

3-SHARE PROGRAMS IN TEXAS

Galveston County has taken steps to implement the state's first 3-share program. The University of Texas Medical Branch (UTMB) developed a 3-share waiver proposal, and the Health and Human Services Commission (HHSC) applied for a Medicaid 1115 waiver on behalf of the county to use CHIP Federal Funds to cover working uninsured who are parents of Medicaid- and CHIP-eligible children. During the planning stage, when UTMB surveyed businesses to assess their interest in the program, they found that 53 percent of businesses did not offer health insurance, and those who did, had to pay more than $400 a month per employee. Overall, the uninsurance rate in Galveston County was 30 percent, which is higher than the 25 percent state level. The goal of the 3-share program is to reduce the uninsurance rate in the county by 10 percent over 5 years. UTMB is not requesting additional appropriations of General Revenue Funds for the program, but plans to use existing appropriations to match Federal Funds for the community portion.

Based on the provisions in the federal Deficit Reduction Act of 2005, states can no longer provide coverage to individuals without children with CHIP Federal Funds. Since the 3-share waiver is proposing to use available CHIP funds, funding for "childless" individuals will have to be provided either with Local Funds or increased contributions from employers and employees. Texas has recently applied for a Medicaid transformation grant, which includes 3-share programs. HHSC submitted a request to fund a portion of the community funds in the Galveston 3-share program for childless adults in the amount of $590,873 for two federal fiscal years.

According to UTMB, many individuals who would participate in the 3-share program are already served by their facilities; however, the care is expensive, fragmented and concentrates on treatment versus prevention. To improve care coordination and achieve better health outcomes, UTMB plans to implement two tele-health clinics to provide 3-share participants with after-hours and weekend access to physicians. Establishment of electronic health records is also included in the plan.

There is a growing interest in 3-share programs from other Texas counties. In February 2006, Houston/Harris County developed a proposal for a 3-share program with the goal of providing coverage to 100,000 individuals in three years. Based on the county's estimation the uninsurance rate for individuals under age 65 in Harris County was 31 percent. Under this proposal, companies that do not offer health insurance or offer it at rates that are not affordable to the employees, and individuals with annual income under $50,000 could participate in the program. Harris County estimated that $90 million would be needed to pay the community portion ($50) of a $150 monthly premium to achieve its coverage goal. This amount includes $6 million for program start-up costs. The county sent this proposal directly to the Centers for Medicare and Medicaid Services (CMS), but CMS responded that these proposals need to go through the Medicaid waiver process at HHSC.

Travis and Bexar Counties are also evaluating a 3-share approach to address access to healthcare services for the working uninsured.

IMPLEMENTATION OPTIONS FOR TEXAS

Experience in other states has shown that 3-share programs can be implemented on a county or statewide level. States that have implemented programs statewide typically apply for 1115 waivers and for the most part use their available CHIP allocations (Federal Funds) to provide coverage for the working uninsured. Based on recent changes in federal rules, childless adults can no longer be covered with CHIP funds, but could be provided coverage by using Medicaid funds. States can also use DSH funds to finance community share, if they have not completely used federal allotments available to them or if healthcare providers are willing to use their DSH allocations for 3-share programs.

STATEWIDE IMPLEMENTATION

If Texas were to implement this program on a statewide basis through a Medicaid waiver with use of Medicaid and/or CHIP funds, several issues should be considered:

- The state has recently implemented a CHIP perinatal waiver, under which pregnant women would receive services related to their unborn children, by using CHIP funds. Based on HHSC projections, with the perinatal waiver in place, by 2014 the state would spend more that it receives in its CHIP allotment (Federal Funds) assuming no changes at the federal level.
- The state would have to identify resources for a state portion of the community share, which could be additional General Revenue Funds or Local Funds used as intergovernmental transfers, or certified public expenditures. The state could also evaluate current programs funded with General Revenue Funds, such as Community Primary Care Services, to see if these populations could be covered under 3-share programs. In addition, the possibility of using a small part of the Texas Enterprise Fund for the regions with new awards could be considered.
- If the state decides to implement changes to a Medicaid program through a comprehensive reform, funding for a 3-share program could be included in the reform proposal.

If the state decides to implement a 3-share program through a Medicaid waiver with use of Medicaid and/or CHIP funds, Texas would benefit from receiving CMS approval for a statewide program. HHSC sent the Medicaid waiver request related to the Galveston County 3-share program in December 2005. As of December 2006, a 3-share waiver proposal has not been approved by CMS. This experience shows that receiving CMS approval can be a lengthy process, which would be necessary for each county that would like to request to use Federal Funds for a community share.

However, among the statewide programs identified, healthcare premium costs appeared to be higher and participation from small businesses appeared to be lower than the locally implemented programs that were identified.

USE OF A LOCAL ASSISTANCE PROGRAM

With absence of a statewide program, the state could facilitate expansion of 3-share programs on local level through a technical assistance program to develop plan designs and/or provide grant assistance.

According to 3-share program administrators, planning of a program is essential to its success. Critical steps in designing a successful 3-share program include the following:

- Collection of information. At the beginning, program initiators conduct surveys, round table discussions, and polls to gather information about community characteristics, needs and terms on which businesses and individuals are willing to participate.
- Technical expertise. Knowledge of data collection methods and analysis of these data is crucial to develop the right product. If this step is not done correctly, the business community might not be interested in this program and participation would be low.
- Governing body. The program also needs to select a governing body responsible for organizational issues and community support to address access to healthcare.
- Model selection. When the analysis and studies are completed, planners must carefully choose between the insurance or coverage models depending on which would work best for their community.
- Program design. Contingencies must be anticipated to ensure stability during the early stages, especially if coverage model is selected. For example, based on other programs' experience, individuals with high needs are usually the first ones to apply for the program.

The steps necessary to establish a good program can be time consuming, expensive and administratively burdensome. Based on Texas' experience, UTMB contributed approximately $500,000 of in-kind salaries and support for the planning steps. $80,000 from the Kempner Fund

assisted the program to conduct research regarding benefit design and marketing.

Since planning a 3-share program requires resources and expertise and is critical to the program's success, the state could dedicate funds that counties could match with Local Funds for program development. In addition, there could be a designated expert who would provide technical assistance at the local level. This assistance would be especially valuable for counties with fewer technical and financial resources. Recommendation 1 would require TDI to provide technical assistance, and dedicate funds for grants, which would be awarded to local communities wanting to develop 3-share programs.

The state could approach awarding grants based on the uninsurance rate in the area. **Figure 2** shows the number of employed uninsured individuals age 18 to 64 by the metropolitan statistical areas. In addition to the uninsurance rate, grant allocation could incorporate regional characteristics of healthcare delivery. This is important because delivery of healthcare and related spending are not tied to county boundaries and residents of one county might receive services from healthcare providers in other counties. Development of a 3-share program could be done based on the most appropriate regional method of service delivery.

In its Medicaid Transformation Grants proposal, HHSC requested $500,000 in Federal Funds to be used as seed funds for up to five communities to develop and implement 3-share programs. CMS is scheduled to have grant awards in January, 2007. If Texas receives a $500,000 award of Federal Funds, then the state could use the General Revenue Funds appropriated under Recommendation 1 for the community share of 3-share programs ready to be implemented, or as grants for other communities interested in this program.

Texas should also monitor federal legislation that allocate additional funds for 3-share programs. In 2006, Congress considered a provision that would have allocated $36 million in grants to eligible public or nonprofit entities during federal fiscal years 2007 to 2013 for multi-share healthcare coverage projects for the working uninsured.

FIGURE 2
TEXAS UNINSURED EMPLOYED INDIVIDUALS AGE 18 TO 64 BY METROPOLITAN STATISTICAL AREAS, 2002 TO 2003

MSA	EMPLOYED INSURED	EMPLOYED UNINSURED	TOTAL EMPLOYED	EMPLOYED UNINSURED AS A PERCENT OF TOTAL EMPLOYED
Laredo	55,139	44,125	99,265	44%
El Paso	169,175	126,226	295,400	43
Brownsville-Harlingen-San Benito	66,666	40,785	107,450	38
McAllen-Edinburg Mission	99,829	55,431	155,259	36
Corpus Christi	100,831	54,995	155,826	35
Galveston-Texas City	114,542	52,926	167,467	32
Odessa-Midland	99,598	42,509	142,106	30
Houston	1,346,833	556,030	1,902,863	29
Beaumont Port Arthur	94,088	38,757	132,845	29
San Antonio	532,074	217,693	749,766	29
Dallas	1,489,023	527,182	2,016,204	26
Waco	116,792	40,068	156,860	26
Fort Worth-Arlington	737,436	249,388	986,824	25
Lubbock	74,843	24,206	99,048	24
Brazoria	111,299	30,296	141,595	21
Austin-Round Rock	531,884	141,700	673,583	21
Non-Metro (175 counties)	1,285,648	434,613	1,720,261	25
Total	**7,025,700**	**2,676,930**	**9,702,622**	**28%**

SOURCES: Legislative Budget Board; Health and Human Services Commission.

The following rider could be included in the General Appropriation Bill to implement Recommendation 1:

> **Three-Share Premium Assistance Programs**. Amounts appropriated above to the Department of Insurance of $300,000 in fiscal year 2008 and $450,000 in fiscal year 2009 in General Revenue Funds (i.e., Insurance Companies Maintenance Tax and Insurance Department Fees) in Strategy I.1.1, Three Share Assistance Programs and 1.0 Full-time Equivalent Positions (FTEs) each fiscal year included above in the "Number of Full-time Equivalent Positions (FTE)" for the purpose of awarding, through a competitive application process, grants to local government entities for the research, planning, and development of "three-share" premium assistance programs to increase access to private healthcare coverage for the uninsured, and providing technical assistance to grant recipients. The agency shall consider the following factors in selecting recipients of grant funds:
>
> - Proposals to match grant awards with Local Funds
> - Percentage of uninsured in the applicable area
> - Existing efforts in pursuing "three-share" premium assistance programs
> - Healthcare use and delivery factors affecting the area's healthcare infrastructure and capacity.
>
> The agency shall develop grant application requirements, process, and award criteria and shall report that information to the Legislative Budget Board and the Governor no later than January 1, 2008. The agency shall report a summary of the grants awarded to local government entities to the Legislative Budget Board and the Governor no later than January 1, 2009.

The 3-share approach is not a solution to solve all instances of uninsurance. Not all companies would be willing to participate in this program despite lower costs. According to TDI, 14 percent of small businesses indicated that they would not purchase health insurance at any cost. Furthermore, not all individuals would be able to participate because of high costs. However, this approach facilitates access to healthcare services for companies and individuals who are willing to contribute their share.

FISCAL IMPACT OF THE RECOMMENDATIONS

Establishing 3-share programs in Texas could have a significant affect on access to affordable healthcare, quality of care received by uninsured individuals and reduce the burden on state and local governments and healthcare providers. As shown in **Figure 3**, the recommendation would appropriate $750,000 in General Revenue Funds (i.e., Insurance Maintenance Tax Funds) to TDI in the 2008–09 biennium. It is expected that TDI would use available balances in TDI's Operating Fund, or increase its maintenance taxes to generate sufficient revenue to cover this appropriation.

Appropriating $750,000 would provide funding for 1 full-time equivalent at TDI and funding for several grants (estimated to be between 6 and 10) to counties to develop plans for 3-share programs.

The introduced 2008–09 General Appropriations Bill includes a rider appropriating $300,000 in fiscal year 2008 and $450,000 in fiscal year 2009 in General Revenue Funds (i.e., Insurance Maintenance Tax Funds) to provide grant awards and technical assistance to local communities to develop and implement 3-share programs.

FIGURE 3
ESTIMATED FISCAL IMPACT, FISCAL YEARS 2008 TO 2012

FISCAL YEAR	PROBABLE REVENUE GAIN TO GENERAL REVENUE INSURANCE MAINTENANCE TAX FUND	SAVINGS/(COST) TO GENERAL REVENUE FUNDS	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2006–07 BIENNIUM
2008	$300,000	($300,000)	1
2009	$450,000	($450,000)	1
2010	$450,000	($450,000)	1
2011	$450,000	($450,000)	1
2012	$450,000	($450,000)	1

SOURCE: Legislative Budget Board.

ALLOW U.S.-BASED INSURERS AND HMOS TO OFFER TEXAS-MEXICO CROSS BORDER HEALTH PLANS

Sixty-one percent of non-aged Texas residents living in the three most populous counties in the Mexico border region are either uninsured or insured through government-sponsored programs, including Medicaid and the Children's Health Insurance Program (CHIP). The lack of private health insurance coverage increases federal, state, and local government healthcare spending. Cost is a significant barrier to obtaining health insurance for both individuals and employers. Cross-border health plans present an opportunity to increase rates of private health insurance coverage. Under cross-border health plans, U.S. or Mexican insurers or health maintenance organizations (HMOs) contract with Mexican doctors or medical networks for the provision of non-emergency healthcare in Mexico. Plan enrollees may include U.S. citizens and/or Mexican citizens legally in the U.S. and their dependents. Cross-border health plans cost on average 40 percent less than plans that provide healthcare in the U.S. In California, two U.S. companies and one Mexican company currently offer fully-insured cross-border health plans.

People may obtain health coverage through fully-insured or self-funded group plans or directly from insurance companies on an individual basis. While self-funded plans may offer cross-border plans without state approval, current state regulations governing fully-insured group and individual plans prevent implementation of cross-border plans. To decrease the number of uninsured and reduce public healthcare expenditures, which total about $1.4 billion per year in the Texas border region, the Texas Insurance Code should be amended to allow insurers and HMOs based in the U.S. to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens.

CONCERNS

- Sixty-one percent of non-aged Texas residents living in the three most populous counties in the Mexico border region are either uninsured or insured through government-sponsored programs. Of the population under age 65 in Cameron, El Paso, and Hidalgo counties, about one-third (35.2 percent) are uninsured and about one-quarter (25.8 percent) are enrolled in Medicaid or the Children's Health Insurance Program. The remaining 39 percent have either private health insurance coverage or another type of government-sponsored health insurance, including Medicare or TRICARE.
- The lack of private health insurance increases federal, state, and local government healthcare spending in several areas, including: hospital uncompensated care, county indigent health care programs, community health centers, the Children's Health Insurance Program, Medicaid acute care expenditures, and Medicaid immigrant emergency services.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Insurance Code to allow U.S. based insurers and HMOs to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens.
- **Recommendation 2:** Amend the Texas Insurance Code to require the Texas Department of Insurance to conduct a study to evaluate the effectiveness of allowing insurers and HMOs to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens, including impact on the uninsured rate, public healthcare expenditures, and healthcare providers, and submit a report to the Legislative Budget Board and the Governor by January 1, 2011.
- **Recommendation 3:** Include a contingency rider in the 2008–09 General Appropriations Bill requiring the Texas Department of Insurance to submit a progress report on the status of implementing licensing and regulatory requirements related to fully-insured cross-border group and individual health plans and the status of the evaluation study to the Legislative Budget Board and the Governor by January 1, 2009.
- **Recommendation 4:** Include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 in General Revenue–Dedicated Funds to the Texas Department of Insurance for implementing licensing and regulatory requirements related to fully-insured cross-border group and individual health plans, and conducting a study to evaluate effectiveness.

DISCUSSION

Health insurance helps to ensure that individuals receive the healthcare they need and protects them from financial losses should an illness or injury occur. There are two classifications for health insurance plans: fee-for-service and managed care. Traditional insurance companies sell fee-for-service plans, also called indemnity plans, and providers receive a fee for services performed. Managed care plans, which include Preferred Provider Organization (PPO) plans offered by insurance companies and health maintenance organization plans, use networks of selected providers that have contracted with the plan to provide healthcare services to the plan's members. Depending on the type of managed care plan, enrollees may have the option to receive care from providers outside the network at a higher cost.

Many people receive health coverage as part of a group—such as an employer, professional association, or other organization—that offers health coverage to its employees or members. Others may buy individual health coverage directly from an insurance company or HMO. These policies can cover the purchasing individual only or include a spouse and dependents. Most Texans with health coverage are in group plans, through either their own employer or their spouse´s employer.

Group plans are either fully-insured or self-funded. Fully-insured plans are purchased from insurance companies or HMOs. The insurer bears the financial responsibility of guaranteeing claim payments and paying for all incurred covered benefits and administration costs. These types of plans are regulated by the Texas Department of Insurance (TDI). Self-funded plans are sponsored by groups with the financial ability to bear the costs and risks of coverage themselves. Groups that provide these plans set aside funds to pay the actual healthcare claims submitted to the plan. Even though an insurance company or HMO may administer the benefits, the group accepts the financial risk and must pay the healthcare costs. Self-funded plans, which are governed by the federal Employee Retirement Income Security Act (ERISA) and are therefore often called ERISA plans, are regulated by the U.S. Department of Labor. TDI has limited authority over self-funded plans.

The Texas Insurance Code does not explicitly authorize fully-insured group plans or individual plans to market, sell, or operate cross-border plans in Texas. Current state regulations governing these plans prevent implementation of these types of cross-border plans. For example, the Texas Insurance Code defines the term "physician" as only doctors who are licensed to practice medicine in Texas. This requirement would prevent insurers or HMOs from including any Mexican physicians in their networks unless they are also licensed in Texas. However, self-funded plans may offer cross-border plans without state approval. As a result, the Texas cross-border market is confined to self-funded plans. It is unclear to what extent existing self-funded plans in Texas are already operating cross-border services. **Figure 1** summarizes the types of health plans that are currently allowed to operate cross-border products in Texas.

FIGURE 1
TYPES OF HEALTH PLANS ALLOWED TO OPERATE CROSS-BORDER PLANS IN TEXAS

PLAN TYPE	CURRENT REGULATIONS ALLOW CROSS-BORDER PRODUCT
Fully-Insured	No
Group or Individual	
Fee-for-Service (indemnity)	
Managed Care (HMO, PPO)	
Self-Funded	Yes
Group	
Fee-for-Service (indemnity)	
Managed Care (HMO, PPO)	

Source: Legislative Budget Board.

BORDER REGION DEMOGRAPHICS

A number of demographic factors suggest that the state take action to increase the rate of private health insurance in the border region. **Figure 2** defines the border region for this report. This section describes the following demographic characteristics:

- population growth;
- citizenship status;
- uninsured rates;
- poverty rates; and
- type of insurance coverage.

Population growth: The 2005 population estimate for the 32-county border region is 2.4 million. The population in the border region increased 41.2 percent from 1990 to 2005 compared to 34.6 percent statewide. As shown in **Figure 3**, the population of several counties in the border region grew significantly between 1990 and 2005.

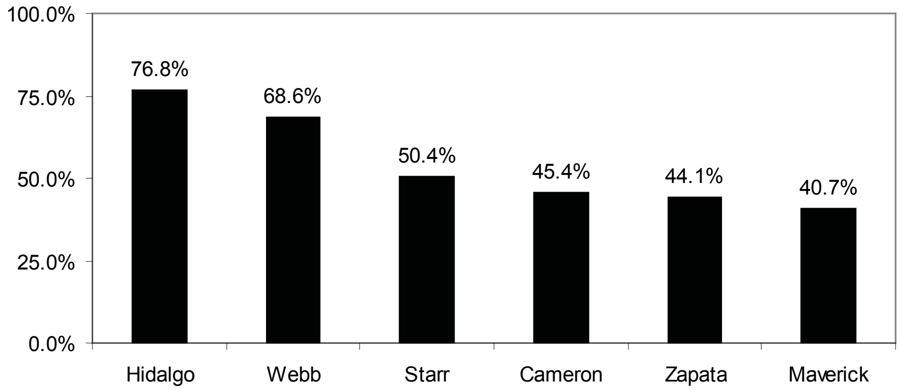
FIGURE 2
BORDER REGION DEFINITION

FOR PURPOSES OF THIS REPORT, THE BORDER REGION IS DEFINED AS THE AREA WITHIN 62 MILES OF THE RIO GRANDE IN THE LA PAZ AGREEMENT OF 1986 AND INCLUDES THE FOLLOWING 32 TEXAS COUNTIES:

Brewster	Duval	Jeff Davis	McMullen	Sutton	Zapata
Brooks	Edwards	Jim Hogg	Pecos	Terrell	Zavala
Cameron	El Paso	Kenedy	Presidio	Uvalde	
Crockett	Frio	Kinney	Real	Val Verde	
Culberson	Hidalgo	La Salle	Reeves	Webb	
Dimmit	Hudspeth	Maverick	Starr	Willacy	

SOURCE: Legislative Budget Board.

FIGURE 3
POPULATION PERCENTAGE CHANGE IN SIX BORDER COUNTIES: 1990 TO 2005



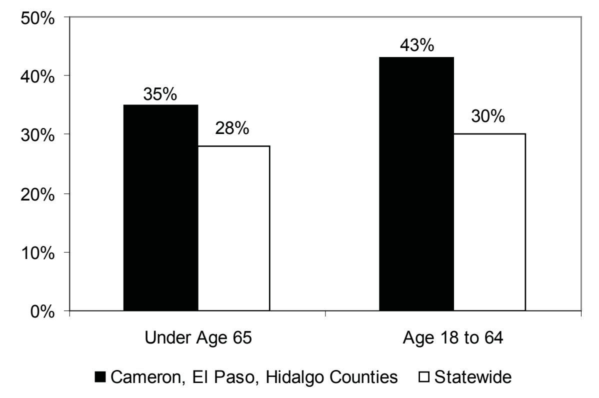
SOURCE: Legislative Budget Board.

Three counties comprise 75.2 percent of the total border region population: Cameron, El Paso, and Hidalgo. Because data was not available for all border counties, the remaining demographic information this report presents is for these three counties only.

Citizenship status: Of the total population in Cameron, El Paso, and Hidalgo counties, 72.9 percent are native U.S. citizens, and 27.1 percent are foreign born. Of the foreign-born population, 32.2 percent are naturalized U.S. citizens and 67.8 percent are not citizens, including lawful permanent residents, temporary migrants, humanitarian migrants, and persons illegally present in the U.S. Also, 85.3 percent of people in these counties are Hispanic.

Uninsured rates: As shown in **Figure 4**, the percentage of the population in Cameron, El Paso, and Hidalgo counties under age 65 without health insurance is approximately 35 percent compared to 28 percent statewide. The percentage of working age persons (i.e., age 18 to 64) in these counties without health insurance is approximately 43 percent compared to 30

FIGURE 4
UNINSURED RATE IN CAMERON, EL PASO, AND HIDALGO COUNTIES VERSUS STATEWIDE
3-YEAR AVERAGE FOR 2002–2004



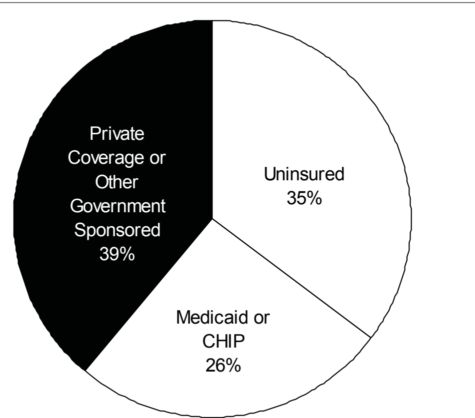
SOURCE: Texas Health and Human Services Commission.

percent statewide. The uninsured rate is even higher for the foreign-born population in Texas: 51 percent.

Poverty rates: The border region has higher poverty rates in comparison to the rest of the state. Almost one-third (32.8 percent) of residents 16 years of age and older in Cameron, El Paso, and Hidalgo counties had income in the past 12 months that was below the federal poverty level compared to 14.4 percent statewide. The 2006 federal poverty level for a family of four is $20,000. About two-thirds of residents under age 65 without health insurance in these counties have incomes below 200 percent of the federal poverty level.

Type of insurance coverage: Most non-aged Texas residents living in the three most populous counties in the border region are either uninsured or insured through government-sponsored programs, including Medicaid and CHIP. As shown in **Figure 5**, of the population under age 65 in Cameron, El Paso, and Hidalgo counties, about one-third (35.2 percent) are uninsured and about one-quarter (25.8 percent) are enrolled in Medicaid or CHIP. The remaining approximately 39 percent are covered by either private health insurance or another type of government-sponsored health insurance, including Medicare or TRICARE.

FIGURE 5
INSURANCE STATUS OF THE UNDER AGE 65 POPULATION CAMERON, EL PASO, AND HIDALGO COUNTIES AS OF OCTOBER 2005



NOTE: Uninsured rate is based on a three-year average for 2002 to 2004.
SOURCE: Legislative Budget Board.

REASONS FOR LOW RATES OF PRIVATE HEALTH INSURANCE IN THE BORDER REGION

Low rates of private health insurance coverage in the border region are partly due to lack of access to employer-sponsored health insurance. Approximately 58 percent of the uninsured population age 18 to 64 in Cameron, El Paso and Hidalgo counties are employed. The likelihood of having employer-sponsored health insurance varies among workers based on job characteristics, such as industry, employer size, and hourly earnings. For example:

- The top three border industries have uninsured rates ranging from 17 percent to 49 percent. As shown in **Figure 6**, nearly two-thirds (65.1 percent) of

FIGURE 6
NON-AGRICULTURAL EMPLOYMENT BY INDUSTRY SECTORS FOR CAMERON COUNTY, EL PASO COUNTY, AND HIDALGO COUNTY

INDUSTRY	AVERAGE EMPLOYMENT	PERCENTAGE OF TOTAL EMPLOYMENT	PERCENTAGE UNINSURED WITHIN INDUSTRY (STATEWIDE)
Education and Health Services	189,713	33.7%	17.4%
Trade, Transportation and Utilities	122,806	21.8	26.5
Leisure and Hospitality	54,264	9.6	49.0
Professional and Business Services	46,199	8.2	28.3
Manufacturing	38,286	6.8	20.7
Public Administration	28,941	5.1	5.2
Construction	26,304	4.7	53.3
Financial Activities	23,495	4.2	19.7
Other Services	13,146	2.3	44.3
Natural Resources and Mining	10,300	1.8	17.2
Information	9,024	1.6	16.3
Unclassified	698	0.1	--
Total	**563,176**	**100.0%**	**27.6%**

SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

nonagricultural workers in Cameron, El Paso, and Hidalgo counties are employed in three industries—education and health services; trade, transportation and utilities; and leisure and hospitality. The percentage of uninsured workers in these industries statewide ranges from 17.4 percent to 49.0 percent.

- Small employers are less likely to offer health insurance coverage. As shown in **Figure 7**, 28.1 percent of the nonagricultural workforce in Cameron, Hidalgo and El Paso counties works for small firms. In 2003, 31.4 percent of small firms in Texas offered health insurance coverage compared to 96.1 percent of medium and large firms. Only 32 percent of small-firm employees statewide were enrolled in coverage compared to 61.5 percent of medium and large-firm employees.
- Border workers are more likely to work in low-wage jobs as compared to the rest of the state. Higher hourly wages are associated with a greater likelihood of having employer-sponsored health insurance. The statewide median hourly wage is $12.86. This report defines a low-wage employee as someone with hourly wages that fall below two-thirds of the statewide median hourly wage, or $8.58. The median hourly wage is $8.82 in Cameron County, $10.28 in El Paso County, and $9.05 in Hidalgo County. The median annual wage or salary is $18,348 in Cameron County, $21,392 in El Paso County, and $18,826 in Hidalgo County compared to $26,757 statewide.

Cost is also a barrier to obtaining health insurance for both individuals and employers. When employers offer insurance coverage, the premium cost may be prohibitive for employees.

According to the Texas Department of Insurance, the national 2003 Medical Expenditure Panel Survey (MEPS) reports that the average annual premium for employer-sponsored insurance in Texas was $3,400 for single coverage (i.e., employee-only) and $9,575 for family coverage (i.e., employee and dependents) across small, medium, and large employers. Given annual increases in premium rates, these figures are almost certainly higher for 2006. The 2003 MEPS data indicates that employers who offer health insurance coverage contribute on average $2,852 or 83.9 percent per employee for single coverage and $7,007 or 73.2 percent for family coverage. This leaves the annual employee contribution at $548 or 16.1 percent for single coverage and $2,568 or 26.8 percent for family coverage.

Low wage employment makes it difficult for individuals and families to afford the cost of health insurance. **Figure 8** shows the percentage of annual gross median salary employees in Cameron, El Paso, and Hidalgo counties spend on average for single or family coverage after paying housing and utility expenses compared to statewide percentages. For example, on average, the employee contribution for single coverage represents 4.8 percent of the annual gross median salary in Hidalgo County after paying housing and utility expenses compared to 2.7 percent statewide. The employee contribution for family coverage increases to 22.3 percent of the remaining annual gross median salary compared to 12.5 percent statewide.

FIGURE 7
EMPLOYMENT BY FIRM SIZE FOR CAMERON COUNTY, EL PASO COUNTY, AND HIDALGO COUNTY

FIRM SIZE BY EMPLOYEES PER FIRM	EMPLOYMENT IN SIZE CLASS	PERCENTAGE OF TOTAL EMPLOYMENT	PERCENTAGE OF EMPLOYEES ENROLLED IN EMPLOYER-SPONSORED COVERAGE WITHIN EMPLOYER SIZE CATEGORY (STATEWIDE)
Small Firm (0–49 Employees)	161,127	28.1%	32.0%
Medium Firm (50–249 Employees)	132,580	23.1	61.5
Large Firm (250 or more Employees)	279,555	48.8	
Total	**573,262**	**100.0%**	**54.3%**

Sources: Legislative Budget Board; Texas Department of Insurance.

FIGURE 8
PERCENTAGE OF SALARY SPENT ON EMPLOYEE CONTRIBUTION FOR SINGLE OR FAMILY COVERAGE IN CAMERON COUNTY, EL PASO COUNTY, AND HIDALGO COUNTY VERSUS STATEWIDE

SALARY, EXPENSES, AND CONTRIBUTIONS	CAMERON	EL PASO	HIDALGO	TEXAS
Annual gross median salary	$18,348	$21,392	$18,826	$26,757
Annual Fair Market Rent for 2-bedroom unit (gross rent estimates including shelter rent plus utilities, except telephone)	$5,916	$6,768	$7,320	$6,223
Remaining gross median salary	$12,432	$14,624	$11,506	$20,534
Employee contribution for single coverage as percentage of remaining annual gross median salary	4.4%	3.7%	4.8%	2.7%
Employee contribution for family coverage as percentage of remaining annual gross median salary	20.7%	17.6%	22.3%	12.5%

NOTES: Annual gross median salary is based on 2004 data from the Texas Workforce Commission. Annual Fair Market Rent is based on fiscal year 2006 data from the U.S. Department of Housing and Urban Development. Employee contributions for coverage are based on 2003 MEPS data.
SOURCE: Legislative Budget Board.

PUBLIC HEALTHCARE SPENDING IN THE BORDER REGION

As shown in **Figure 9**, the lack of private health insurance coverage increases government healthcare spending in several areas. Specifically, government healthcare spending in the 32-county border region is approximately $1.4 billion per year.

FIGURE 9
GOVERNMENT HEALTHCARE SPENDING IN THE 32-COUNTY BORDER REGION: STATE FISCAL YEAR 2005

CATEGORY	GOVERNMENT EXPENDITURES
Hospital Uncompensated Care	$341,691,667
County Indigent Healthcare Programs	20,462,818
Federally-Qualified Health Centers	56,423,419
CHIP	46,546,741
Immigrant Children Health Insurance	1,653,844
Medicaid Fee-For-Service and PCCM	766,715,086
Medicaid HMO	98,182,054
Medicaid Immigrant Emergency Services	74,441,933
Total Spending	**$1,406,117,562**

NOTE: The amount listed for Medicaid fee-for-service and PCCM includes acute care expenditures for non-disabled, low-income families, children and pregnant clients. See Figure 2 for a definition of the border region.
SOURCE: Legislative Budget Board.

Hospital Uncompensated Care: While a broad range of providers serve uninsured patients, the largest share of uncompensated care, in dollar terms, is delivered by hospitals. Most hospitals provide health services free of charge (i.e., charity care) to individuals who meet certain financial criteria. Charity care is never expected to result in cash payments. Not including state-owned hospitals, 46 hospitals in the border region reported providing $197.4 million in charity care in 2005, after adjusting for the difference between what hospitals charge and the amounts they receive in negotiated payments (i.e., cost-to-charges ratio). In addition to charity care, these hospitals reported nearly $144.3 million in bad debt in 2005 after adjusting for the cost-to-charge ratio. Bad debt charges are un-collectible hospital charges that result from the extension of credit. Therefore, total uncompensated care in the border region, which combines charity care and bad debt, was $341.7 million in 2005 when adjusted for the cost-to-charge ratio.

Local public hospitals, which represent 20 percent of the reporting border region hospitals, account for more than one-third of the total uncompensated care. Specifically, out of the 46 reporting border region hospitals, nine hospitals are owned by city, county, or hospital districts/authorities. These local public hospitals reported a total of $130.4 million in charity care and bad debt in 2005 after adjusting for the cost-to-charge ratio.

Disproportionate Share Hospital (DSH) Payments: Safety net hospitals serve predominantly low-income communities and have substantial caseloads of Medicaid patients whose costs frequently are not covered by Medicaid reimbursement rates. Often, these hospitals are also the principal source of

care for uninsured patients in their communities and incur higher uncompensated care costs. Congress established the Medicaid DSH program in 1981 to help ensure that states provide adequate financial support to hospitals that serve a significant number of low-income patients. Net DSH payments to hospitals in the border region totaled $98.0 million in state fiscal year 2005. These payments represent 18.1 percent of total net DSH payments made statewide. These payments cover a portion of the uncompensated care costs reported by hospitals.

County Indigent Health Care Programs: In addition to hospital uncompensated care, the uninsured also gain access to healthcare services through county indigent healthcare programs (CIHCPs) that are funded with local tax money and state matching funds. State law requires counties to offer a state-mandated set of basic healthcare services to income eligible residents without health insurance as the payer of last resort. Counties can choose to serve this population by creating a hospital district, administrating a public hospital, or participating in a CIHCP. As of state fiscal year 2005, 14 border counties reported spending $17 million in their CIHCPs. Counties become eligible to apply for state assistance after they spend 8 percent of their general revenue tax levy on approved indigent healthcare expenditures. In state fiscal year 2005, of the 14 border counties that reported CIHCP spending, 3 received state funds totaling $3.5 million, 10 reported indigent spending below the threshold, and one border county met the 8 percent threshold, but did not apply for state matching funds. Border counties received 67.3 percent of total CIHCP state matching funds.

Community Health Centers: Community health centers, some of which are part of or receive funding from CIHCPs, also provide significant amounts of uncompensated care. Community health centers are local, non-profit, community-owned healthcare providers serving low-income and medically underserved communities. Some community health centers are Federally-Qualified Health Centers (FQHCs) and must meet federal health center grant requirements. FQHCs in the border region reported providing $56.4 million in uncompensated care in 2005 including $3.2 million in bad debt and $53.2 million in sliding fee discounts. Sliding fee discounts are the difference between the full charge for the service and what the patient paid for the service. Federal grants covered the sliding fee discount portion of the uncompensated care costs, while the $3.2 million in bad debt was written off as uncollectible. State grants and contracts, which are awarded for the provision of specific services to FQHCs, totaled $4.3 million in the border region for fiscal year 2004. Only FQHCs receiving federal health center grants are required to provide data to the federal Bureau of Primary Health Care. Thus, the $56.4 million in uncompensated care reported by FQHCs may underreport the volume of uncompensated care delivered by all community health centers.

CHIP: The Children's Health Insurance Program (CHIP), which provides healthcare services to eligible children up to 200 percent of the federal poverty level, is funded with state funds, federal matching funds, and client contributions. Expenditures on CHIP premiums in the border region totaled $46.5 million in state fiscal year 2005. In addition, the state spent approximately $1.7 million on premiums for legal permanent resident children in the border region during state fiscal year 2005.

Medicaid: Medicaid, financed with both federal and state funds, is a healthcare program for low-income families, the elderly, and persons with disabilities. Medicaid acute care expenditures for non-disabled, low-income families, children and pregnant clients who received services through fee-for-service or Primary Care Case Management in the border region totaled $766.7 million during state fiscal year 2005. The state spent an additional $98.2 million in premium payments to Medicaid health maintenance organizations serving clients in the border region.

Medicaid Immigrant Emergency Services: Texas has chosen not to provide full Medicaid coverage to documented or undocumented immigrants, except for documented immigrants who entered the U.S. prior to August 22, 1996. However, the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (OBRA 86) amended the Medicaid law to authorize the reimbursement of medical providers for childbirth care and other emergency medical services delivered to all persons, including documented and undocumented immigrants, who meet the state's Medicaid eligibility criteria. Medicaid immigrant emergency services in the border region totaled $74.4 million in state fiscal year 2005.

CALIFORNIA'S EXPERIENCE WITH CROSS-BORDER HEALTH PLANS

California law allows U.S. insurers and HMOs licensed in California to sell fully-insured group and individual cross-border health plans to U.S. and Mexican citizens working in California. The law also allows Mexican insurers and HMOs to sell these plans to Mexican citizens legally employed in

California. Currently, two U.S. companies (Blue Shield of California and Health Net) and one Mexican company (Sistemas Medicos Nacionales Sociedad Anonima) offer fully-insured cross-border health plans in California. In addition, self-funded plans operated by individual employers or multiple employer welfare arrangements (MEWAs) also offer cross-border plans. MEWAs permit employers who are members of associations to create trust funds for providing healthcare benefits to their employees. Following is a chronological summary of the implementation of cross-border plans in California:

- Western Growers Association (WGA), a membership organization of agricultural businesses in California and Arizona, offers group health plans that are legally considered MEWAs and are regulated by the U.S. Department of Labor and the California Department of Insurance. WGA's MEWA plan has offered a cross-border health insurance option to its membership since 1972. For an additional fee, this option can be attached to any plan offered by WGA.
- The Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"), the law regulating managed care in California, allows American companies licensed in California to sell fully-insured cross-border plans to U.S. and Mexican citizens working in California. Even though the Knox-Keene Act authorized cross-border plans in 1975, no American company entered the cross-border market until 2000. In June 2000, Blue Shield of California became the first U.S.-based company to receive approval to sell a cross-border plan—Blue Shield Access Baja. A second U.S.-based company Health Net offers a family of cross-border products known as Salud con Health Net. Its first cross-border product was approved in October 2000.
- In 1998, California passed legislation (SB 1658) to allow healthcare plans offered by a Mexican company to market and sell their products in California to Mexican citizens. In January 2000, Mexico-based Sistemas Medicos Nacionales Sociedad Anonima (SIMNSA) was licensed by the California Department of Managed Health Care (DMHC) to offer cross-border plans to Mexican citizens legally employed in California. SIMNSA offers HMO and PPO plans sold directly to employers in California.
- In March 2006, Health Net announced that it would begin offering individual-based cross-border plans in addition to its employer-based plans.

Figure 10 shows certain characteristics of the cross-border plans offered by the U.S.-based companies Blue Shield of California and Health Net.

Healthcare service providers in Mexico are outside of California's jurisdiction and are under the purview of Mexican regulators. California recognizes that health services provided in Mexico are regulated under Mexican regulation according to Mexican standards. However, HMOs and PPOs offering cross-border plans are subject to oversight by the State of California and must meet certain requirements to receive a license to market and sell these plans in California.

Although California law sets forth certain requirements that Mexican-based HMOs must meet in order to receive a license to market and sell cross-border insurance products in California, U.S.-based cross-border plans in California are currently subject to greater regulatory oversight than similar

FIGURE 10
CHARACTERISTICS OF ACCESS BAJA AND SALUD CON HEALTH NET

CHARACTERISTIC	BLUE SHIELD ACCESS BAJA PLANS	SALUD CON HEALTH NET PLANS
Type of Coverage	Coverage for services provided in Mexico designated service areas	Coverage for services provided in both California and Mexico designated service areas
Eligible Persons	U.S. or Mexican citizens (and their dependents) legally employed by a California employer and living or working in the border plan service area.	U.S. or Mexican citizens (and their dependents) legally employed by a California employer and living or working in the border plan service area.
Number Enrolled	3,200	19,000
Number of Employers	117 small, mid-size or large employers	400 small, mid-size, or large employers
Costs	Premiums are on average 40 percent less than comparable U.S. plans offered by Blue Shield of California	Premiums are on average 40 percent less than comparable U.S. plans offered by Health Net.

Source: Legislative Budget Board.

plans operated by Mexican-based companies. Specifically, with very few exceptions, U.S.-based HMOs offering cross-border health plans are subject to all sections of Knox-Keene and all regulations promulgated by DMHC. In contrast, Mexican-based HMOs offering cross-border products are exempt from several sections of Knox-Keene. For instance, U.S.-based HMOs offering cross-border products are subject to provisions in the California Code of Regulations related to a Health Care Service Plan Quality Assurance Program whereas Mexican-based HMOs are exempt.

In addition to statutory requirements related to quality of care, U.S.-based insurers operating cross-border plans in California have voluntarily adopted their own quality measures. For example, Blue Shield implemented an internal quality improvement program known as Baja Quality Improvement program. The program works in conjunction with the Mexican administrator who manages their provider network. Previously, Blue Shield staff performed annual quality of care audits of the hospitals and providers in the network. However, Blue Shield recently delegated this function to their contracted administrator. Blue Shield also requires that hospitals achieve minimum standards for certain essential activities and be accredited by Mexico's official hospital accreditation program. Health Net's quality initiatives include conducting annual audits of SIMNSA's consultations, pharmacies, laboratories, and hospitals and requiring that hospitals be accredited by Mexico's official hospital accreditation program. Blue Shield of California and Health Net also require that physicians in their Mexican network meet the following requirements:

- Have a current valid Mexican license to practice medicine;
- Have clinical privileges in good standing at participating hospitals according to specialty,
- Be registered with the Secretaria de Salud (i.e., board-certified)
- Have verification of medical school completion;
- Be a member of the Tijuana Medical Association;
- Have evidence of Registro de la Secretaria de Salud to prescribe drugs;
- Have a verifiable work history; and
- Have liability insurance.

DEMOGRAPHIC COMPARISON OF TEXAS AND CALIFORNIA

As shown in **Figure 11**, the California and Texas border regions have some similar demographics.

BENEFITS OF CROSS-BORDER HEALTH PLANS

Cross-border health plans present an opportunity to insure a portion of the population along the Texas-Mexico border that has historically been uninsured. The target market for cross border plans is the uninsured, not those who currently have insurance coverage for U.S.-based care.

A reduction in the uninsured rate in the border region would lower government healthcare spending. The target population includes individuals who are partially responsible for

FIGURE 11
DEMOGRAPHIC COMPARISON OF TEXAS AND CALIFORNIA BORDER REGIONS

VARIABLE	CAMERON COUNTY, EL PASO COUNTY, HIDALGO COUNTY	SAN DIEGO COUNTY
Population	1.8 million	2.9 million
Hispanic	85.3%	70.6%
Foreign Born	27.1%	23.2%
Naturalized U.S. Citizen	32.2%	40.9%
Not a U.S. Citizen	67.8%	59.1%
Poverty Rate	32.8%	10.5%
Uninsured (under age 65)	35%	27%
Top Nonagricultural Industries	Education and Health Services (33.7%) Trade, Transportation and Utilities (21.8%) Leisure and Hospitality (9.6%)	Trade, Transportation and Utilities (18.0%) Education and Health Services (17.4%) Leisure and Hospitality (11.7%)
Workforce in Small Firms	28.1%	37.3%
Median Hourly Wage	$8.82 in Cameron County $10.28 in El Paso County $9.05 in Hidalgo County	$15.23

Note: Demographic information is based on data collecting during the 2004 to 2005 timeframe.
Source: Legislative Budget Board.

healthcare expenditures in the following areas: hospital uncompensated care, county indigent healthcare programs, community health centers, and Medicaid immigrant emergency services. In addition to the target population, some of the children of low-income workers who currently qualify for Medicaid or CHIP could potentially receive healthcare coverage through an employer-sponsored cross-border health plan. These plans would not only insure the child, but the parent too, thereby further reducing the number of uninsured.

Cross-border plans could help address a significant barrier for both individuals and employers in obtaining health insurance—cost/affordability. Some employers do not offer health insurance coverage or have scaled back their offerings due to cost. Cross-border plans provide a cost-effective method for employers to offer health insurance to their employees. The premium cost for cross-border health plans is on average 40 percent less than comparable plans that provide healthcare in the U.S. Furthermore, some employees who are offered employer-sponsored health insurance choose not to enroll due to high premium cost. The employee contribution represents a significant amount of annual wages for some workers in the border region. Employees may be more inclined to enroll in an employer-sponsored cross-border plan because their employee contribution will be less than a comparable U.S. plan.

Although healthcare service providers in Mexico would be outside of Texas' jurisdiction, insurance company and HMO operations could be subject to Texas oversight. State law could set forth specific requirements that insurance companies and HMOs must meet in order to receive a license to market and sell cross-border insurance products in Texas. TDI could be given the authority to issue and revoke licenses for the operation of these plans. In addition to statutory requirements related to quality of care, the licensed companies operating cross-border plans in Texas could be expected to adopt their own quality measures similar to companies operating these types of plans in California.

The U.S. Department of Health and Human Services may designate counties as Health Professional Shortage Areas (HPSAs) and/or Medically Underserved Areas (MUAs) based on their ability to provide health services to local residents. The majority of the counties in the border region have been designated as HPSAs and MUAs, indicating poor access to care. Cross-border health plans have the potential to increase access to care by providing coverage for services in Mexico.

The healthcare infrastructure in Mexico includes hospitals, clinics, private physician practices, and pharmacies. The growth in the healthcare infrastructure in Mexico is due in part to an increase in private health insurance companies and providers in Mexico and to U.S. demand for healthcare services in Mexico. Implementing cross-border health plans in Texas could increase the construction of medical facilities in Mexico.

ALLOW U.S.-BASED INSURERS AND HMOS TO OFFER CROSS-BORDER HEALTH PLANS

Despite efforts to increase rates of private health insurance coverage, most non-aged Texas residents living in the three most populous counties in the Mexico border region are either uninsured or insured through government-sponsored programs. The lack of private health insurance increases federal, state, and local government healthcare spending. The significant population growth in the border region coupled with high uninsured rates requires that options be considered to increase the number of individuals with private health insurance.

Recommendation 1 would amend the Texas Insurance Code to allow U.S.-based insurers and HMOs to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens. When establishing cross-border health plans, the type of insurance carrier allowed to sell and operate cross-border products and the type of person eligible to enroll in a given plan should be a consideration. Recommendation 1 proposes allowing only U.S.-based companies to offer cross-border health plans to both U.S. and Mexican citizens (i.e., Option 3 shown in **Figure 12**).

Statutory requirements could be enacted that would subject U.S.-based insurance companies and HMOs operating cross-border plans to a greater level of regulatory oversight by TDI than plans operated by Mexican-based companies. Also, allowing U.S.-based insurance companies and HMOs to offer cross-border plans would require fewer statutory changes related to regulatory oversight than allowing

FIGURE 12
POTENTIAL OPTIONS FOR A CROSS-BORDER HEALTH PLAN

OPTION 1	OPTION 2
U.S.-based company Mexican citizen only	Mexican-based company Mexican citizen only
OPTION 3	**OPTION 4**
U.S.-based company Mexican and U.S. Citizens	Mexican-based company Mexican and U.S. Citizens

SOURCE: Legislative Budget Board.

Mexican-based companies to offer these plans. Allowing Mexican and U.S. citizens to enroll in cross-border plans expands the potential pool of enrollees and helps to increase rates of private health insurance across both populations, thus having a greater impact on government healthcare spending.

Based on California's experience with cross-border health plans, legislation to authorize the operation of cross-border health plans in Texas should include the following provisions:

- Companies that market and sell a cross-border plan in Texas should be licensed by TDI.
- TDI should have the authority to revoke licenses to market and sell cross-border products in Texas.
- The operations of licensed U.S.-based insurance companies or HMOs offering fully-insured cross-border health plans should be subject to some level of regulatory oversight by TDI.
- Companies that receive a license to market and sell cross-border health plans in Texas should meet quality of care requirements established by TDI.
- The service area should be limited to a geographic region within Mexico with the exception of emergency care services provided in Mexico and Texas.
- Cross-border products should be offered to individuals and employers.
- Insurance companies providing cross-border plans should employ or designate a medical director. The medical director should either hold a license to practice medicine in Texas or, for health services provided only in Mexico, operates under the laws of Mexico.

Authorization of cross-border health plans requires statutory changes within the Texas Insurance Code. The statutory changes that would be required to allow cross-border health plans to operate in Texas fall into three general categories: (1) licensing and financial oversight provisions; (2) general regulatory provisions; and (3) specific statutes that pertain to indemnity plans, PPOs, and HMOs. **Figure 13** provides a high-level summary of the statutory changes that might be required to allow U.S. insurance companies to offer cross-border health plans in Texas. However, the exact changes to

FIGURE 13
SUMMARY OF STATUTORY CHANGES REQUIRED TO AUTHORIZE U.S.-BASED CROSS-BORDER HEALTH PLANS IN TEXAS

LICENSING AND FINANCIAL OVERSIGHT PROVISIONS:

No statutory change would be required to apply existing licensing and financial oversight provisions to allow U.S.-based companies to offer cross-border health plans. However, internal changes at TDI might be needed to accommodate increased oversight requirements or specific financial provisions that may apply.

GENERAL REGULATORY PROVISIONS:

The following statutory requirements and their applicability to cross-border health plans would need to be considered:

- Provisions related to fraudulent activities and investigations by TDI
- Various reporting requirements
- Foreign currency issues in the filing of financial reports and the processing and payment of health insurance claims
- Advertising requirements and oversight responsibilities of TDI
- Enforcement capabilities in general and the ability of TDI to address offenses that occur in Mexico
- Fraudulent and/or deceptive and unfair trade practices and the power of the state of Texas to pursue penalties

SPECIFIC STATUTES PERTAINING TO INDEMNITY/PPOS OR HMOS:

The following statutory requirements may need to be amended, or an exemption specified, to allow for licensing and oversight of cross-border indemnity/PPO health plans:

- Definition of healthcare practitioner
- Health insurance risk pool requirements
- Coverage of prescription drugs
- Other provisions related to preferred provider benefit plans

The following statutory requirements may need to be amended, or an exemption specified, to allow for licensing and oversight of cross-border HMO health plans:

- Definition of physician and provider
- Applicability of point-of-service (POS) plans

Source: Texas Department of Insurance.

statute depend on the specific design of the cross-border product.

The Texas Insurance Code also includes minimum mandated benefit requirements (e.g., mammography screening) that must be provided in certain group and individual health plans, including indemnity/PPO and HMO contracts. In some cases, it may not be possible for cross-border health plans to provide these required services in Mexico. The Texas Insurance Code can either be amended to exempt cross-border plans from providing the mandated benefits or the insurance company can be required to provide coverage for the mandated services in the U.S.

Recommendation 2 would amend the Texas Insurance Code to require TDI to conduct a study to evaluate the effectiveness of allowing insurers and HMOs to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens, including impact on the uninsured rate, public healthcare expenditures, and healthcare providers, and to submit a report to the Legislative Budget Board (LBB) and the Governor by January 1, 2011. The study would evaluate the effectiveness of using cross-border health plans as a method to reduce the uninsured rate and public healthcare spending in the border region. It would also assess past concerns raised about quality of care, the financial impact on Texas doctors in the border region, and client access to healthcare.

Recommendations 3 would include a contingency rider in the 2008–09 General Appropriations Bill requiring TDI to submit a progress report on the status of implementing licensing and regulatory requirements related to fully-insured cross-border group and individual health plans and the status of the evaluation study to the LBB and the Governor by January 1, 2009.

Recommendation 4 would include a contingency rider in the 2008–09 General Appropriations Bill that appropriates $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 in General Revenue–Dedicated Funds (i.e., Texas Department of Insurance Operating Fund Account) to TDI for implementing licensing and regulatory requirements related to fully-insured cross-border group and individual health plans, and conducting a study to evaluate effectiveness.

The following Texas Department of Insurance contingency rider could be included in the General Appropriations Bill for the 2008–09 Biennium:

Cross-Border Health Plans.

(a) Contingent upon enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation allowing U.S. based insurers and HMOs to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens and requiring the Department of Insurance to conduct an evaluation study, the Department of Insurance shall submit a progress report by January 1, 2009, on the status of implementing licensing and regulatory requirements related to fully-insured cross-border group and individual health plans and the status of the evaluation study, to the Legislative Budget Board and the Governor.

(b) Amounts appropriated above to the Department of Insurance of $150,000 each fiscal year in General Revenue–Dedicated Funds (i.e., Texas Department of Insurance Operating Fund Account) in Strategy H.1.2, Contingency Cross-Border Health Plans and 2.0 Full-Time Equivalent Positions (FTEs) each fiscal year included above in the "Number of Full-Time Equivalent Positions (FTE)"for the purpose of implementing licensing and regulatory requirements related to a fully-insured cross-border group and individual health plans, and conducting a study to evaluate effectiveness, are contingent upon enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation allowing U.S. based insurers and HMOs to offer fully-insured cross-border group and individual health plans to U.S. and Mexican citizens and requiring the Department of Insurance to conduct an evaluation study,

FISCAL IMPACT OF THE RECOMMENDATIONS

As shown in **Figure 14**, Recommendation 4 would appropriate $300,000 in General Revenue–Dedicated Funds (i.e., Texas Department of Insurance Operating Fund Account) in the 2008–09 General Appropriations Bill to Texas Department of Insurance for the purposes of implementing licensing and regulatory requirements related to fully-insured cross-border group and individual health plans, and conducting a study to evaluate effectiveness. It is expected that TDI would use available balances in Fund 36, TDI's Operating Fund, or increase its maintenance taxes and fees to generate sufficient revenue to cover this appropriation. The $300,000 includes $200,000 for salary and benefits for 2 full-time equivalents to implement licensing and regulatory

FIGURE 14
FISCAL IMPACT OF ALLOWING U.S.-BASED INSURERS AND HMOS TO OFFER CROSS-BORDER HEALTH PLANS

FISCAL YEAR	PROBABLE REVENUE GAIN TO GENERAL REVENUE–DEDICATED FUND NO. 36	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED FUND NO. 36	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2006–07 BIENNIUM
2008	$150,000	($150,000)	2
2009	$150,000	($150,000)	2
2010	$100,000	($100,000)	2
2011	$100,000	($100,000)	2
2012	$100,000	($100,000)	2

Source: Legislative Budget Board.

requirements and $100,000 to conduct the evaluation study.

Allowing U.S.-based insurers and HMOs to offer cross-border health plans has the potential to decrease the number of uninsured in the Texas-Mexico border region and thus reduce public healthcare expenditures.

The introduced 2008–09 General Appropriations Bill includes a rider that requires TDI to provide a progress report to the LBB and the Governor by January 1, 2009 and appropriates $300,000 in General Revenue–Dedicated Funds (i.e., Texas Department of Insurance Operating Fund Account) for TDI to implement the recommendations. The introduced bill does not include any other adjustments as a result of these recommendations.

DEVELOP A LONG-TERM STRATEGIC PLAN TO REDUCE THE STATE'S UNINSURED POPULATION

In 2004, 45.8 million Americans lacked health insurance in the United States. This amount is an increase of more than 7 million people since 2000. Research indicates rising healthcare costs, an erosion of employer-sponsored insurance, and public healthcare program cutbacks are factors contributing to the increasing uninsurance trend. In Texas, similar conditions contribute to the state's current uninsured population of 25 percent, which translates to more than 5 million uninsured Texans. According to the Texas Department of Insurance, one of the main reasons for Texas' high uninsurance rate is that Texas workers are less likely to have access to employer-sponsored insurance than workers are in other states. Based on the 2004 U.S. Census Bureau's Current Population Survey, 53.2 percent of Texas workers had employer-sponsored insurance coverage, compared to the national average of 59.8 percent. This percentage is down from 2001 when the employer-sponsored insurance rate in Texas was 55.9 percent.

Healthcare costs are increasing and affect people's insurance status. Treatment of chronic diseases is increasing which leads to increased health expenditures. Additionally, untreated or unchecked chronic disease, regardless of insurance status, increases mortality and contributes to increased healthcare costs. Government subsidies pay for approximately 85 percent of uncompensated care, leaving hospitals and other providers to charge insured patients more for their services to recover un-reimbursed costs. Across the country, states are developing a variety of ways to address their respective uninsured populations. In Texas, to develop effective strategies to reduce the uninsured rate, it is necessary to understand who is uninsured and why coverage is lacking. Establishing a state advisory committee to identify the uninsured and to create a long-term state strategic plan are the first steps to addressing the state's uninsured population.

FACTS AND FINDINGS

- ♦ Texas leads the nation with the highest percentage of uninsured children, 1.3 million or 21 percent.
- ♦ Texas young adults aged 18 to 24, like their national counterparts, have the fastest growing uninsured rates among adults.
- ♦ Texas small business employees and their families are about twice as likely to be uninsured as workers employed by large firms.
- ♦ According to the Texas Department of Insurance, more than 75 percent of all part-time employees in Texas work in firms that offer insurance, however only 23.4 percent of part-time employees are eligible for coverage.

CONCERN

- ♦ Despite various attempts to address the uninsured rate in Texas, the state does not have a long-term strategic plan to guide and coordinate state efforts.

RECOMMENDATION

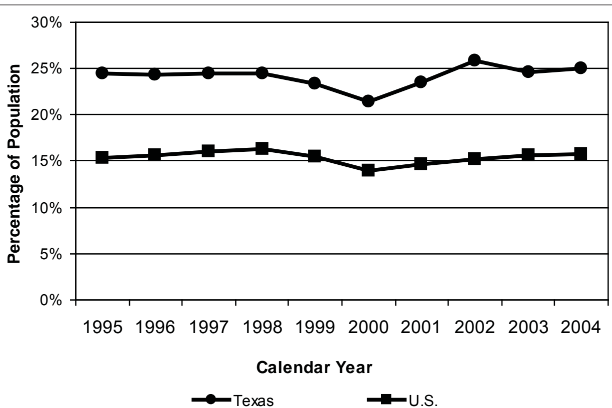
- ♦ **Recommendation 1:** Amend Texas Health and Safety Code §113.003 to require the Texas Health Care Policy Council to establish an advisory committee to provide input to the council regarding ways to reduce the uninsured rate in Texas and for the council to develop a long-term strategic plan recommending specific strategies to address the various segments of the state's uninsured population.

DISCUSSION

Over the last decade, Texas experienced one of the highest uninsured rates in the country. According to the Texas Department of Insurance (TDI), the 2004 uninsured rate in Texas was nine percentage points higher than the national percentage of 15.7 percent. **Figure 1** shows the uninsured rate in the U.S. and Texas from 1995 to 2004.

TDI conducted research about uninsured Texans and issued a report in September 2005. This report was part of a national initiative to help states develop options to expand access to affordable health insurance. Through its research, the agency identified the characteristics of the state's uninsured population. Key populations of the state's uninsured are children, young adults, small business workers, part-time or seasonal workers, and childless adults. Following is a brief description of these populations and possible causes for their lack of health insurance.

FIGURE 1
TEXAS AND THE U.S. UNINSURED PERCENTAGE
1995 TO 2004



SOURCES: Texas Department of Insurance; U.S. Census Bureau.

UNINSURED CHILDREN IN TEXAS

In 2004, Texas led the nation with the highest rate of uninsured children with 1.3 million or 21 percent. More than half (891,768) of these uninsured children are in families earning less than 200 percent of the federal poverty level (FPL) or $33,200 for a family of three. However, a family's earnings do not always create access to health insurance. Approximately 432,067 Texas children whose families earn more than 200 percent of FPL are uninsured despite their family's income.

A national study conducted by the Urban Institute, revealed that the three most frequently cited reasons for children's lack of insurance coverage are (1) high cost of insurance, (2) job-related reasons (lost a job, changed jobs, or lack of access to employer-sponsored insurance (ESI)) and, (3) loss of eligibility for public coverage.

UNINSURED YOUNG ADULTS IN TEXAS

Young adults in Texas, similar to their national counterparts, have the fastest growing uninsured rates among adults with 40.4 percent of 18 to 24 year-olds uninsured in 2003, an increase from 38.7 percent in 2001. TDI reports the increase among adults ages 25 to 34 is even higher with 26.7 percent uninsured in 2001, while 39.2 percent were uninsured in 2003. The total number of uninsured adults between ages 18 and 34 increased by more than 674,000 from 1.5 million in 2001 to 2.2 million in 2003.

The young adult group is particularly vulnerable to losing health insurance coverage due to the many life transitions that occur during this period. Children previously covered by public insurance often lose their eligibility when they reach adulthood. Children covered under the Texas' Children's Health Insurance Program (CHIP) lose eligibility when they turn age 19 and eligibility criteria for Medicaid coverage becomes more stringent at this age.

Nationally, young adults covered through their parents' health insurance risk losing coverage at age 18 or 19. According to the TDI, a 2004 national survey of employer-sponsored health plans found that nearly 60 percent of the plans stop covering dependents age 18 or 19 who are not enrolled in college. However in Texas, the law requires fully-insured group and individual health plans to allow parents to continue coverage of unmarried dependents until they are age 25, regardless of their school or work status.

UNINSURED WORKERS IN SMALL BUSINESSES IN TEXAS

Texas is no exception to the nationwide trend that small employers (less than 50 employees) are less likely to offer health insurance coverage than large employers. According to TDI, small business employees and their families are twice as likely to be uninsured as workers employed by large firms, and firms with 25 or fewer workers are even less likely to offer coverage than those with 25 to 50 employees. According to TDI, in 2003, 96.1 percent of large firms (50 or more employees) in Texas offered health insurance to their workers, while 31.4 percent of small businesses offered coverage.

Small employers cite many reasons for their lack of insurance coverage. They are: unaffordable premium costs, the presence of preexisting conditions which make the group uninsurable, a high number of low-income workers, high employee turnover, and a lack of interest among employees. The U.S. Congress attempted to address some of these issues by passing the Health Insurance Portability and Accountability Act (HIPAA) in 1996. Key provisions of HIPAA that affect small businesses include:

- guarantee issue requirement for all groups, regardless of health status of the group applicants; and
- rating restrictions that limit the extent to which insurers can increase rates for small firms.

The Texas Legislature also adopted insurance reforms for small employers in 1993 and 1995. They include:

- authority to establish purchasing cooperatives that allow small firms to band together for the purpose of purchasing health insurance and
- creation of standard benefit plans that provide reduced benefits with the expectation that premium costs would be significantly lower.

UNINSURED PART-TIME, SEASONAL, TEMPORARY WORKERS IN TEXAS

While more than 75 percent of all part-time employees in Texas work in firms that offer insurance, only 23.4 percent of part-time employees were eligible for coverage in 2004. According to TDI of those part-time workers who were eligible, only 39.4 percent were actually enrolled, a significant drop from 69.4 percent in 2002. However, of all part-time workers employed in firms that either offer health insurance or do not offer it, only 7.4 percent enrolled in ESI plans. In small firms, less than two percent of workers had ESI coverage.

Texas' occupational makeup has historically been recognized as a contributing factor to the state's uninsured problem. TDI studies indicate most insurers or employers have provisions that exclude part-time employees, contract workers, and seasonal employees and may partly explain why certain occupations with large numbers of these workers are more likely than others to remain uninsured. Workers in construction, manufacturing, and wholesale/retail trade accounted for more than half (53 percent) of all Texas uninsured workers in 2001. These industries typically offer part-time and seasonal employment, cyclical work patterns with frequent layoffs, and low paying wages.

UNINSURED CHILDLESS ADULTS IN TEXAS

While childless adults may comprise some of the above-mentioned groups (young adult, small business workers, and part-time workers), this population, especially if also low income, is more likely to be uninsured than are other Americans. According to the U.S. Department of Health and Human Services, the uninsured are more likely to be childless adults than parents. Childless adults represent 45 percent of the U.S. under age 65 population, but 57 percent of the uninsured. National and Texas data show young adults have the fastest growing uninsured rate. In Texas, almost 40 percent of the state's uninsured are childless adults between the ages of 18 and 64.

In addition to age, a second factor influencing this population's insurance status is public insurance. Few childless adults qualify for public coverage unless they are pregnant, elderly, or severely or permanently disabled. States can cover these populations through Medicaid if they receive a waiver; however, such waivers do not provide additional federal funding. According to the Kaiser Commission, as of January 2004, 36 states did not cover any childless adults, while 14 states and the District of Columbia covered some. Of the states offering some coverage, the Kaiser Commission reports that "10 states provided coverage through Medicaid waivers, three states operated entirely state-funded programs, and two state-level jurisdictions operated both state-funded and waiver programs for childless adults."

RELATIONSHIP BETWEEN HEALTHCARE COSTS AND THE UNINSURED

Healthcare costs continue to increase more than general consumer prices in 2005. The medical care price index increased 4.3 percent but the consumer price index for all items was 3.4 in 2005. Rising healthcare costs make insurance less affordable and contribute to the number of uninsured. Rising health insurance costs have outpaced both employer wages and inflation. In the past five years, health insurance costs have risen 54 percent leading to the percentage of employers offering health insurance to decrease to 60 percent, the lowest rate in the past decade.

The rise in the prevalence of treated disease is the primary driver of healthcare spending. According to Journal of the American Medical Association (JAMA) the increase in the number of cases treated is a greater cause of higher spending than is the cost per case. Furthermore, JAMA reports, "chronic disease is now the principal cause of disability and use of health services and consumes 78 percent of health expenditures."

Leaving chronic disease unchecked, whether insured or uninsured, will add to increased healthcare spending once care is sought. According to the Kaiser Commission, "because the uninsured are less likely than the insured to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems. When they are hospitalized, the uninsured are more likely to receive fewer services and to have a higher mortality rate in the hospital than insured patients."

Once at the hospital, most uninsured do not receive health services for free or at a reduced charge. According to the Kaiser Commission, "Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services." The Kaiser Commission reports that only about one quarter of low-income, uninsured adults (those with incomes below 200 percent of the federal poverty limit) report they have received care for free or reduced rates in the past year.

When hospital patients cannot pay for care they receive, the cost is uncompensated, but it is partially offset through

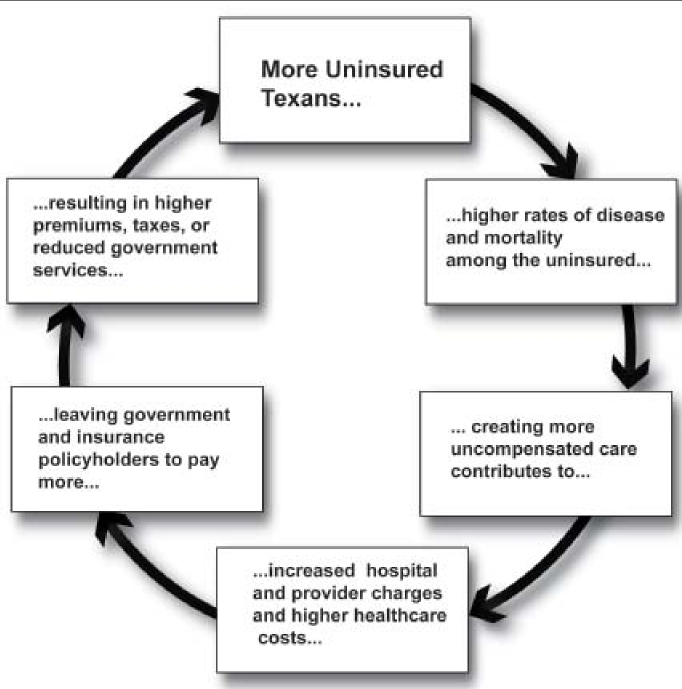
federal, state, and private funds. In 2004, the Kaiser Commission estimated uncompensated care to cost $41 billion nationwide. For the same period in Texas, hospitals reported $4.1 billion in uncompensated care. In 2005, Texas hospitals' uncompensated care increased to $4.7 billion. These Texas uncompensated care amounts have been adjusted to reflect the difference between what hospitals charge and the amounts they receive in negotiated payments (i.e. cost to charges ratio).

HHSC Rider 61 in the 2006–07 General Appropriations Act, Seventy-ninth Legislature, Regular Session, 2005, required HHSC to conduct a study of the components and assumptions used to calculate Texas hospitals' uncompensated care amounts. According to the results of this study, HHSC reports that the cost of bad debt and charity care can be further reduced by accounting for other offsetting payments such as the federal portion of disproportionate share hospital and upper payment limit funds, charitable contributions, and tax revenue. All uncompensated care contributes to federal, state, and local governments raising taxes to help cover uncompensated healthcare costs and to hospitals charging the insured higher rates to make up for the uncompensated care given. According to the Institute of Medicine (IOM), an additional effect of uncompensated care is that physicians, clinics, and hospitals may limit or not offer services in areas with large uninsured populations, resulting in reduced access to care for local residents regardless of their health insurance status. **Figure 2** shows the relationship between healthcare costs and the cost of uninsurance.

OTHER COSTS OF UNINSURANCE

A person's health status affects income earning potential and workplace productivity. The Institute of Medicine (IOM) reports "illness and functional limitations impair people's abilities to work and consequently impose the cost of forgone income and productive effort on those who are sick or disabled, their families, and potentially on their employers as well." In the IOM report, *Hidden Costs, Value Lost: Uninsurance in America*, researchers point out that the lack of health insurance among U.S. residents age 18 to 64 is one factor contributing to the burden of disease, functional limitations, and reduced health status of those without coverage. However, the extent to which the lack of health coverage plays a role in workforce participation has not been studied directly, but studies demonstrated that impaired health is related to absenteeism and reduced productivity.

FIGURE 2
RELATIONSHIP BETWEEN THE UNINSURED AND HEALTHCARE COSTS



SOURCE: Legislative Budget Board.

The costs of uninsurance include not only health services costs (uncompensated care, hospitalizations) but also include the costs resulting from families and individuals bearing the financial burdens and risks of out-of-pocket healthcare spending. The IOM reports that families with members who do not have health insurance face substantial financial risks. Out-of-pocket (OOP) spending for those who are uninsured is comparable to those with private coverage; however, OOP spending for the uninsured is more likely to consume a higher portion of the family income than OOP spending of the insured. From 2001 to 2002, an average of 13 million families per year had OOP costs consuming 10 percent or more of the family income. The likelihood of higher OOP costs increases when any or all family members go without health coverage for all or part of the year.

People with chronic conditions like diabetes, asthma, or depression are at risk of financial problems due to the high and rising costs of healthcare. Adults with chronic conditions whose families had problems paying medical bills can face serious consequences regarding their access to medical care. Of this group, 2.4 million people went without needed care, 4.7 million delayed care, and 6.6 million failed to get needed prescription drugs because of cost concerns.

Negative effects can result in other areas of family finances for families with problems paying medical bills. Moreover, 55 percent of this group delayed making major purchases, 50 percent had to borrow money, and 68 percent had problems paying for food and shelter.

OTHER STATES' EFFORTS TO REDUCE UNINSURED RATE

In 2005, several states made health insurance coverage a priority. The Robert Wood Johnson Foundation through their State Coverage Initiative tracks states' progress in reducing the number of uninsured.

State strategies to expand coverage included assisting small businesses, ensuring coverage for all children, and creating affordable health coverage for low income individuals and families. Strategies addressing the uninsured problem from five states are discussed below. Three states, Oklahoma, New Mexico, and West Virginia, have high rates of uninsured and each addressed a different segment of their uninsured population with a new initiative. Illinois, a state with a moderate uninsured rate, aimed to make health insurance coverage available to all children. Massachusetts, a state with a low uninsured rate, passed legislation with the goal of creating universal state health coverage. More detailed information about Massachusetts' efforts and their history leading up to near universal coverage is provided below. **Figure 3** shows a summary of these states' efforts. The affect of these efforts on state uninsured rates is unknown.

MASSACHUSETTS HEALTHCARE REFORM EFFORTS

Massachusetts made the decision to reduce its uninsured rate over two decades ago. Building on its previous successes and current low uninsured rate, Massachusetts is one of the first states to take substantive legislative action to try to achieve near universal health coverage for its citizens.

The first wave of healthcare reforms in Massachusetts occurred from 1985 to 1994. During this period, the legislature created the Uncompensated Care Pool to equitably distribute the costs of caring for uninsured patients. The legislature also established a special commission to develop a plan to provide health insurance for everyone in the state. Consumer and labor groups had a new opportunity to join policymakers in the healthcare reform discussion. In 1988, the Universal Health Care law passed and was signed into law. Key parts of the bill exist today, including:

- CommonHealth: a program providing coverage for disabled adults and children;
- Healthy Start: a program providing coverage for uninsured pregnant women;
- Medical Security Plan: a program providing coverage for uninsured workers; and
- Student Insurance Requirement: requires college students to have health insurance.

The Universal Health Care law included an employer mandate but it was never successfully implemented due to the state's declining economy in the early 1990s.

The next wave of healthcare reforms took place from 1995 to 2003. In 1993, Massachusetts worked to reinvent the state's Medicaid program by negotiating a special waiver from the federal government. The federal government approved the waiver in 1994. During this period, the Insurance Partnership program was created to provide qualified small businesses, lower-income employees, and the self-employed to pay for health insurance. The major healthcare reforms during this time came as a result of the passage of legislation known as "Chapter 203". These reforms expanded opportunities for various populations to obtain better healthcare coverage. Key provisions of "Chapter 203" reforms included:

- renaming Massachusetts Medicaid program MassHealth;

FIGURE 3
RECENT STATES' EFFORTS TO REDUCE THEIR UNINSURED RATE, 2005

STATE	UNINSURED RATE	PROGRAM DESCRIPTION	POPULATION AFFECTED	COST OR FINANCING INFORMATION
New Mexico	21.5%	New Mexico State Coverage Insurance (NMSCI), a public/private partnership creating a new employer-sponsored insurance program.The state contracts with managed care organizations to provide the product.	21,000 working residents (age 19-64) with incomes less than 200% FPL	NMSCI is created through a Medicaid HIFA waiver.
Oklahoma	20.1%	Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) created through a Medicaid HIFA waiver.	50,000 residents with incomes at or below 185% FPL.	State committed $50 million per year for program through a new tobacco tax.
West Virginia	16.5%	A public/private partnership created between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies offering the Small Business Plan.	Small business employees	The Small Business Plan builds on the purchasing power of large groups by allowing small businesses access to the buying power of PEIA. PEIA is the largest self-insured plan in the state.
Illinois	14.2%	Passage of the Covering All Kids Health Insurance Act makes coverage available to all uninsured children.	All uninsured children	The program is estimated to cost $45 million in the first year and will be funded through savings generated by implementing a new primary care case management program in other state health care programs. Premiums will be also charged on a sliding scale by income. Children in families with higher incomes will be eligible, but the premiums will also be higher.

SOURCES: Robert Wood Johnson Foundation; U.S. Census Bureau.

- covering more than 300,000 additional people under MassHealth;
- creating the Children's Medical Security Plan to cover children whose families earn to much to qualify for MassHealth but cannot afford coverage; and
- creating the Senior Pharmacy program to limit the amount of out-of-pocket expenditures senior citizens pay for prescriptions.

The third wave of healthcare reforms is occurring now. In 2004, a combination of federal demands for changes in healthcare financing and pressure from constituents and advocates prompted the Massachusetts legislature to begin work on advancing healthcare access further. The result is landmark legislation passed and signed into law in April 2006. The Massachusetts Health Care Reform Plan should provide nearly universal healthcare coverage to state residents. The reform plan combines the concept of individual responsibility through an individual mandate on the purchase of health insurance with government subsidies that ensures its affordability as well as an employer mandate requiring employers to offer health insurance coverage or contribute up to $295 annually per employee. The employer mandate will be required of all employers with more than 10 employees. **Figure 4** shows the major components of the Massachusetts healthcare reform plan.

NEXT STEPS FOR TEXAS

The lack of health insurance affects the health of people without health insurance and society. In recent years, Texas has not made sufficient progress to reduce its uninsured population and continues to maintain the highest uninsured rate in the country. As previously mentioned, a number of states started innovative programs to cover the uninsured through incremental steps. Many of these programs are funded with a mix of local, state, and federal funds. As an additional option, many states, like Massachusetts and Maine, have also expanded eligibility standards for children

FIGURE 4
COMPONENTS OF THE MASSACHUSETTS HEALTH CARE REFORM PLAN

Commonwealth Health Insurance Connector
Small businesses and individuals will be able to find and purchase affordable, quality insurance products through the newly created Commonwealth Health Insurance Connector. The Connector will "connect" people to insurance products, thereby helping them to fulfill the individual mandate required by the new healthcare reform law. It is expected up to 215,000 residents will purchase health insurance coverage through the Connector.

Insurance Market Reforms
Individual and small-group insurance market will be merged by July 2007, which is expected to reduce premium costs for individuals by 24 percent.

Commonwealth Care Health Insurance Program
The Commonwealth Heath Insurance Program will provide sliding-scale subsidies to individuals with incomes up to 300 percent FPL for the purchase of health insurance. Individuals with incomes below 100 percent FPL will not be required to pay any premiums. The Commonwealth Care Health Insurance Program is expected to subsidize coverage for 207,500 residents.

MassHealth Expansion
MassHealth will be an expansion of Medicaid to children up to 300 percent FPL. Enrollment caps on existing Medicaid programs for adults will be raised. This expansion is expected to provide coverage for 92,500 people, mostly children.

Preservation of Safety Net
A new Safety Net Care Fund will be created from the existing Free Care Pool, which reimburses providers for uncompensated care. The new Safety Net Care Fund will combine these funds with other Medicaid funds, including Medicaid Disproportionate Share Program funds.

Financing
The Massachusetts Health Care Reform Plan is anticipated to cost $1.2 billion over three years and relies on the redistribution of existing funding, including federal Medicaid payments previously paid to safety net providers and funds from the Massachusetts Free Care Pool. Employer contributions from the employer mandate and General Fund Revenue Funds ($308 million over three years) will also be earmarked to finance the Reform Plan.

Source: Kaiser Family Foundation.

and adults in the Children's Health Insurance Program (CHIP) and Medicaid, respectively. A Commonwealth Fund study found that if parents of CHIP-eligible children were allowed to become eligible for Medicaid, Texas and nine other states would experience the greatest decline in their uninsured rates because of the high levels of uninsured low-income families in these states.

Many states recognized the negative effects a high-uninsured rate and are committed through aggressive policy measures and dedicated revenue to reduce the problem. Regardless of the approach Texas adopts to reduce its uninsured rate, research and experimentation by other states demonstrate that a successful approach will likely involve multiple strategies aimed at the different populations who make up the Texas uninsured. States with significantly lower uninsured rates than Texas reduced their uninsured rate over time.

Identifying the uninsured is the first step necessary to create a long-term state strategic plan to address the uninsured problem. Recommendation 1 would have a long-term plan created to serve as a "roadmap to coverage" over time and specify strategies to reduce the uninsured rate. Inevitably, other state priorities will emerge and without a plan and coordinated effort, the state's uninsured rate will not decline significantly over time and the financial and societal costs of the uninsured will continue to affect the state negatively.

Recommendation 1 would amend the Health and Safety Code §113.003 to direct the Texas Health Care Policy Council to establish an advisory committee to provide input to the council regarding ways to reduce the uninsured rate in Texas and for the council to develop a long-term strategic plan recommending specific strategies to address the various segments of the state's uninsured population.

The advisory committee should include a broad spectrum of public and private sector representation including, but not limited to, insurance, business/employers, small businesses, healthcare consumers, patient advocates, community and religious organizations, doctors/nurses, hospitals, and non-profit health centers. With their input, the Texas Health Care Policy Council would be required to develop a long-term strategic plan with input from the advisory committee. The plan would include, but not be limited to, the following:

- objectives for insuring each segment of the uninsured population;
- an estimated cost and savings of implementing each recommended strategy;

- an estimated amount of the number of uninsured impacted by strategy;
- a suggested timeline for implementation by strategy; and
- a rationale for recommending a specific strategy or strategies for specific populations.

The Texas Health Care Policy Council would submit their plan to the Governor, the Texas Legislature, and the Legislative Budget Board by October 1, 2008.

This recommendation would require a statutory change and appropriation authority for travel expense reimbursement for advisory committee members could be given by including a rider in the 2008–09 General Appropriations Bill as follows:

Office of the Governor

XX. Reimbursement of Travel Expenses for the Texas Health Care Policy Council Advisory Committee on the Uninsured. Contingent upon the enactment of legislation by the Eightieth Legislature, Regular Session, or similar legislation relating to the creation of an advisory committee to provide input to the Texas Health Care Policy Council regarding specific strategies for the state to pursue to reduce the number of uninsured Texans and for the Texas Health Care Policy Council to develop a long-term strategic plan for reducing the number of uninsured Texans, the Texas Health Care Policy Council is authorized, pursuant to Chapter 2110, Texas Government Code, reimbursement of expenses for advisory committee members, out of funds appropriated above in Strategy ___________, is limited to the following advisory committee: Texas Health Care Policy Council Advisory Committee on the Uninsured.

FISCAL IMPACT OF RECOMMENDATION

The recommendation, if implemented, would not have significant fiscal impact during the 2008–09 biennium.

The introduced 2008–09 General Appropriations Bill does not address this recommendation.

INCREASE CONSUMER ACCESS TO HEALTHCARE PRICE INFORMATION

Consumers need cost and quality information to make informed choices when purchasing healthcare services. Without price disclosure, providers of healthcare services have little incentive to compete on the basis of cost and quality. If consumers do not have information about costs when they make a purchase then they cannot affect healthcare cost. In the past, patients had less need for cost data because their financial exposure was limited. However, the need for information is growing as consumers are required to pay more of their healthcare costs.

Most states require healthcare facilities and providers to disclose charges and fees at an individuals request. The Texas Department of State Health Services gathers certain information from hospitals and health maintenance organizations, but the information cannot be used by consumers to compare hospitals and provider costs. If physicians, hospitals, and insurers do not provide price information to individuals, then consumers cannot seek the best value. Insured consumers seek services at covered facilities to obtain lower out-of-pocket costs, but do not have the ability to control their cost. Requiring healthcare providers and insurers to publish useful price information would allow consumers to evaluate cost and quality information when they purchase healthcare services.

FACTS AND FINDING

- ♦ Thirty-two states have laws addressing hospital and healthcare providers' price disclosure. The laws commonly require the healthcare providers to either (1) disclose charges and fees to the public or the state health department or (2) require facilities to provide a patient with an estimate or an itemized bill upon request.

CONCERNS

- ♦ Texas does not require hospitals or healthcare providers to publish price information; therefore, it is difficult for patients to be informed healthcare consumers.
- ♦ Hospital-based provider groups, such as radiologists and anesthesiologists, may not contract with the same insurer as the hospital, making the patient financially responsible for the full charge of the non-contracting providers' services.
- ♦ Individuals with health insurance coverage, including insured state employees, are not always informed of the charge of medical services provided by non-contracting provider's as part of a preauthorized procedure until the individual is billed for the services.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend the Texas Health and Safety Code to require hospitals to publish price information for the most common non-emergency inpatient services and the most common outpatient procedures.
- ♦ **Recommendation 2:** Amend the Texas Health and Safety Code to require healthcare providers and insurers to publish the same consumer price information required of hospitals to patients and members in advance of medical visits.
- ♦ **Recommendation 3:** Amend the Texas Insurance Code to prohibit a patient from being "balance billed" by a non-contracting provider when the patient goes to a facility that contracts with their insurer and, as part of their treatment, receives services from a provider that does not contract with the insurer.

DISCUSSION

Consumers have little access to useful information on the cost and quality of healthcare. Insurance companies, hospitals, and physicians do not always provide per-service price estimates or make cost information available to patients. This lack of disclosure makes healthcare one of the few services consumers purchase without knowing prices in advance.

The 2006 Health Care Expectations survey found that a majority of employers feel that offering employees tools to better manage their healthcare can result in moderate to significant savings on health insurance. Yet few employers who provide health insurance are also providing cost and quality data as part of the benefit plan, likely because this data is not widely available.

Consumers are requesting more healthcare price information. According to a 2005 national survey conducted by Towers Perrin (a professional services firm that previously served as the actuary for the Employees Retirement System), 85

percent of respondents said they need more data and tools to make wise healthcare decisions. Another June 2005 survey of 2,500 employees found that 80 percent of those enrolled in consumer-driven plans were frustrated by the lack of information available on the cost of physician services.

In the past, consumers had less need for cost and quality data because managed-care plans limited a patient's financial exposure. To maintain health benefits levels, employers shifted more healthcare costs to plan members. Therefore, price transparency has taken on new importance since health maintenance organizations (HMOs), preferred provider networks and high deductible health plans increased member cost sharing. According to Hewitt (a human resources consulting company that collects data and reports on employer health insurance), the average employee out-of-pocket cost is expected to increase from $1,489 in 2006 to $1,627 in 2007. Overall, employees' total healthcare costs, which include copayments, deductibles and premiums, are projected to be $3,305 in 2007, up 7.8 percent from $3,065 in 2006. As health plans are requiring members to pay for a greater portion of their healthcare costs, members need cost and quality information to be good consumers and manage their out-of-pocket costs.

In 2006, the National Center for Policy Analysis observed that one can see how transparency affects healthcare by looking at cosmetic and laser vision correction surgery. Unlike other forms of surgery, laser vision and cosmetic surgery patients can find and compare a package price that covers all services and facilities. In these instances, patients pay a price that is lower in real terms than the price charged a decade ago for comparable procedures.

STATE AND FEDERAL EFFORTS

As state and federal lawmakers pursue price transparency efforts, hospitals and providers are publishing some information, but the information is minimally helpful for patients comparing cost and quality. The President issued an executive order in August 2006 calling for federal agencies to adopt health information technology and publicly report healthcare price and quality data in a push for greater transparency. The President urged insurance companies and medical providers to make healthcare price and quality information readily available to consumers. He directed federal healthcare programs, which include Medicare and the Federal Employees Health Benefits, to make price and quality information available to the public.

The American Medical Association (AMA) supports transparency and urges physicians, hospitals and others to publicly post their fees. AMA believes that the President's plan is a step toward healthcare price transparency, but that full transparency should include insurers' charges. The American Hospital Association endorsed The Health Care Price Transparency Act of 2006 (HR 6053, One Hundred-ninth Congress, Second Session, 2006) which promotes price transparency for hospitals and insurers. This legislation, referred to committee in September 2006, would require:

- hospitals to disclose charges,
- hospitals to provide the public with access to such information, and
- Insurers to supply individuals with health insurance a statement of the estimated out-of-pocket costs for particular healthcare services.

The National Conference of State Legislatures reports that currently, 32 states enacted laws encouraging healthcare price disclosure. Commonly, these laws require healthcare facilities and providers to disclose charges and fees to the public or the state health department, or require facilities or providers to supply a patient with an estimate or an itemized bill upon request. Minnesota is developing a web-based system for reporting charge information, including average charge, average charge per day and median charge, for each of the 50 most common inpatient diagnosis-related groups and the most common outpatient surgical procedures. Florida requires healthcare facilities to notify patients of their right to receive an itemized bill upon request, either at admission or upon discharge.

The Texas Health Care Information Council (THCIC), a division of the Department of State Health Services, was created by the Texas Legislature in 1995 to gather information from hospitals and HMOs and publish reports to help consumers compare hospitals and health plans. Based on the data it collects, a portion of the information is summarized and posted on their website. The most current reports (2004) compare the volume and mortality rates for less than 20 procedures at most hospitals across the state. The number of hospitals with reported data varies based on the number of procedures conducted at the hospital.

THCIC collects data using a software tool provided by the Agency for Healthcare Research and Quality (AHRQ). This federal agency's mission is to improve the quality, safety, efficiency, and effectiveness of healthcare. The data is collected in a specific format for AHRQ; as a result it is not user

friendly and is not helpful to consumers to compare hospital cost and quality information. THCIC sells the Texas Public Use Data File which contains statewide data for all diagnostic categories at all reporting hospitals for $4,600 per calendar year.

PRICE TRANSPARENCY INITIATIVES

Minimal price information is available to the public because the information is often difficult to understand or too general to be meaningful. Retail prices assist individuals to compare cost if they are uninsured or health plan members receiving services from providers who have are not part of their insured network. However, most patients are charged a rate for healthcare services that the patient's insurance company negotiated with the hospital or provider. For this group, the insurance company would need to provide cost information to encourage consumers to seek the best value.

In 2005, the health insurance provider Aetna began giving its members in the Cincinnati area access to the prices it negotiated with area physicians. Health plan members could see what they would be charged before they went to the doctor. Aetna posted the actual discounted rates it paid physicians for about 25 of their most common office-based procedures, such as physicals, electrocardiograms, and vaccinations, allowing members to better gauge their out-of-pocket costs. Posting the insurers negotiated fee rather than the retail fee gave members accurate information before services were rendered. Insurers typically disclose the amount paid to providers for services only on the explanation of benefits statement sent to patients after the claim is processed. Aetna has not changed this policy. Instead they changed the timing of the information by providing cost information in advance.

Cigna, a Pennsylvania-based company that provides insurance benefits, recently launched a web tool that allows members to compare medications at 52,000 pharmacies nationwide. Enrollees can view the discounted drug prices at various pharmacies and determine their out-of-pocket costs for the drug.

Hospital pricing remains one of the more difficult areas to apply transparency in healthcare. The difficulty can be attributed to the myriad cost variables that are involved in each hospital based procedure. A hip replacement, for example, includes several distinct hospital services. Hospitals charge for each individual service, they do not bundle services by procedure. As a result, a consumer would need extensive knowledge of medical care to identify which services might be included in a procedure like a hip replacement.

Since 2004, California required hospitals to publish their retail price list for every medical service and product they provide. These lists can be thousands of pages long and difficult for consumers to comprehend. Retail prices are not always representative of the amount a patient will pay, these prices can be as much as four times the Medicare rate and twice as much as the insurers' negotiated rate.

The Oregon Association of Hospitals and Health Systems' website allows consumers to compare hospitals' average prices for common procedures. The website, developed in response to proposed state legislation seeking greater provider price transparency, lists only hospitals' charges, or retail prices for services, not the discounted rates that health plan members actually pay.

By using the Oregon hospital association's website, an individual could find that the average undiscounted price for major hip, knee, ankle or foot surgery at one Portland medical center is $31,377. According to Modern Healthcare, an area insurer that publishes price information for member's estimates based on medical claims data, the average discounted price for arthroscopic knee surgery in the Portland area for its members ranges from $9,500 to $15,200.

Blue Cross Blue Shield of Texas (BCBS) administers a large portion of the state employee health plans at Employees Retirement System (ERS), Teacher Retirement System (TRS), University of Texas System (UT), and the Texas A&M University System (A&M), which 1.2 million employees, retirees, and dependents are enrolled. BCBS does not provide prospective information to plan members on cost and quality of healthcare, but created two Internet-based tools to assist members. The hospital comparison tool compares criteria such as patient volume, location, mortality rates, and outcomes. However, price information is not detailed, and the information is only available for hospitals, not for other healthcare providers.

The second BCBS tool, the Treatment Cost Advisor, publishes an estimated price range for specific tests and services. The estimated price range is based on claims paid for a particular service and reflects the average amount the insurer paid for the service. This tool does not estimate patients out-of-pocket cost or specify the amount certain hospital or physicians' charge. For example, the Treatment Cost Advisor estimated the cost of one service, a skin biopsy, to be $167 to $332, but

it did not specify which provider charged the lower rate within the range.

Neither tool combines cost and quality in a manner that allows members to identify an individual provider who offers the best value. There is not specific information about hospitals or providers prices and members are not able to estimate out of pocket cost with the information provided.

BENEFITS OF PRICE TRANSPARENCY

Price transparency allows patients to be better consumers of healthcare services and refocuses the healthcare system on the patient as a customer. Individuals are becoming more active consumers of health information. According to Pew Research Center (a national non-profit organization that provides information on issues, attitudes and trends in America), 63 percent of Americans use the Internet, and 8 out of 10 of those have used it to seek health information.

Economists suggest that it is necessary to change the way consumers purchase healthcare to reform healthcare, and they point to price transparency as a needed step toward improving quality and reducing the cost of healthcare. In July 2006, the American Hospital Association agreed that hospital price information needs to be easy to find and understand, and that consumers need to be aware of why prices vary.

Consumers need price and quality information now because their decisions affect their out-of-pocket cost and their health. Quality improvements in healthcare should occur as consumers demand more information and make better decisions. Informed consumers have proven they will spend more wisely. According to the Employee Benefits Research Institute (a non-profit organization concerned with employee benefit programs and sound public policy), 27 percent of patients in comprehensive health plans ask their doctor to recommend a less costly prescription compared to 44 percent of patients who are exposed to the cost of medical services through high deductible plans.

Consumers need cost information to make informed choices when purchasing healthcare. Recommendation 1 would amend the Texas Health and Safety Code to require hospitals to publish price information for the most common non-emergency inpatient services and the most common outpatient procedures. Recommendation 2 would amend the Texas Health and Safety Code to require providers and insurers to supply the same price information to ensure that individuals who are insured, uninsured, or seeking services outside of their insured network can consider costs when selecting a hospital or provider. Recommendations 1 and 2 are the first steps toward increasing consumerism in healthcare, and supplying individuals the information they need to manage their out-of-pocket costs. Economists believe a long-term benefit of healthcare price transparency is that it encourages individuals to seek the best value in healthcare which could ultimately reduce the cost of healthcare services. When patients consider cost when choosing a hospital or provider, the hospital or provider may be more likely to compete.

The price information could be published on a single website at a state agency like the Department of State Health Services or the Texas Department of Insurance, on an association's website, or on each hospital, provider or insurer's website. The price information should be made available to the public at no charge. The information should be in a format that consumers can easily understand and it should include detailed information about the price hospitals, providers, and insurers charge for the most common procedures. Upon request, a hospital, provider, or insurer should provide individuals an itemized estimate of the cost of all services associated with a visit or procedure. Though an estimate would not provide exact price information it would allow consumers to compare similar services at various hospitals and recognize the range of prices that are charged for a service. With this knowledge, consumers in certain circumstances, can budget for their out-of-pockets costs.

NON-CONTRACT PROVIDER BILLING

Even with price transparency, some patients cannot shop for services. Health plan members seek services from hospitals that are in their insured network to obtain lower out-of-pocket costs and fuller benefits. While receiving care at a network hospital, a member may receive services from a provider who does not contract with the same insurance company as the hospital. Hospital-based provider groups, such as radiologists, pathologists, and anesthesiologists, may choose not to contract with the same insurers as the hospitals where they are based or not contract with any health insurer. Yet, these providers provide services to patients because of their arrangement with the hospital. Patients rarely have a choice of providers while in the hospital and are unaware of the non-contracting provider's charges until they receive a bill. This scenario leads to patients being balance billed by a non-contracting provider while receiving services at a network hospital.

With the information from recommendations 1 and 2, insured and uninsured patients could consider cost before selecting services. However, the most proactive healthcare consumers could not avoid being balance billed for services they receive at a network facility from a non-contracting provider.

Hospital-based providers expect full payment of billed charges rather than accepting the network rate the insurer negotiated with providers in the same medical field. Full-billed charges can be significantly higher for the member. Because of this, there may be incentives for hospital-based provider not to participate in the insured networks. The insured member is typically unaware that a provider is not part of the insured network until the member is billed by the individual provider.

The state employee health plans, ERS, TRS, UT and A&M, cannot identify the exact amount members are balance billed because of the way claims are processed. There is no additional cost to the health plan when members receive services from non-contracting providers. When patients receive services from non-contracting providers, the health plan pays the network level of benefit and the plan member is responsible for the difference. The health plan cannot ensure that a member admitted to a network hospital for a preauthorized procedure will receive services only from network providers; therefore, the insurer or the patient cannot avoid balance billing situations. **Figure 1** shows the amount paid in out-of-network claims in fiscal year 2005 by the state employee health plans. Members may have been balance billed for costs in these circumstances, but the exact amount members paid cannot be determined.

Other states have struggled to find ways to protect patients from balance billing. Maryland, for example, prohibits balance billing for covered services and, in the case of HMOs, sets the maximum amount that a provider may collect at 125 percent of the HMOs contract rate. Colorado enacted legislation in 2006 that holds patients harmless when they go to a facility contracted with their insurer and as part of their treatment receive services from a non-contracting provider. In these circumstances the insurer and the provider must settle the bill. California published administrative rules in August 2006 to clarify unfair billing practices by non-contracting providers who provide emergency services to insured members. The rules prohibit balance billing and provide an independent claims payment dispute resolution process to provide non-contracting providers a fair and effective process to resolve claims with the insurer. Connecticut bans network and out-of-network physicians from balance billing patients.

The Seventy-ninth Legislature, Regular Session, 2005, considered nine bills relating to balance billing. The legislation identified ways to prohibit patients from being balance billed by making the provider or the insurer responsible for the unpaid charge. None of the legislation passed both houses.

Someone other than the patient will be responsible for the unpaid amount if Texas law establishes a hold-harmless clause stating that non-contracting providers are prohibited from attempting to collect any amounts not paid by the insurer from individuals for healthcare services received at a network facility. By holding patients harmless, the portion of the amount that patients were previously billed will either be unpaid or paid by the insurer or the hospital. Effects of the hold harmless clause may include the following:

1. Capping the charge non-contracting providers can bill a patient at a network hospital. The state would establish a usual and customary change for the service or establish a rate such as a percentage of the Medicare reimbursement rate, and the provider would be required to accept that amount as full payment.

FIGURE 1
STATE EMPLOYEE HEALTH PLAN OUT-OF-NETWORK SPENDING, FISCAL YEAR 2005

PLAN	PERCENTAGE OF OUT-OF-NETWORK MEDICAL CLAIMS	HEALTH PLAN COSTS FOR OUT-OF-NETWORK MEDICAL CLAIMS (IN MILLIONS)
Employees Retirement System	3.9%	$40
Teacher Retirement System-Care (retirees)	8.9%	$24
Teacher Retirement System-ActiveCare (teachers)	3.9%	$21
University of Texas System	3.2%	$12
Texas A&M University System	5.5%	$4

SOURCES: Legislative Budget Board; State Employee Health Plans.

2. Insurers could require by contract that hospitals ensure that only network services are provided to network patients while at the hospital. If the insurer is unable to establish an agreement with the hospital, then either the hospital would be excluded from the network or the insurer would become responsible for the amount billed by the non-contracting provider.
3. Require hospitals to package services for network patients. When a hospital chooses to contract with an insurer, the hospital must also contract with providers who accept the same insurance or agree to accept a specified negotiated rate as full payment when non-contracting providers provide services to network patients. If the hospital cannot provide a sufficient number of hospital-based providers who accept the same insurance as the hospital then the hospital would become responsible for the amount billed by the non-contracting provider.

Recommendation 3 would amend the Texas Insurance Code to hold patients harmless by prohibiting non-contracting providers from billing patients for the amount not paid by their insurer when the patient goes to a network facility that contracts with their insurer and as part of their treatment they receive services from a provider that does not contract with their insurer.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations, if implemented, would not have a significant fiscal impact. The Seventy-ninth Legislature, Regular Session, 2005 introduced similar legislation that required medical facilities to provide consumers with a copy of the facility's common procedure price list. This legislation required the Department of State Health Services to administer the program. The agency estimated it would incur minimal costs to ensure consumers had access to price information.

The introduced 2008–09 General Appropriations Bill does not address these recommendations.

CREATE A LONG-TERM CARE INSURANCE PARTNERSHIP TO REDUCE FUTURE RELIANCE ON MEDICAID

Increasing demand for long-term care is one effect of the growing elderly population. In Texas, the age 65 and older population totaled 2.1 million in 2000 and is projected to increase to 3.7 million by 2020, a 76 percent increase. In 2005, $4.5 billion in Medicaid All Funds were spent on long-term care services and supports through programs provided by the Texas Department of Aging and Disability Services and the Texas Health and Human Services Commission. Medicaid continues to be the single largest source of financing for formal long-term care services, including nursing home care, in Texas. Two-thirds of nursing home patients in 2005 were Medicaid recipients.

An alternative source of funding for long-term care, private long-term care insurance, is available, but few individuals buy it. The federal Deficit Reduction Act of 2005 provides states with new opportunities to make long-term care insurance more appealing to individuals. Under the Long-term Care Insurance Partnership, policyholders can keep more assets than are normally allowed if they turn to Medicaid after exhausting their private benefits. With this incentive, people will be more likely to prepare for the risk of long-term care, thus potentially slowing the future growth of the Medicaid program.

CONCERNS

- The lack of private long-term care insurance unduly shifts the financial burden for individual long-term care to the Medicaid program. Forty-eight percent of long-term care costs are covered by Medicaid nationally, with 10 percent of costs paid privately.
- The demand for long-term care will continue to grow with the aging of the population. Long-term care insurance is an option that exists, but few individuals buy it. Approximately 1.5 percent of Texans have private long-term care insurance.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Insurance Code to require the creation of a public-private Long-Term Care Insurance Partnership to encourage consumers to financially prepare for the risk of long-term care by purchasing insurance.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill requiring the Texas Department of Insurance to submit a progress report in collaboration with the Health and Human Services Commission on the status of implementing the Long-term Care Insurance Partnership to the Legislative Budget Board and the Governor by September 1, 2008.
- **Recommendation 3:** Appropriate $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 from General Revenue–Dedicated Funds (Texas Department of Insurance Operating Fund Account) to the Texas Department of Insurance to add three full-time equivalents to implement the licensing and regulatory requirements related to the Long-term Care Insurance Partnership.

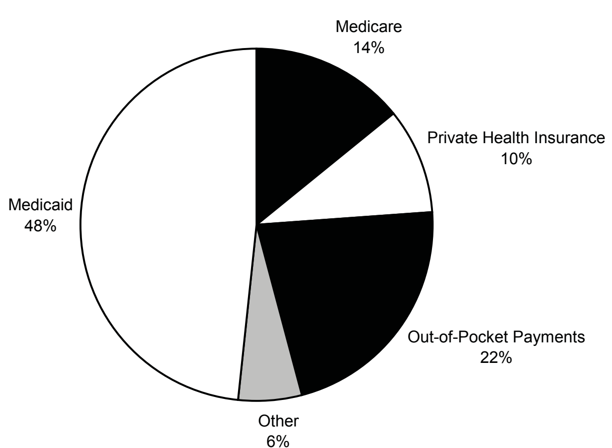
DISCUSSION

Long-term care is care provided on a regular basis for a prolonged period, including providing help with basic personal-care tasks such as bathing or dressing, help for people who cannot perform daily activities such as cooking or taking medications, or help with nursing care such as monitoring blood pressure. This type of care can be provided in an institutional setting such as a nursing home, in a person's home or in other community-based facilities.

While information specific to Texas is not available, **Figure 1** shows that nationally, 48 percent of total long-term care spending provided in a formal setting is paid through the Medicaid program, and only 10 percent is paid through private insurance.

Medicaid long-term care spending in Texas, through the programs administered via the Department of Aging and Disability Services (DADS) and the Health and Human Services Commission (HHSC), totaled $4.5 billion in fiscal year 2005 and is estimated to increase to $4.8 billion in fiscal year 2006. Nursing home expenditures have made up the vast share of this spending for several years, and accounted for 36 percent of the state's long-term care Medicaid budget in fiscal year 2005. Home- and community-care spending also makes up a growing share of Medicaid long-term care spending, with $1.8 billion being spent in fiscal year 2005.

FIGURE 1
NATIONAL LONG-TERM CARE SPENDING BY PAYOR, 2001



Source: National Health Statistics Group.

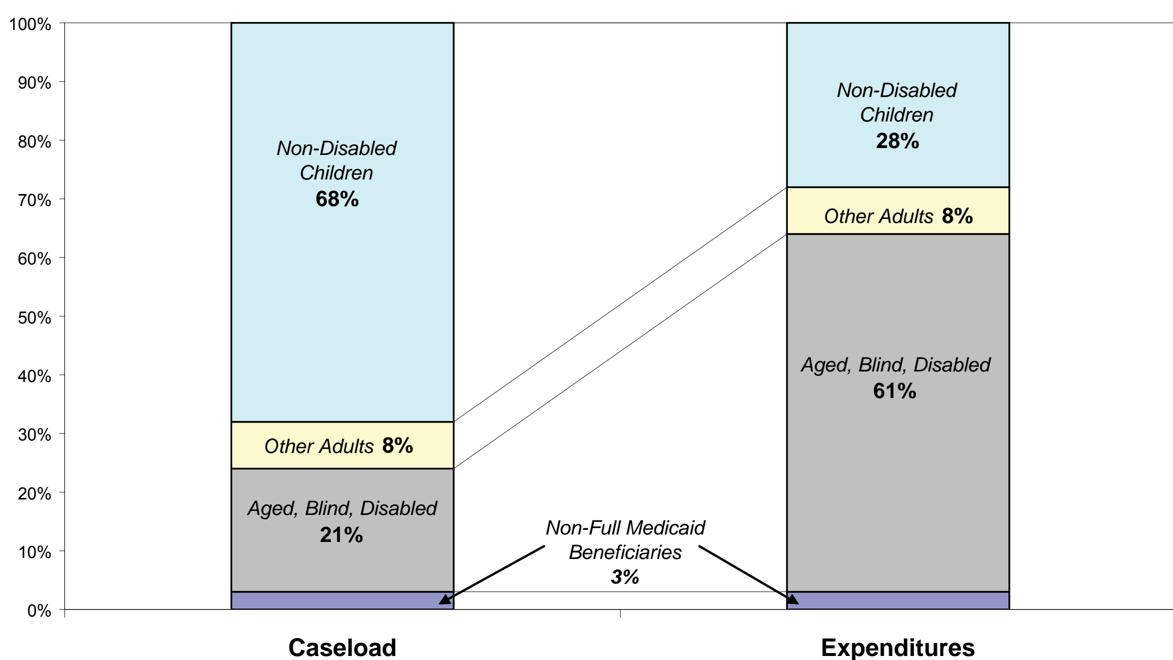
A majority of those accessing formal long-term care services do so through Medicaid. Currently, two-thirds of nursing facility patients in Texas are Medicaid beneficiaries. According to DADS, the total number of nursing facility patients has remained level at 59,000 from fiscal year 2005 to fiscal year 2006. Home-and community-care populations have grown steadily for the last few years, and grew by an estimated 4.2 percent in fiscal year 2006.

Figure 2 shows the distribution of Medicaid expenditures by eligibility category. In fiscal year 2005, 61 percent of Medicaid expenses are due to the aged and disabled population, who make up only 21 percent of all Medicaid recipients. Inversely, non-disabled children make up 68 percent of medicaid beneficiaries and account for 28 percent of the Medicaid expenditures. Pregnant women, Medically needy, and Temporary Assistance for Needy Families (TANF) parents account for 8 percent of expenditures and caseload, combined, and the remaining 3 percent of caseload and expenditures is accounted for by non-full Medicaid beneficiaries, such as persons eligible for Medicare premium and deductible reimbursement and non-citizens' emergency services.

This inverse relationship shows that the provision and cost of long-term care services currently have a significant fiscal impact on the state's budget.

The cost of providing long-term care to the aged and non-aged persons with disabilities is expected to continue to rise with the projected growth in Medicaid nursing facility

FIGURE 2
TEXAS MEDICAID BENEFICIARIES AND EXPENDITURES, FISCAL YEAR 2005



Notes: Aged, Blind, and Disabled includes clients under 19. Total Expenditures includes all Acute and Long-Term Care expenditures, including Vendor Drugs and Case Management. Non-full Medicaid beneficiaries include persons eligible for Medicare premium and deductible reimbursement, and persons eligible for Emergency Medical Services Only.
Source: Health and Human Services Commission.

caseloads, growth in home and community based populations, increased life expectancy, and fewer available informal caretakers. The most significant contributor to the projected increase in long-term care spending is the dramatic growth of the elderly population in Texas. As shown in **Figure 3**, in 2000, Texans 85 years or older totaled 237,000. By 2040, this population is expected to increase approximately 249 percent to 831,000, making up one-quarter of the Texas population.

This change in demographics will have a great effect on the healthcare infrastructure and economy of the state. If the state can divert even a small portion of this population from Medicaid long-term care, it will avoid future Medicaid long-term care costs.

PRIVATE LONG-TERM CARE INSURANCE

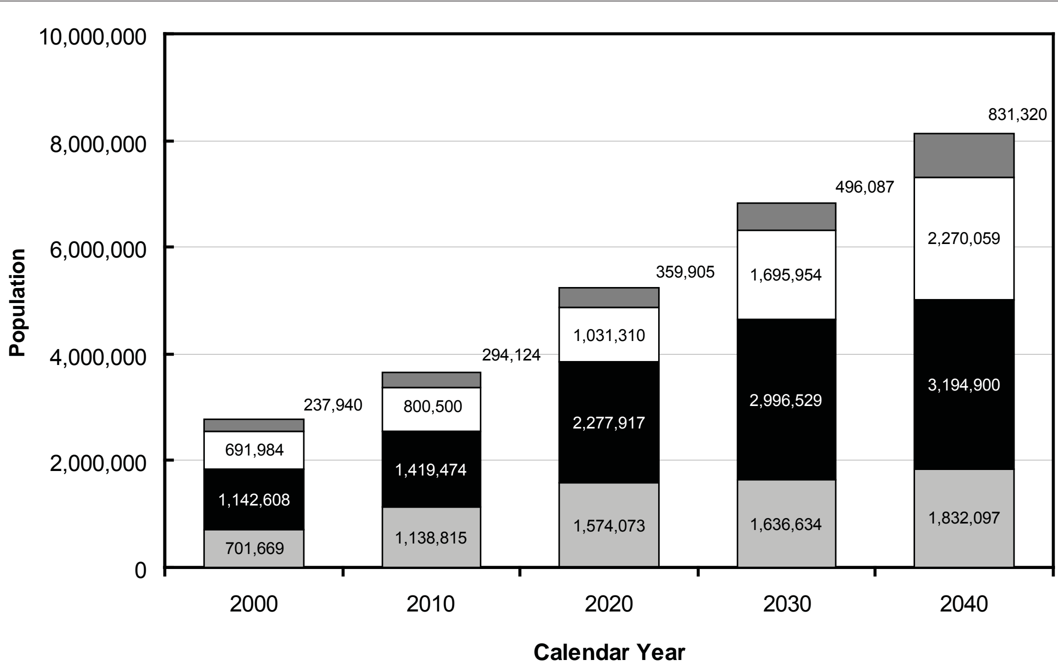
Private long-term care insurance (LTC insurance) is a potential source of funding for long-term care needs. LTC insurance is an insurance policy that covers some or all of the costs of long-term care services provided in settings other than acute-care hospital units. This option offers greater flexibility in the type and quality of long-term care. It also ensures independence and control over personal assets that one might want to protect or leave to others.

As of October 2006, the LTC insurance market in Texas included 35 companies. Annual statements from 2005 provided to the National Association of Insurance Commissioners show that there are 354,085 individuals, or 1.5 percent of the Texas population, who have LTC insurance policies. California and Connecticut are examples of states with higher market penetration rates, with 6 to 9 percent of their eligible population covered.

RECENT CHANGES TO MEDICAID LAW FOR LONG-TERM CARE

Medicaid offers two general forms of medical coverage to help low-income aged and non-aged persons with disabilities. The first is the basic Medicaid benefit package, or full benefit eligibility. This coverage includes physician, hospital, nursing facility, prescription drug, and other services. The second form of medical coverage includes assistance with premiums, deductibles, and coinsurance for low-income Medicare beneficiaries who are considered "dual eligibles." Most out-of pocket Medicare costs are associated with acute services and

FIGURE 3
PROJECTED POPULATION TREND FOR OLDER ADULTS IN TEXAS, 2000 TO 2040



SOURCE: Department of Aging and Disability Services.

limited hospital stays, since Medicare is not designed to cover long-term care services.

There are eligibility requirements for Medicaid's long-term care benefits. These vary depending on the setting a person is in. In Texas, to qualify for nursing home long-term care Medicaid benefits an applicant must be:

- age 65 or over, blind or disabled;
- below 300 percent of monthly Supplemental Security Income level, $2,712 per family of 2 as of January 2006;
- a United States citizen (unless a legal immigrant before August 1996), and resident of Texas; and
- in medical need of a registered nurse.

In addition to meeting residential, age and medical requirements, applicants for Medicaid long-term care benefits must meet income and asset restrictions to qualify for services. If an applicant's income exceeds a certain amount, some legal solutions are available to bypass the eligibility rules. Applicants may shelter their assets by putting money or property under different ownership or by converting their assets into exempt resources such as home remodeling expenses, burial policies, a more expensive vehicle or home (up to $500,000 in value if single), and household goods. Such transfers of homes, money, and businesses can reduce the assets of future long-term care patients that they could have otherwise used to pay for nursing facility care or other long-term care services prior to qualifying for Medicaid benefits. The more quickly that long-term care recipients spend down their assets to Medicaid qualifying levels, the sooner they become dependents of the state and the greater the cost of the long term care program.

The federal government has taken some steps to address these loopholes. One of the provisions in the Deficit Reduction Act of 2005 (DRA) changes the look-back period related to asset transfers for determining eligibility from 3 to 5 years prior to applying for Medicaid. Any asset transferred within five years of applying for Medicaid benefits will be used to determine the penalty period. The penalty period for Medicaid ineligibility due to asset transfers also changed to begin when the applicant becomes eligible for benefits. Before the DRA, the penalty period started when the transfer was made, reducing the amount of time the person was ineligible for Medicaid benefits.

In addition to these mandatory requirements, there are several optional provisions in the DRA. One option is the expansion of the Long-term Care Insurance Partnership (the Partnership). The Partnership provides an incentive to individuals to buy long-term care insurance to protect against the costs of long-term care. Under this federal-state insurance program, individuals purchase a qualifying long-term care insurance policy which allows them to protect a portion of their assets if they need to apply for long-term care Medicaid benefits. While the Centers for Medicare and Medicaid Services (CMS) has not yet finalized the rules for the establishment of the Partnership, they require interested states to submit a Medicaid state plan amendment for approval.

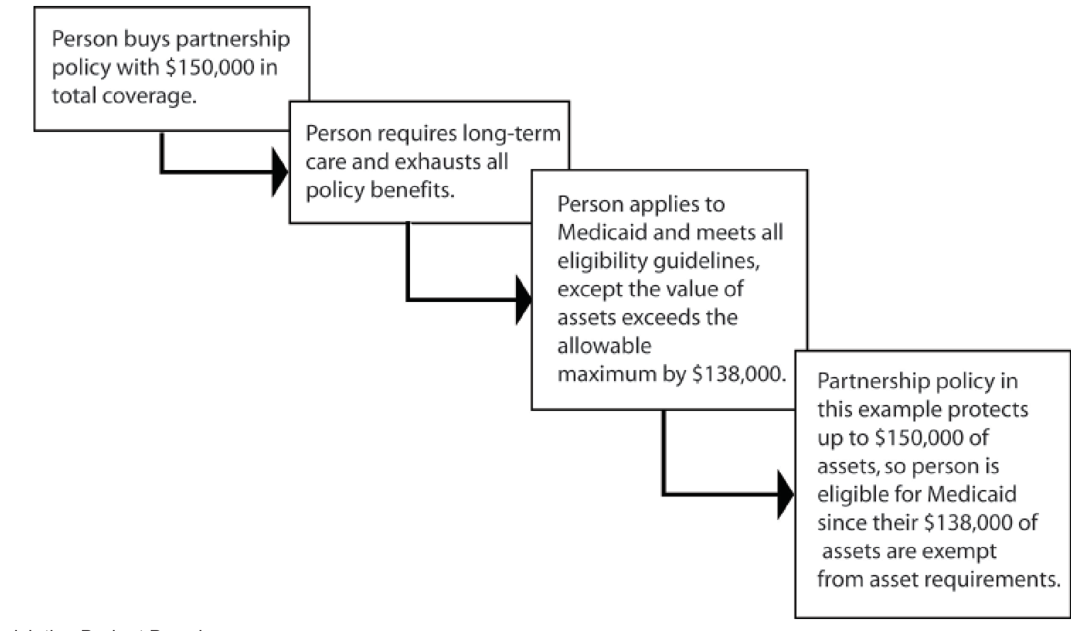
LONG-TERM CARE INSURANCE PARTNERSHIP

Before the passage of the DRA, the Partnership was allowed in only six states (four of which chose to implement the program) per the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). This program started as a demonstration program in 1987 to save states money by diverting policyholders from accessing Medicaid long term care services to private LTC insurance. Individuals who purchased long-term care insurance were allowed to qualify for Medicaid long term care services without meeting certain eligibility guidelines after their private insurance benefits were exhausted. For example, in California, Connecticut, Indiana, and New York, the four states that currently participate in the Partnership, when a person with a qualifying long term care policy exhausts their benefits, they can qualify for Medicaid even if the value of their assets exceeds the maximum threshold set by federal law. Policyholders must still meet income requirements.

In California and Connecticut, Partnership policyholders receive protection of their assets equivalent to that of the benefits paid out in their policy. This same dollar-for-dollar model is required under the DRA. An example of how the dollar-for-dollar model works is shown in **Figure 4**.

In the example shown in **Figure 4**, the person would not have been eligible for Medicaid had they purchased a long term care partnership policy with total coverage amounting to anything less than the value of their assets. For example,with assets valued at $138,000, a policy of $125,000 would make them ineligible for Medicaid benefits until they spend down to a level where the value of their assets was at or below $125,000. While not fully exempt from Medicaid estate recovery upon death, a policyholder's estate is protected from recovery in an amount equal to what their private LTC insurance policy paid out in benefits. In this example, a state

FIGURE 4
DOLLAR-FOR-DOLLAR MODEL UNDER THE LONG-TERM CARE INSURANCE PARTNERSHIP



SOURCE: Legislative Budget Board.

with a Partnership would have to disregard the first $150,000 of a person's estate for recovery purposes.

Conversely, New York uses a total assets model that protects a policyholder's entire assets for purposes of qualifying for Medicaid. Under this model, policyholders must purchase a policy that covers benefits in an amount equal to or above the minimum determined by the state for the year the policy was purchased. Indiana is the only state that offers both options.

According to the U.S. General Accountability Office, of the 211,972 partnership policies purchased since 1992, 81 percent remain active. **Figure 5** shows Partnership policyholder information by state and the number of participants who accessed Medicaid.

Connecticut was the first state to establish the Partnership and has estimated it has saved $3 million per year for the approximately 300 policyholders who responded to a 2005 survey. The demographics of the respondents are important to consider in understanding the estimate. Twenty-four percent of the respondents were age 65 or older, and only 10 percent of the total respondents had a monthly income below $2,499. Over 88 percent of respondents had assets valued at

FIGURE 5
PARTNERSHIP POLICYHOLDER INFORMATION BY STATE

PARTNERSHIP POLICIES	CALIFORNIA	CONNECTICUT	INDIANA	NEW YORK	TOTAL
Purchased	77,501	38,144	34,969	61,358	211,972
Active	64,915 (84%)	30,834 (81%)	29,189 (83%)	47,539 (77%)	172,477 (81%)
Policyholders who:					
Received/ing Benefits	1,256 (1.6%)	492 (1.3%)	332 (0.9%)	1,890 (3.1%)	3,970 (1.9%)
Exhausted Benefits	89	35	31	96	251
Accessed Medicaid	25	19	16	59	119
Bought Comprehensive Coverage	95%	99%	88%	100%	
Nursing Home only Coverage	5%	1%	12%	Not an option	

SOURCE: U.S. General Accountability Office.

over $100,000. With incomes that high, the majority of policyholders would not qualify for Medicaid benefits.

The average annual premium paid in Connecticut for a two-year minimum coverage policy, with inflation protection and nursing home and home and community based services for a 55-year-old person is approximately $2,000, and $4,700 for a person 70 years of age. These premiums are comparable to what other policyholders in Partnership states pay. It is important to note that the younger an individual is, the less expensive the policy. Since insurance companies cannot increase an individual policyholder's premium, an individual paying $1,000 at the time of purchase, will pay the same premium in future years, assuming no changes have been made to the policy. This is a major advantage to those individuals purchasing LTC insurance at a younger age.

The other Partnership states have estimated savings from participation in the program but have not provided details on their methodology.

STATE EFFORTS TO INCREASE LONG-TERM CARE INSURANCE PARTICIPATION

Other states have taken steps to increase the number of residents who have LTC insurance. As part of an education and outreach program that promotes the idea of long-term care as a personal responsibility and encourages people to prepare for the risk and cost of long term care costs, the U.S. Department of Health and Human Services has launched the "Own Your Future" program. Texas is one of the six states selected to participate in the program that will target people between the ages of 45 and 70. This program can help promote awareness and educate people about the role of Medicaid and Medicare, especially since surveys have found that most of those between the ages of 40 and 64 believe that Medicare will cover prolonged long-term care expenses or they are unaware that Medicaid has strict income and asset guidelines that require impoverishment.

In addition to educational campaigns, 28 states (including the District of Columbia), all of which have state income taxes, offer tax credits or deductions to individuals who purchase LTC insurance. The federal government allows insurance premiums to be claimed if individuals itemize their deductions. Tax incentives make LTC insurance more affordable by lowering the relative cost of the product and serve to encourage people to buy this type of insurance. Five states extend the tax deduction to individuals who purchase LTC insurance for relatives such as children, parents, and grandparents. The American Council of Life Insurers also identified four states—Idaho, Maine, Maryland, and Oregon—that offer tax incentives for employer-sponsored, group LTC insurance.

Some states, including Texas, offer LTC insurance to their employees for which they must pay the premium. Currently, 11,902 state and higher education employees and retirees who receive health benefits through the Employee's Retirement System have LTC insurance through the state plan. Five-thousand five-hundred and eighty-seven University of Texas System employees and retirees, and dependents are enrolled in the state's LTC insurance plan. Higher education employees can pay their premium through payroll deduction.

Other efforts that states have taken to encourage the purchase of LTC insurance include passing legislation to establish long-term care partnerships, contingent upon federal approval. In anticipation of the repeal of the OBRA 1993 provision prohibiting states from establishing such programs, the 21 states listed in **Figure 6** have legislation that allows individuals to participate in the Partnership.

CREATING A LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM

Recommendation 1 proposes creating a Partnership in Texas by amending the Insurance Code to statutorily recognize the Long-term Care Insurance Partnership (the Partnership). TDI and HHSC would be required to develop the Partnership under the guidance of CMS. Per CMS guidelines, HHSC would be required to submit a Medicaid state plan amendment

FIGURE 6
STATES WITH LEGISLATION ALLOWING PARTNERSHIP, 2006

Arkansas	Hawaii	Maryland	Montana	Oklahoma	Washington
Colorado	Idaho	Massachusetts	Nebraska	Pennsylvania	
Florida	Illinois	Michigan	North Dakota	Rhode Island	
Georgia	Iowa	Missouri	Ohio	Virginia	

NOTE: Does not include four current Partnership states.
SOURCE: National Association of Health Underwriters.

to CMS. The U.S. Department of Health and Human Services is drafting the Partnership related regulations required under the DRA. HHSC and TDI have indicated that they are working together on this matter and are waiting on direction from the federal government. Establishing the Partnership would put Texas in line with several other states that are seeking to establish Partnerships. The uniform approach to a long-term care partnership program includes:

- dollar for dollar asset protection;
- state reciprocity that ensures the portability of policies purchased under the Partnership;
- approved tax qualified long-term care policy;
- consumer education; and
- uniform and simplified annual reporting to a single repository.

Joining the Partnership is likely to increase the number of companies offering LTC insurance policies in Texas.

The Insurance Code contains several safeguards for purchasers of LTC insurance. Like other insurance products, LTC insurance requires that consumers see the risk involved in not purchasing the insurance; therefore, safeguards that add value to the product and diminish the risk of financial loss are needed. In Texas, LTC policies are required to offer the applicant the option to purchase a policy that provides for benefit levels to increase throughout the interval of coverage to account for reasonably anticipated increases in costs of long-term care services covered by the policy. Consumers in Texas are also protected against the insolvency of an insurance company, with the Texas Guaranty Fund offering protection to policyholders of up to $300,000 for LTC insurance. Similar safeguards would also be required of policies sold through the Partnership.

Recommendation 3 would appropriate $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 in General Revenue–Dedicated Funds (Texas Department of Insurance Operating Fund Account) to TDI to implement the licensing and regulatory requirements related to the Partnership. The appropriation would cover salary and benefits for 3 full-time equivalents and the additional expenses of administering the program for the biennium. The appropriation and the addition of three full-time equivalents is based on what other states with Partnership programs have determined is necessary to administer the program. Depending on the number of individuals who participate in the program, staffing needs may need to be adjusted as the program is implemented. TDI has indicated that there are certain requirements of the Partnership that may be absorbed with no additional cost since they would be within their normal course of operations. Recommendation 2 would include a rider in the 2008-09 General Appropriation Bill that would direct TDI to submit a progress report on the status of implementing the Partnership to the Legislative Budget Board and the Governor by September 1, 2008. The status report would include: efforts that have been made to create the Partnership, including the submission of the state plan amendment and other CMS requirements; the number of FTEs contributing to these efforts; and the costs of administering the program. Since HHSC is required to submit a Medicaid state plan amendment to CMS for approval of a Partnership, this progress report would be a joint effort between TDI and HHSC.

The following Texas Department of Insurance contingency rider could be included in the 2008–09 General Appropriations Bill to implement this recommendation:

> Contingent on the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation relating to the establishment of the federally sponsored Long-term Care Insurance Partnership, in addition to the amounts appropriated above, the Department of Insurance is appropriated $150,000 for each fiscal year from the Texas Department of Insurance Operating Fund Account for the purposes of adding three full-time equivalents to implement licensing and regulatory requirements related to the Long-term Care Insurance Partnership. The Department of Insurance shall submit a progress report by September 1, 2008, on the status of establishing the Long-term Care Insurance Partnership, to the Legislative Budget Board and the Governor.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations would be cost neutral in the 2008–09 biennium. As shown in **Figure 7**, Recommendation 3 would appropriate $300,000 in General Revenue–Dedicated Funds (Texas Department of Insurance Operating Fund Account) to TDI for the salary and benefits for three full-time equivalents to implement licensing and regulatory requirements related to the Long-term Care Insurance Partnership. Because the Texas Department of Insurance Operating Fund Account is self-leveling, it is expected that TDI would use available balances, or increase its maintenance

FIGURE 7
FISCAL IMPACT OF CREATING THE LONG-TERM CARE INSURANCE PARTNERSHIP

FISCAL YEAR	PROBABLE REVENUE GAIN TO GENERAL REVENUE–DEDICATED FUND NO. 36	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED FUND NO. 36	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2006–07 BIENNIUM
2008	$150,000	($150,000)	3
2009	$150,000	($150,000)	3
2010	$150,000	($150,000)	3
2011	$150,000	($150,000)	3
2012	$150,000	($150,000)	3

Source: Legislative Budget Board.

taxes and fees to generate sufficient revenue to cover this appropriation.

As seen in the four original Partnership states, the Partnership has the potential to divert individuals from Medicaid and thus reduce public healthcare expenditures. However, this fiscal impact is not easy to measure, and is expected to be found in future savings, at a point when a significant number of policyholders have drawn on their insurance benefits.

The introduced 2008–09 General Appropriations Bill includes a contingency rider to implement Recommendations 2 and 3.

CONTAINING COSTS OF THE STUDENT ASSESSMENT SYSTEM FOR TEXAS PUBLIC SCHOOLS

The cost of Texas' student assessment system, the array of tests and related tools used to measure and support student achievement, has risen sharply over the last three biennia, more than doubling between fiscal years 2001 and 2006. Assessment-related expenditures by the Texas Education Agency rose from $46.4 million in All Funds in fiscal year 2001 to $91.6 million just five years later, and expenditures for fiscal year 2007 are budgeted to increase again to $100.4 million.

Some of these cost increases have come in response to state or federal legislative direction. However, part of the cost increases over the last five years, and those requested for the 2008–09 biennium, result from expenditure decisions made by the Commissioner of Education or from Executive Order without legislative direction.

The state of Texas pays for its assessment system with state aid that otherwise would be distributed to school districts through the school finance system. Therefore, additional assessment costs means less state formula funding to districts. In recent years, the limitations of this method of funding assessments have shifted the burden of assessment costs to fewer districts, which have less relative wealth and representing fewer students as a percentage of statewide enrollment than in prior years. By adopting a broader distribution of testing costs and pursuing other cost containment measures, Texas can lessen the financial burden of the assessment system for a majority of school districts across the state.

CONCERNS

- The Texas Education Agency is expanding the size and scope of the assessment system in significant ways, including the development of end-of-course exams and several online initiatives, without formal approval or direction from the Texas Legislature.
- The rapid growth in the cost of the state's assessment system places an increasing burden on the school districts that pay for it through reduced state aid in the compensatory education allotment. On a statewide basis, assessment costs, combined with other state-level programs funded out of the allotment, absorb nearly 10 percent of the compensatory education allotment.
- Funding state assessment costs through a "set-aside" from districts' compensatory education allotment state aid exempts wealthy districts from paying for any part of the state's assessment system because, although they do receive state aid, they do not receive it through the compensatory education allotment. Compounding this distribution of assessment costs is the fact that several large, urban districts have attained a wealth level that removes them from the group of districts responsible for paying for the assessment system. As a result, the cost burden has shifted to fewer districts representing fewer students as a percentage of statewide enrollment than in prior years.

RECOMMENDATIONS

- **Recommendation 1:** Require the Texas Education Agency to place on hold expenditures for the development of end-of-course exams, and require the agency to seek specific legislative authority from the Eightieth Legislature to pursue this expansion of the assessment program.
- **Recommendation 2:** Amend Texas Education Code Sections 39.031 and 42.152(e) to limit the funds set aside from the compensatory education allotment for assessment costs to an amount determined by the Legislature.
- **Recommendation 3:** Amend Texas Education Code Section 39.023(e) to allow a less costly schedule by which test items must be publicly released.
- **Recommendation 4:** Include a rider in the 2008–09 General Appropriations Bill to require the Texas Education Agency to evaluate the use and cost effectiveness of its study guides, an area in which expenditures have increased three-fold from the prior biennium.
- **Recommendation 5:** Amend Texas Education Code Sections 39.031 and 42.152 to fund assessment costs from state aid distributions that all districts receive, including state aid for property tax reduction and the $110 per weighted student allotment, in order to distribute the costs of the assessment system across all districts.

DISCUSSION

Achievement testing in Texas public schools began in 1979 in response to the Legislature's demand that students' basic skills be assessed. Since then, state and federal law requiring increasingly more comprehensive and rigorous testing has driven the scope and size of the assessment system. Texas' current system comprises several core elements, each based on state or federal statute:

- Texas Assessment of Knowledge and Skills (TAKS). The Texas Education Code, Chapter 39, directs the Texas Education Agency (TEA) to adopt or develop assessment instruments designed to test student knowledge and skills in reading, writing, mathematics, social studies and science. The statute states that Reading/English language arts and mathematics exams be given in grades 3 to 10; writing, social studies and science are to be given at selected grade levels. Spanish versions of these tests are available in grades 3 to 6. The agency also must adopt or develop an exit-level exam to be taken in grade 11, covering these same essential subjects. Finally, state law requires the TEA to develop a single end-of-course exam, for Algebra I; it currently is an optional exam available only online.

- Alternative Tests for Special Education. State law requires the development of alternative assessment instruments for students receiving special education services for whom the TAKS is inappropriate, currently represented by the second generation of the State Developed Alternative Assessment (SDAA II).

  The No Child Left Behind Act (NCLB) of 2001 requires that that all students be included in the state assessment of their proficiency at grade level. Texas' set of alternative assessments, designed to establish student progress based on personalized benchmarks established for each student and not necessarily corresponding to grade level, was deemed inadequate by the U.S. Department of Education. In response, the TEA has developed, and continues to develop, a set of exams—TAKS-Inclusive, TAKS-Alternate, and TAKS-Modified—to replace the current SDAA II.

- Tests of English Language Proficiency. For English language learners, the TEA is directed to develop English language proficiency tests; this requirement is fulfilled by the Reading Proficiency Test in English (RPTE), given to students in grades 3 through 12.

  NCLB requires the assessment of limited-English proficient students in not only reading, but also writing, listening, and speaking, and for students in all grades. In response, the TEA has developed the Texas Observation Protocols (TOPs) for English language learners in grades K–12.

- Study Guides. Chapter 39 of the Texas Education Code requires the TEA to produce and distribute study guides to assist students who fail one or more TAKS tests.

ASSESSMENT COSTS

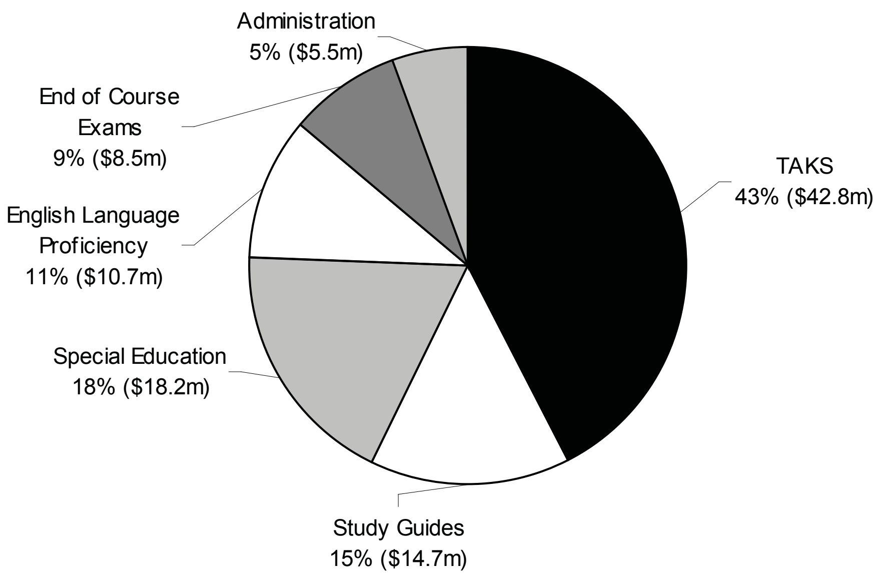
Figure 1 shows the budgeted cost of each of these assessment components for fiscal year 2007. The regular TAKS tests represent a large portion of testing costs, at 42 percent, and development costs of the new special education alternative exams have driven its share of the total assessment budget higher. Study guide costs, at $14.7 million or 15 percent of the total budget, have quadrupled from levels just two years earlier. Also, the TEA's implementation of the Governor's executive order to develop end-of-course exams has resulted in a sharp increase in costs from an insignificant amount to $8.5 million, or 9 percent of the total budget.

Figure 2 shows the total cost increase of the assessment system over 8 years, and includes the TEA's budget request for the 2008–09 biennium. As the figure shows, 2006–07 biennial spending on student assessments and study guides will have more than doubled from the 2001–02 biennial amount.

Several increases in assessment expenditures have come in response to state or federal mandates. The Seventy-sixth Legislature in 1999 directed the TEA to develop and implement a new assessment system that aligns with more rigorous state curriculum standards. Development costs of this system increased in following years, culminating in 2002 when the state transitioned from the old TAAS system to the new TAKS system. Similarly, NCLB and subsequent negotiations on implementing the system have led to substantial test development costs for special education and English language learners.

During the current 2006–07 biennium, assessment costs have risen significantly, increasing by 50 percent, or $60 million, over 2004–05 biennial expenditures. While some of this growth is due to NCLB requirements, other expenditures represent expansions of the assessment system to areas where the statutory basis or legislative intent behind such an allocation of state funds is not clear.

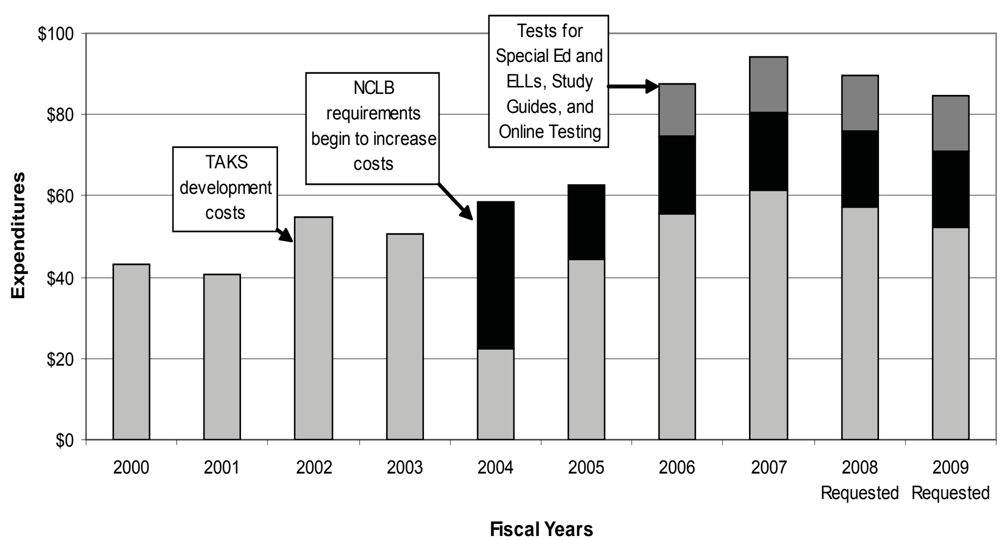
FIGURE 1
STUDENT ASSESSMENTS – COST COMPONENTS, FISCAL YEAR 2007



SOURCE: Texas Education Agency.

FIGURE 2
EXPENDITURES ON ASSESSMENTS AND STUDY GUIDELINES, 2000–2009

(IN MILLIONS)



SOURCE: Texas Education Agency.

Recommendation 1 would require TEA to place on hold expenditures for the development of the voluntary end-of-course exams, and require the Commissioner to seek specific legislative authority from the Eightieth Legislature, 2007, to expend state funds in this manner.

For example, the TEA currently is developing voluntary end-of-course assessments in Geometry, Biology, Physics, Chemistry and U.S. History, at a total development cost of $41.7 million between 2006 and 2011. The agency was directed to do so by Executive Order RP52, issued by the Governor in December 2005, as part of an effort to create college readiness standards and programs.

However, the Agency does not have the statutory authority to develop these end-of-course tests; Chapter 39 of the Texas Education Code directs the Commissioner only to develop a grade 11 exit-level exam covering these subjects, an Algebra I end-of-course test, and allows the Commissioner to participate in multi-state efforts to develop voluntary end-of-course assessments. This authority doesn't appear to apply to the end-of-course tests being developed at the Governor's order. The Legislature should have the opportunity to review and approve such a large allocation of state funds.

Recommendation 2 would amend statute to limit the funds set aside from the compensatory education allotment for assessment costs to an amount determined by the Legislature in the General Appropriations Act (GAA). Currently, the Legislature sets an appropriation amount for assessments in the GAA and, in doing so, establishes initial parameters regarding the size and scope of the assessment system. However, since Chapters 39 and 42 of the Texas Education Code state that assessment and study guide costs be paid from a set-aside to the compensatory education allotment of the Foundation School Program (FSP), the Commissioner can determine what those costs are and thus draw as much funds from the FSP as is needed.

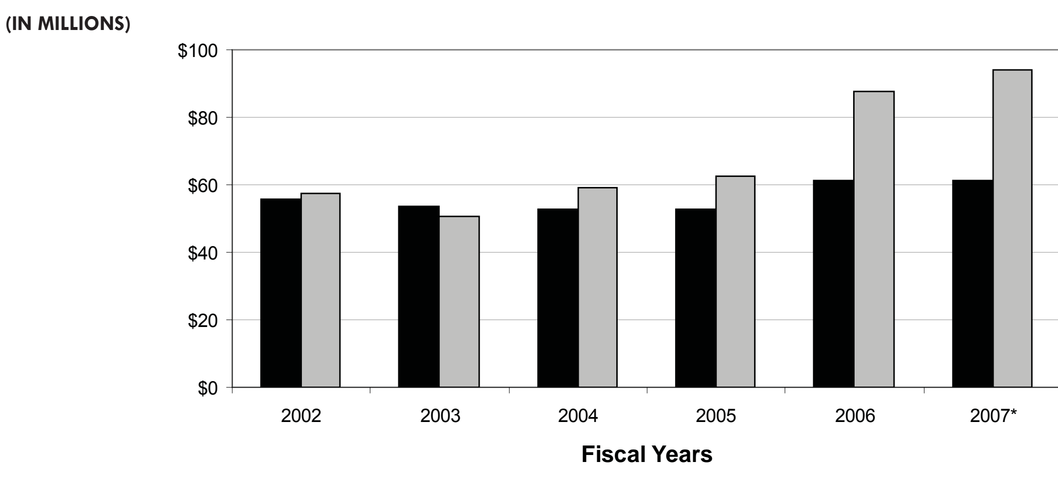
As **Figure 3** shows, the TEA usually spends more on assessments than the Legislature initially appropriated. In the 2006–07 biennium especially, the amount actually set-aside by the Commissioner was far in excess of the GAA allocation.

In addition to end-of-course exam costs described above, the TEA initiated several online assessment initiatives in the 2006–07 biennium, including test result reporting, online testing, and interactive testing, which required additional spending. These initiatives are projected to cost nearly $16 million over five years. The TEA states that state legislators and policymakers have encouraged the agency to make such expenditures. However, the Legislature recently has considered legislation that plotted the direction of online assessments and related tools, but to date has not passed any into law.

Absent such legislative direction, and at an assessment appropriation level that does not support expansion into online assessment initiatives, it is unclear whether these and

FIGURE 3
TEA ASSESSMENTS: APPROPRIATIONS VS. EXPENDITURES, 2002–2007

(IN MILLIONS)



NOTE: Excludes administrative costs.
SOURCES: Legislative Budget Board; Texas Education Agency.

other expenditures made by the TEA during the 2006–07 biennium reflect the will of the Legislature. Amending statute to limit assessment expenditures to the appropriated level would allow the Legislature to consider any desired expansion of the program during the appropriations process.

Recommendation 3 would amend Texas Education Code Section 39.023(e) to allow a less costly schedule by which test items must be publicly released; for example, test items could be released every third year instead of the current schedule of every other year. Other release changes should be explored, including adopting alternate release schedules for special education exams or releasing only a sample of items from each test.

In addition to expenditures on end-of-course tests or online initiatives, core assessment costs also continue to rise. For example, the Texas Education Code requires the release of test items to the public, which contributes to annual cost; the Seventy-eighth Legislature, Regular Session, 2003, attempted to slow the growth in assessment costs by directing the TEA to release test items every other year instead of every year. However, the cost to develop new items for the increasingly large array of tests administered by the state, including TAKS retests at high-stakes grade levels, offset the savings gained by the revised release policy.

Further revision to the release schedule could help mitigate the growing costs of the state assessment system. For example, a policy of releasing test items every three years instead of every other year could reduce costs by approximately $2 million during the 2008–09 biennium.

Recommendation 4 would include a rider in the 2008–09 General Appropriations Bill that would require the Commissioner to evaluate the effectiveness and cost efficiency of its array of study guide materials and programs.

Study guides are an area of strong expenditure growth. The Texas Education Code requires the TEA to develop summer remediation study guides for students that fail one or more TAKS tests. In fiscal year 2004, the agency supplemented these guides with personalized study guides for grades 9, 10 and 11, tailored to each student based on his or her test results. For fiscal year 2007, TEA developed an online, interactive study guide program.

These initiatives have led expenditures on study guides that have more than tripled in the last two years, from $8.2 million in the 2004–05 biennium to $26.1 million in the 2006–07 biennium. While anecdotal evidence suggests study guides are popular and helpful to students, there has been no analysis as to the actual student and parent usage of the guides, or whether the current study guide system represents the most efficient use of funds. Such an analysis could help contain costs and help direct limited funds on the most important student needs.

Cost efficiency is a relevant concern because the school districts pay a majority of the cost of the state's assessment system through a reduction to the state aid they receive for the compensatory education allotment in the Foundation School Program. On a statewide basis, assessment costs, combined with other state-level programs funded out of the allotment, absorb nearly 10 percent of the compensatory education allotment; assessments are the largest single use of set-aside funds, representing over one-third of the total.

Recommendation 5 would amend the Texas Education Code Sections 39.031 and 42.152 to fund assessment costs from state aid distributions that all districts receive, including hold harmless state aid for property tax reduction and the $110 per weighted student allotment. This amendment would distribute the costs of the assessment system across all districts by changing the method by which it is funded.

As **Figure 2** showed, the TEA has substantially offset the impact of assessment cost increases by using available Federal Funds. Despite this funding, assessment costs to the compensatory education allotment will reach an all-time high of $61.6 million in fiscal year 2007. Compounding this impact is the fact that the wealthiest districts in the state are exempt from helping to pay for the state's testing costs.

The current source of state funding for the assessment system is a "set-aside" from the Foundation School Program compensatory education allotment to school districts. With this funding method, the TEA reduces—proportionately, based on wealth and state aid—payments to districts for their economically disadvantaged students, "setting aside" an amount sufficient to cover state costs of the assessments.

However, this funding source means that only districts that receive compensatory education state aid pay for the assessments that all districts use. Therefore, wealthy districts, where local revenue generates their entire compensatory education entitlement, do not contribute to assessment costs.

This method of funding the assessment system poses questions of fairness and equity, as less wealthy districts are effectively

subsidizing the testing costs of wealthy districts. Until recently, the bulk of assessment costs were borne by the very large, urban districts with substantial compensatory education state aid. However, several of these districts, including Austin ISD and recently Dallas ISD, have experienced rapidly increasing wealth levels, reducing to zero their state aid for compensatory education and thus eliminating their assessment set-aside costs. As **Figure 4** shows, the result is a shifting of the assessment cost burden to a smaller number of relatively poorer districts that represent a smaller percentage of the statewide student population.

FIGURE 4
DISTRICTS EXEMPT FROM ASSESSMENT COSTS

		2002	2007
1	Number of districts exempt from paying assessment costs	102	176
2	Percent of statewide ADA represented by exempted districts	9%	17%
3	Percent of statewide local taxable value represented by exempted districts	22%	36%

Source: Texas Education Agency.

Until recently, spreading the burden of assessment costs across all districts was problematic, because wealthy districts received no state aid from which one may deduct assessment costs, other than the constitutionally-protected Available School Fund. However, with the passage of House Bill 1 by the Seventy-ninth Legislature, Third Called session, 2005, all districts are receiving a significant amount of state aid, whether in the form of hold harmless state aid for property tax reduction or the continuation of the school district allotment, which provides each district $110 per weighted student.

There is no characteristic of the compensatory education allotment that uniquely qualifies it to be the sole source of state funding for the assessment system; every school district uses student tests and study guides developed by the TEA for a wide variety of uses, from identification of at-risk students to indicators of college readiness. By shifting assessment funding from the compensatory education allotment to other sources of state aid, the cost burden will be distributed across all districts, resulting in a cost decrease for most districts.

FISCAL IMPACT OF RECOMMENDATIONS

Because the costs of the assessment system are paid with a combination of federal funds and school district funds set aside from the compensatory education allotment, these recommendations have no direct fiscal impact on the state. Cost savings realized from actions taken based on Recommendation 3 (action to mitigate assessment system costs) would result in less state aid being set aside from the FSP; the introduced 2008–09 General Appropriations Bill reduces the set-aside by $2 million for the biennium related to revising the test item release schedule to every three years. Similarly, Recommendation 5 (shifting assessment funding away from the compensatory education allotment to other sources of state aid) simply would redistribute the cost burden across school districts.

The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendations 2 and 4, and addresses Recommendation 3. The introduced 2008–09 General Appropriations Bill does not address Recommendations 1 and 5.

INCREASE THE CAPACITY OF THE PERMANENT SCHOOL FUND BOND GUARANTEE PROGRAM

The Permanent School Fund Bond Guarantee program allows public school districts to avoid the expense of private bond insurance, and receive a Aaa bond ratings that result in low interest rates. Since its inception in 1983, the program guaranteed 3,232 bond issues with a total principal of $59.6 billion.

Both the Texas Education Code §45 and the most recent Internal Revenue Service (IRS) private letter ruling limit the total amount of guaranteed bonds to 2.5 times the lower of cost or market value of the Permanent School Fund. To prevent the total guaranteed bonds from exceeding the IRS limit, State Board of Education rules call for a reserve limit equal to 5 percent of the statutory limit. If this effective limit is reached, school districts seeking bond funding must either purchase private bond insurance or receive lower bond ratings and higher interest rates.

FACTS AND FINDINGS

- ♦ The Permanent School Fund bond guarantee program had a capacity $6.7 billion as of November 30, 2006 (i.e., the ability to guarantee newly eligible bonds), down from $11 billion as of August 31, 2005. This amount is based on a guarantee limit of $46.3 billion, and total bond guarantees of $39.6 billion.
- ♦ The Permanent School Fund will reach the state's limit on bonds guaranteed in fiscal year 2010 according to a Texas Education Agency projection.
- ♦ By fiscal year 2010, the program's bond guarantee capacity is projected to be about $1.3 billion, which is equivalent to the five largest bond guarantees awarded in fiscal year 2005. If similar guarantees are granted in subsequent years, the closure date could be reached one year sooner and possibly before the 2009 regular legislative session.
- ♦ An increase in both the statutory limit and the IRS limit from a 2.5 to 3.0 multiplier would lengthen the projected closure date to fiscal year 2014, which is seven years, or three biennia, from the next regular session of the legislature in 2007. An increase to this level would follow the legislative precedent of increasing the multiplier in 0.5 increments. While the state can increase its limit by legislative action, the IRS must also raise its limit to extend the guarantee closure date.
- ♦ The TEA has hired outside counsel to reach a long term solution through the IRS or the U.S Congress so that the IRS will raise its limit. Raising the state limit during the Eightieth Legislature, 2007, would strengthen the TEA's case for raising the IRS limit. When the IRS limit is increased, a 3.0 state limit would provide additional guarantee capacity without further legislative action.
- ♦ Excluding the debt related to extracurricular facilities from receiving bond guarantees would not delay the program's guarantee closure date in a significant way. A phone survey found that among the eight school districts that accounted for almost a quarter of the guarantees in fiscal year 2005, only three included extracurricular facility debt in their bond issues. The three school districts, Dallas, Garland, and Fort Bend used 8.8 percent, 6 percent, and 0.7 percent of their bonds for this purpose—a relatively small proportion.

CONCERN

- ♦ If the state and IRS limit of 2.5 is reached before the projected closure date of fiscal year 2010, school districts must either defer bond-related projects, pay higher interest rates resulting from lower bond ratings, or purchase private bond insurance. The median cost of private bond insurance paid by school districts that were ineligible for Permanent School Fund-backed guarantees in fiscal year 2005 was $53,488 per district.

RECOMMENDATION

- ♦ **Recommendation 1:** Amend Texas Education Code §45 to increase the statutory limit to 3.0 times the lower of cost or market value of the Permanent School Fund.

DISCUSSION

The Permanent School Fund (PSF) Bond Guarantee program was created in 1983 by Texas constitutional amendment so that school district tax-exempt bonds could avoid the expense of private bond insurance and receive a "Aaa" credit rating, the highest possible rating. With this credit rating, districts

are eligible for low interest rates. During fiscal year 2006, the program guaranteed 219 bond issues with a value of $6.4 billion.

Texas Education Code §45 provides protections against a bond default adversely affecting the fund or its bond rating advantage. If a district cannot make a bond payment, the PSF will cover the default; however, the state Comptroller of Public Accounts will deduct an equivalent amount from the following fiscal year's state allocation to the school district, and credit it to the PSF. Fortunately, a default has never occurred in the history of the program.

Each month, the Texas Education Agency (TEA) reviews guarantee applications based on the following eligibility criteria.

- Bonds must be voter approved and have less than a Aaa rating.
- Refunding bonds, that is, those issued to take advantage of falling interest rates, must show a present value savings over the life of the new bond.
- In accordance with the program's authorizing legislation, Texas Education Code, Section 45 and Texas Administrative Code, §33, no revenue, lease purchase, or maintenance tax-supported debt are eligible.
- School districts must be accredited and financially sound. Total debt at the time of the guarantee application must not exceed $1,250 per student in average daily attendance, unless the school district's enrollment is 25 percent higher than it was five years before its application date.

Upon completing the eligibility reviews, TEA compares the total bond guarantees to limits established by state and IRS mandates to ensure that the state does not exceed the limits. The Texas Education Code, Section 45 limits the total amount of guaranteed bonds at 2.5 times the lower of cost or market value of the PSF. The IRS limit currently matches the state limit. As of November 30, 2006, TEA calculated a guarantee capacity of $6.7 billion, down from $11 billion as of August 31, 2005.

In compliance with State Board of Education rules, TEA subtracts an additional 5 percent from the statutory limit so that the state does not exceed the IRS limit. School districts are then ranked from lowest to highest according to their wealth per students in average daily attendance (ADA). If total bond guarantees and total new applications exceed the net capacity cut-off point, then applications are awarded starting with the lowest wealth school district, until the cut-off point is reached. Districts whose wealth per ADA places them over the cut-off point are denied guarantees. Since the program began, this situation occurred only once—during a three-month period in fiscal year 2005 when TEA denied bond guarantee applications because of uncertainty about the IRS limit.

Although IRS' 1993 regulations authorized a 2.5 limit, the rules were unclear about how to calculate the underlying value of the PSF. To resolve the matter, TEA sought clarification from the IRS in July 2004, but did not receive a response until March 31, 2005. During that period, TEA applied an approximate 2.0 limit, based on the previously IRS-confirmed methodology. The result was that TEA denied 85 applications between September 2004 and February 2005, because the limit was reached.

FUTURE GUARANTEE CAPACITY

A TEA projection indicates that school districts could be facing a similar situation in the near future. The agency projects that the program's capacity to guarantee new bonds will be reached in fiscal year 2010. The following factors are the basis of the agency's projection: (1) total guaranteed bonds will rise at an effective rate of approximately 7.5 percent; (2) the Permanent School Fund's book value will increase by 2.9 percent; and (3) the fund's market value will increase by 3.96 percent. These assumptions are moderate, in that hypothetical adjustments in annual growth rates alter the cut-off point by only two or three years.

However, the closure year could come sooner if the TEA approves several large guarantee requests during the 2008–09 biennium. According to TEA's projection, guarantee capacity will be reduced to approximately $1.3 billion by the end of that biennium. This amount is equivalent to the five largest bond guarantees awarded in fiscal year 2005.

Once the program's guarantee capacity is exhausted, school districts must defer bond-funded projects, pay higher interest costs due to lower bond ratings, or obtain private insurance. School districts using private insurance in fiscal year 2005 paid a median cost of $53,488. A similar concern prompted the Seventy-eighth Legislature, Regular Session, 2003, to increase the multiplier from 2.0 to 2.5.

Recommendation 1 would partially address this concern by increasing the guarantee multiplier to 3.0. Assuming the IRS limit is also increased to at least a 3.0 multiplier, the program's guarantee timeframe would extend to fiscal year 2014, based

on TEA's projection. With this extension, there would be six years, or three biennia, to monitor the guarantee capacity of the program. It would also provide a margin of safety in case capacity is depleted before fiscal year 2010. An increase from 2.5 to 3.0 would follow a legislative precedent of increasing the multiplier in 0.5 increments.

To address the IRS limit, the TEA hired outside counsel to seek a long-term solution through the IRS or the U.S. Congress. The goal of the effort is a long-term solution so that another letter-ruling request is not necessary for 10 years or more.

EXTRACURRICULAR FACILITY GUARANTEES

A state law or rule that excludes the portion of bond guarantees associated with extracurricular facility debt is unlikely to delay the program's guarantee closure date. Because comprehensive information on extracurricular facilities does not exist, the eight school districts that received the largest guarantees in fiscal year 2005 were surveyed for this review.

These school districts accounted for almost a quarter of the guarantees in fiscal year 2005. Among these eight school districts, only three included athletic facility debt in their bond issues. The three school districts, Dallas, Garland, and Fort Bend, used 8.8 percent, 6.0 percent, and 0.7 percent of their bonds for this purpose. Assuming these districts are representative of most large school districts, it is unlikely that an exclusion policy would have much impact on the program's guarantee capacity.

An exclusion policy would require school districts to pay additional bond issuance costs. To receive guarantees for all other debt, school districts would have to issue separate athletic facility bonds. For fiscal year 2005, median issuance costs for small (ADA under 1,600), medium (ADA between 1,600 and 5,000), and all other districts were $93,000, $145,000, and $370,000 respectively.

FISCAL IMPACT OF THE RECOMMENDATION

There would be no fiscal impact from Recommendation 1.

The introduced 2008–09 General Appropriations Bill does not address this recommendation.

EXPAND THE USE OF SHARED SERVICE ARRANGEMENTS FOR TEXAS PUBLIC SCHOOL DISTRICTS

In fiscal year 2005, 876 school districts or 84 percent of all school districts in Texas participated in shared service arrangements (SSAs). Funding for SSA operations totaled $206 million. These arrangements are most common among school districts with small and medium size student enrollment. During fiscal year 2005, 788 school districts with enrollments of fewer than 5,000 students participated in SSAs. Membership in each SSA varies from two to 28 school districts, and most provide education services to special needs populations, such as special education, non-English speaking, or gifted and talented students. However, a growing number of school districts are joining SSAs that regional education service centers (ESC) manage.

SSAs have direct benefits for the state as well. Merging program administration responsibilities at multiple school districts under a single SSA allows the Texas Education Agency to interact with a single point of contact rather than numerous district contacts. Texas Education Agency's review of grant applications and oversight of grant implementation can be streamlined when districts request funding under an SSA.

Although many Texas public school districts established successful shared service arrangements for purchasing goods and services, SSA business managers believe focused SSA management training would encourage more districts to use shared services—thereby improving the efficiency of both small district administration and the Texas Education Agency's oversight. Implementing a pilot training program focusing on SSA management for the 10 regions with the lowest SSA participation would cost $90,000 per year.

A corollary issue identified during this review relates to state laws requiring school districts, and by extension their SSAs, to advertise procurement bids in their local newspapers, even when they also use internet postings and notifications. Amending this state law to allow internet bidding notices in lieu of newspaper advertisements would save up to $50,000 for large school districts.

CONCERNS

- SSAs present unique management and financing challenges to school districts. However, training that focuses on the management of SSAs, and on how to create more innovative SSAs, is not available. As a result, both the state and school districts are not taking full advantage of the efficiency these arrangements offer.
- State purchasing laws require SSAs and individual school districts to advertise procurement solicitations in local newspapers. This requirement means that SSAs and school districts must purchase print advertisements, even though many also use and prefer more cost effective internet-based notifications. As SSAs grow in membership, and the number and variety of bid notifications increases, this requirement will become an even more significant expense.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the Texas Education Agency's bill pattern in the 2008–09 General Appropriations Bill that would establish a training program for school district business managers, with the goal of facilitating the management of shared service arrangements.
- **Recommendation 2:** Amend Section 44.031, Texas Education Code to give school districts, shared service arrangements, and education service centers the option of announcing bidding opportunities and receiving bids online, and in lieu of using local newspapers or sealed bids.

DISCUSSION

A shared service arrangement (SSA) is a cooperative (co-op) program involving two or more school districts seeking common services that would otherwise be much more expensive or difficult to acquire independently. Member school districts govern the SSA through an appointed board of directors. One of the school districts agrees to assume the role of fiscal agent for the other member districts. The fiscal agent receives, manages, and distributes money for the SSA. In some cases, the fiscal agent also provides the shared service directly, which can include a variety of educational and support services, such as special education, transportation, and purchasing. Funding for SSAs can come from state grants, federal grants, and local revenue. The Texas Education Agency's (TEA) Financial Accountability System Resource

Guide specifies fiscal and organizational requirements for SSAs.

Special education programs are an example of how SSAs function. The Parker County Special Education Cooperative (PCSEC) located in Weatherford, provides evaluation, therapy, and other services to its five participating school districts. PCSEC's management board oversees the SSA's director, who in turn supervises the SSAs' 20 employees and directs program operations. Funds collected from member school districts based on their respective student enrollments finance the SSA. The fiscal agent, Peaster Independent School District, applies for and receives federal special education funds for the SSA.

A special education SSA is advantageous for school districts because individual members do not have to apply for state and federal special education funds on their own and are not forced to employ costly fulltime professionals in specialized fields. For example, a fulltime diagnostician would cost the Sam Rayburn school district about $50,000 per year, when its special education SSA can provide the required level of service for half that amount. Without their SSAs, many small school districts would struggle to afford the various educational services state and federal laws mandate.

INNOVATIVE SHARED SERVICE ARRANGEMENTS

An SSA can offer high volume discounts and reduce contract administration costs for school districts. The Region 2 ESC purchasing SSA (Corpus Christi) offers discounts up to 80 percent for office products. Seventeen of the 20 ESCs manage one or more type of SSA: commodities (16 ESCs), food products (14 ESCs), and food processing (8 ESCs).

A few ESCs have developed large-scale SSAs that can fill most of a school district's procurement needs. The largest member network is the Texas Cooperative Purchasing Network (TCPN), affiliated with the Region 4 ESC in Houston. TCPN serves over 1,000 school districts, governmental entities, and non-profit organizations in Texas, in addition to New Mexico, Arizona, and Arkansas. The SSA awards competitive contracts for a wide variety of goods. TCPN members benefit by gaining access to significant bulk discounts, while avoiding the cost of competitive bidding.

SSAs can also be formed to meet the technology needs of small school districts. For example, a technology SSA called the SUPERNet Consortium serves 17 school districts in the Tyler area. Under a contract with Cox Communications and the University of Texas Health Center in Tyler, participating school districts can take advantage of a high-speed network that offers distance learning, teacher training, and video conferencing. Typically, a school district would pay $3,000 per month for this service. School districts in the SSA, however, pay a $683 monthly fee.

SCHOOL DISTRICTS PARTICIPATING IN SHARED SERVICE ARRANGEMENTS

Figure 1 shows a statewide summary regarding SSAs by education service region for fiscal year 2005. The statistics indicate that:

- 876 Texas public school districts participated in SSAs —85 percent of the 1,037 public school districts in fiscal year 2005.
- With 681 participating school districts, special education is the most common type of service SSAs provide. School districts spend significantly more money on special education services than any other service, about 74 percent of the $206 million total expenditures for SSAs.
- 788 SSA districts, or 90 percent, of all school districts with a student enrollment less than 5,000 participated in SSAs.
- A reason for this high level of participation is that, beginning in the mid-1970s, the U.S. Department of Education required contiguous small districts to appoint one district as the fiscal agent in order to receive special education funding. This requirement resulted in a proliferation of special education SSAs across Texas.
- 671 school districts participated in a variety of education-related SSAs. This category includes career and technology, general instruction, and gifted and talented programs.
- 316 districts benefited from general support SSAs, which provide purchasing, transportation, and other general business services.
- Region 16 ESC, Amarillo, had the greatest percentage and number of low enrollment school districts in SSAs. Region 1 ESC Edinburg, had the lowest percentage and second lowest number of low enrollment school districts in SSAs with six school districts.

Although a high percentage of small and medium enrollment school districts use SSAs, opportunities exist to encourage the expansion of SSAs beyond the conventional special education services. Information technology SSAs, like the

FIGURE 1
SCHOOL DISTRICTS PARTICIPATING IN SSAS BY EDUCATION SERVICE CENTER REGION
FISCAL YEAR 2005

ESC REGION	GENERAL SUPPORT	SPECIAL EDUCATION	VARIOUS EDUCATION	ALL DISTRICTS IN SSAS	DISTRICTS IN SSAS LESS THAN 5,000 STUDENTS	ALL DISTRICTS LESS THAN 5,000 STUDENTS	PERCENTAGE OF DISTRICTS IN SSAS LESS THAN 5,000
1 Edinburg	2	13	0	14	11	20	55%
2 Corpus Christi	7	14	6	22	22	39	56
3 Victoria	22	37	38	39	39	39	100
4 Houston	13	24	39	45	18	25	72
5 Beaumont	14	16	11	24	22	26	85
6 Huntsville	37	38	55	56	49	49	100
7 Kilgore	21	66	46	87	84	91	92
8 Mt Pleasant	2	40	22	42	41	46	89
9 Wichita Falls	7	38	40	39	38	38	100
10 Richardson	5	34	31	41	37	57	65
11 Fort Worth	0	45	46	61	53	59	90
12 Waco	2	58	70	75	69	71	97
13 Austin	3	28	18	39	32	41	78
14 Abilene	1	41	20	42	42	42	100
15 San Angelo	39	38	39	42	41	41	100
16 Amarillo	63	56	60	63	61	61	100
17 Lubbock	54	55	52	58	55	55	100
18 Midland	0	24	30	33	31	31	100
19 El Paso	0	0	8	8	6	8	75
20 San Antonio	24	16	40	46	37	38	97
Total	**316**	**681**	**671**	**876**	**788**	**877**	**90%**

(1) General Support: Provides goods and services for non-instructional and administrative functions.
(2) Various Education – Instructional programs other than special education.
NOTE: District counts are duplicated across service categories but not within each category.
SOURCE: Texas Education Agency.

SUPERNet Consortium in east Texas, should be more widespread than they are currently. This expansion would benefit not only school districts, but also the TEA by reducing the number of grants and grant compliance reviews it conducts. SSAs provide a single point of contact for TEA, instead of multiple school districts receiving the same grant.

Administrators must have sufficient information about SSA program management and state funding compliance, however, to maintain a viable SSA. Separate accounting policies and reporting systems for SSAs are specified in TEA's financial resource guide. Seven Texas school districts contacted during the review indicated that SSA administration presents challenges that are beyond the domain of basic school district stewardship.

Recommendation 1 would help school districts maximize the positive effect of SSAs by providing training for school district business managers on how to successfully manage a SSA. Under the recommendation, TEA would create a pilot program for fiscal years 2008 and 2009 to train business managers from the 10 regions with the lowest participation in SSAs among small and medium size school districts. The program would train 383 business managers, or about 44 percent of all small and medium size districts, and cost the state $180,000 during the 2008–09 biennium. The following rider would implement this recommendation.

> **Training to Improve and Expand Shared Service Arrangements.** Out of the funds appropriated above in Strategy B.3.2, Agency Operations, the Commissioner of Education shall develop a training program that will facilitate the management of existing shared service agreeements, and encourage the creation of new arrangements. During the 2008–09 biennium, no more than $180,000 shall be expended to provide this training for Education Service Center regions 1, 2, 4, 5, 7, 8, 10, 11, 13, and 19. The Commissioner will submit a report to the Eighty-first Legislature by January 8, 2009 on the implementation and effectiveness of this program.

House Bill 1, Seventy-ninth Legislature, Third Called Session, requires ESCs to help school districts enter into SSAs and to notify school districts about the opportunities available through the ESC to join its SSAs. Recommendation 1 would expand this assistance by providing training in SSA financial management and innovative models. It would also give TEA a role in developing this training to ensure that local practices in one region can be adopted by other regions.

Another concern is that current school district purchasing laws inflate expenses for purchasing co-ops and school districts. Chapter 44 of the Texas Education Code requires school districts to notify vendors of bidding opportunities by advertising in local newspapers, despite many vendors and districts preferring the more efficient and economical method of using internet sites. This statute also prevents school districts from receiving bids from vendors electronically, although cities and counties can accept bids electronically. The local newspaper requirement forces school districts to buy expensive print media advertising, when internet technology could communicate the solicitation to more vendors at a lower cost. The sealed bid requirement means that vendors and school districts must use inefficient printed and mailed sealed bids.

Recommendation 2 would address this concern by amending purchasing statutes to allow school districts to solicit bids online and in lieu of local newspaper advertising; and accept bids through internet sites. Advertising in certain venues, such as the Texas Marketplace (aka the Electronic State Business Daily), is free and is often the only place that potential vendors check, according to the Region 2 ESC staff. Also, school districts should have an option to accept bids from vendors electronically, an alternative already available to other local governments. Amending Section 44.031, Texas Education Code, to authorize internet-based bidding notices and submission of bids in lieu of newspaper advertising and sealed paper envelopes, would allow school districts to realize significant savings. Although the full savings cannot be estimated, savings could be as high as $50,000 for large school districts.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementation of the recommendations would not have a fiscal impact for the 2008–09 biennium, as shown in **Figure 2**. TEA would use $180,000 out of funds appropriated to the agency to pay for the required training. This estimate is based on providing training to districts in the 10 regions with the least SSA participation among districts with less than 5,000 enrolled students. The program would train 383 public school district business managers, one for each school district, or about 44 percent of all low enrollment school districts. The TEA would be required by rider to fund this training out of its 2008–09 biennial appropriation.

Information on statewide savings to school districts by implementing Recommendation 2 is not available. Although the specifics are not available, school districts would however realize significant savings from avoiding newspaper announcements and sealed bid processing costs.

FIGURE 2
FIVE-YEAR FISCAL IMPACT TO THE GENERAL REVENUE FUND

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE FUND
2008	$0
2009	$0
2010	$0
2011	$0
2012	$0

Source: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendation 1. The introduced 2008–09 General Appropriations Bill does not address Recommendation 2.

EVALUATE THE EFFECTIVENESS OF THE COMMUNITIES IN SCHOOLS PROGRAM FOR SERVING AT-RISK STUDENTS IN TEXAS

"Communities in Schools" is a public education program administered at the state level by the Texas Education Agency for preventing student dropout and improving academics, behavior, and school attendance in at-risk students. The 27 local Communities in Schools programs provide a range of individualized services to at-risk students, with guidance and oversight provided by the state Communities in Schools office. Communities in Schools currently receives about $21 million annually statewide in state and federal funds appropriated by the Legislature, the majority of which is funded through a set-aside from the compensatory education allotment of the Foundation School Program. Set-asides are amounts of General Revenue funding by which school district entitlements under the Foundation School Program are reduced, which are then redistributed according to the rules governing the particular program for which funds are designated. Local Communities in Schools programs receive significant funding from local governmental and private sources, which, on a statewide basis, make up an average of $31 million per year, or 63 percent of total funding, since fiscal year 2002.

The purpose of this review is to determine if the source and level of state funding is appropriate to the population of students served by the program and the services provided and to determine if the Communities in Schools program is an effective use of state funds targeted at meeting the needs of at-risk students. Communities in Schools does serve a student population that is aligned with the statutory purpose of the compensatory education allotment, its primary state funding source; and it serves a proportion of students with state funding that is appropriate to its funding level in the context of state funding provided for compensatory education statewide.

Although performance indicators collected by the Texas Education Agency and anecdotal reports of success point to positive outcomes for students served by Communities in Schools, it is difficult to determine the true effectiveness of the program without conducting an appropriately designed independent statewide evaluation.

CONCERN

- ♦ There has been no evaluation based on a valid and reliable research methodology of the Communities in Schools program to determine the effectiveness of the program.

RECOMMENDATION

- ♦ **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill requiring that the Communities in Schools program undergo an independent evaluation with a quasi-experimental design that employs comparison groups or a comparable statistical model so that the impact of Communities in Schools services can be isolated from other factors that may influence student outcomes.

DISCUSSION

Communities in Schools (CIS) is a nationwide program based on a model of coordinated local services and community resources in the school setting aimed at preventing dropout. Programs are established in 27 states through agreements with the national non-profit organization, which began as an initiative of the Milliken Foundation in 1977. Communities in Schools of Texas, which received its first state funding in 1987, currently includes 27 local programs that serve 108 school districts. The stated mission of the program is "to help young people of Texas stay in school, successfully learn, and prepare for life by coordinating the connection of needed community resources in the school setting." Local CIS programs work toward this mission by providing a variety of services targeted primarily at at-risk students. The CIS model provides a broad systematic approach to accomplishing these goals; but implementation is largely locally driven.

There are six categories of services or "components" that local programs are required to provide. These six components, which include supportive guidance and counseling, health and human services, parental and family involvement, career awareness and employment, enrichment activities, and educational enhancement, align with the philosophy of the national model that states that every student needs the following to be successful:

- a one-on-one relationship with a caring adult;
- a safe place to learn and grow;
- a healthy start and a healthy future;
- a marketable skill to use upon graduation; and

- a chance to give back to peers and community.

Each local program must provide services in each of these six areas and must provide documentation to the state CIS office, a division of the Texas Education Agency (TEA), including a campus needs assessment for each campus served and a service delivery plan that details the manner in which the program intends to meet its state goals.

The state CIS office maintains a list of over 250 approved activities or types of activities organized by the component addressed from which local programs choose. **Figure 1** shows a sampling from the list of approved activities. Local programs enter into annual contracts with the state office that specify modes of service delivery and the minimum number of students that must be served with state funds by the program.

Students must be referred for CIS services by school administrators or officials, teachers, counselors, parents, other service providers, and/or other students. Students who receive CIS services are generally classified as either case-managed or non-case-managed. Only case-managed students whose services are supported with state CIS funds may count toward the program's fulfillment of its contractual obligation with the state.

To count as a case-managed student for state funding purposes, a student must meet at least one of 13 criteria to be classified as at-risk under the state statutory definition of at-risk or qualify as at-risk under criteria adopted by the local board of trustees. **Figure 2** provides a list of the 13 criteria in the statutory definition of at-risk.

Participation in the federal free and reduced-price lunch program or receipt of federal Temporary Assistance for Needy Families (TANF) funding, which are means-tested programs and serve as proxies for family income, may be considered, but may not qualify a student for case-management if no other qualifying factors are present.

FIGURE 1
SELECTED SERVICE ACTIVITIES UNDER THE SIX CIS COMPONENTS

SUPPORTIVE GUIDANCE AND COUNSELING	HEALTH AND HUMAN SERVICES	PARENTAL AND FAMILY INVOLVEMENT	CAREER AWARENESS/ EMPLOYMENT	ENRICHMENT	EDUCATIONAL ENHANCEMENT
Academics/ Grades	Agency Referrals	Adult Education	Baby Sitter/ CPR Certification Classes	After School Clubs	Academic Skills
Conflict Resolution	Boys & Girls Clubs	College Awareness	Career Clubs	Community Service	College Course Enrollment
Court Advocacy	Child Care	Family Counseling	Career Fairs	Dance/Drama/Music Clubs/ Activities	Computer Lab Training
Goal Setting	Clothes Closet	Home Visits	Career Panel Presentation	Field Trips	GED Classes
Leadership Training	Dental Care/ Referrals	Letters to parents	Employment Skills Training	Food/ Clothing Drives	Homework Check/ Completion
Mentoring	Emergency Food	Parent Employment Resources	Financial Planning	Graffiti Clean-up	Literacy Programs
Peer Mediation	Health Screenings	Parent/Family Events & Activities	Job Placement	Scouting Activities	Peer Tutoring
Social & Communication Skills	Medical Mental Health/ Referrals	Parent/Student Meals	Job Shadowing	Student Clubs & Meetings	Reading Program/ Clubs
Substance Abuse	Pregnancy/ Parenting Awareness Education	PTA/PTO Night	School to Careers Activities/ Classes	Student Recognition/ Awards	Study Skills Activities
Teen Parent Groups	Vision Care/ Referrals	Translation Services for Parents	Time Management Skills Training	Talent Shows	Tutoring

SOURCE: Texas Education Agency.

FIGURE 2
STATUTORY CRITERIA FOR DEFINING STUDENTS AS AT-RISK

Students are classified as at risk of dropping out under state statute if they meet any of the following criteria:

- failure to advance from one grade level to the next;
- failure to maintain an average of at least 70 in two or more core subjects in grades 7 through 12;
- poor performance on the Texas Assessment of Knowledge and Skills (TAKS) or other state assessment;
- poor performance on a readiness test or assessment administered in grades K through 3;
- pregnancy or parenthood;
- placement in an alternative education program in the preceding or current school year;
- expulsion in the previous or current school year;
- being on parole, probation, deferred prosecution, or other conditional release;
- having been previously reported as a dropout in PEIMS;
- limited English proficiency;
- being in the care of or being referred to the Department of Protective and Regulatory Services;
- homelessness; or
- placement in a residential placement facility (detention facility, substance abuse treatment facility, emergency shelter, psychiatric hospital, halfway house, or foster group home).

Source: Texas Education Code §29.081.

Non-case-managed students may not necessarily meet the eligibility requirements to qualify for case-management or may receive limited services. For instance, a student may be referred for one-time CIS services to address an acute crisis such as becoming homeless due to a catastrophic event (e.g. house fire), loss of a parent, or a specific behavioral issue, but that student may not otherwise be defined statutorily as at-risk. CIS may also provide or sponsor school-wide events such as health fairs, college or career fairs, or parent nights that benefit the entire school. Non-case-managed students cannot count toward a local program's contractual obligation to the state for students served.

COMMUNITIES IN SCHOOLS FUNDING STRUCTURE

Local CIS programs are funded through a combination of state, federal, and local funds. Total funding appropriated by the Texas Legislature to support CIS in fiscal years 2006 and 2007 is $20.6 million annually, which includes an increase of $3 million in each fiscal year over state funding levels in the 2004–05 biennium. State appropriations to CIS include both a $15.8 million set-aside from the Foundation School Program's Compensatory Education Allotment (General Revenue Funds) and $4.8 million in TANF funds (Federal Funds).

TEA allocates CIS state funds to local programs using a formula with three components. The current formula components, which TEA developed in conjunction with program stakeholders, were first applied with the 2005–06 school year. The three components include a base program funding amount of $150,000 per program, a financial resources allocation, and the case-managed student (CMS) set-aside. The financial resources allocation, which totals $1,000,000 statewide, is distributed to programs according to a formula that favors programs serving districts that have relatively low property wealth per student and relatively high concentrations of economically disadvantaged students. The CMS set-aside drives the majority of the state funding allocation and is distributed according to the proportion of case-managed students served by each program. For fiscal year 2006, the CMS set-aside totaled about $12 million on a statewide basis, about 60 percent of total state funding.

On a statewide basis, state appropriations comprise about 42 percent of total local program funding for fiscal year 2006. The majority of funding statewide is provided locally by school districts, other local government entities, and through private sources such as corporate partners, foundations, and individuals. **Figure 3** shows the share of total funding by source from fiscal years 2002 through 2006.

FIGURE 3
COMMUNITIES IN SCHOOLS, PROGRAM FUNDING SHARE BY SOURCE, FISCAL YEARS 2002 TO 2006

FISCAL YEAR	STATE APPROPRIATIONS (GENERAL REVENUE SET-ASIDE AND FEDERAL TANF FUNDS)	LOCAL GOVERNMENT	PRIVATE SECTOR	TOTAL FUNDING (IN MILLIONS)
2002	37.0%	45.0%	18.0%	$47.7
2003	36.0%	47.0%	17.0%	$48.9
2004	35.1%	43.9%	20.9%	$50.2
2005	34.5%	47.4%	18.1%	$51.2
2006	42.1%	44.3%	13.7%	$49.0

Source: Texas Education Agency.

The proportion of program funding from state, local, and private sources varies significantly from program to program with some districts relying more or less heavily on state funds for program support. Some of the variation correlates with the relative size of the programs and the demographics of the areas served.

STATE FUNDING SOURCES FOR COMMUNITIES IN SCHOOLS

The bulk of state funding is provided as a set-aside from the compensatory education allotment in the Foundation School Program. Set-asides are amounts of funding by which school district entitlements under the Foundation School Program are reduced, which are then redistributed according to the rules governing the particular program for which funds are designated. For CIS, funds are set aside from the total compensatory education allotment (General Revenue), and district compensatory education allotment entitlements statewide are reduced proportionately. State compensatory education funds appropriated to support CIS total $15.8 million annually in fiscal years 2006 and 2007.

The remainder of state funding for CIS is an allocation of federal funding received by TEA through the Temporary Assistance for Needy Families program (TANF). For fiscal years 2006 and 2007, the total annual allocation of TANF funds to CIS is $4.8 million.

The compensatory education allotment is intended to provide funding to school districts with students classified as educationally disadvantaged. The Texas Education Code defines an educationally disadvantaged student as one who qualifies for the federal free and reduced-price lunch program. Districts qualify for a funding weight in the Foundation School Program for each educationally disadvantaged student. Funds received as a result of this funding weight together with weights associated with students in residential facilities and pregnant students in remedial programs constitute the compensatory education allotment.

Texas Education Code §42.152 stipulates that funds provided under the compensatory education allotment be used to support programs aimed at eliminating disparities in performance on state accountability assessments (the Texas Assessment of Knowledge and Skills, or TAKS) or disparities in high school completion rates between students defined as at-risk of dropping out and all other students.

Since CIS programs are prohibited from using state funds to serve non-case-managed students, and case-managed students by definition meet the statutory definition of at-risk students, the intended use of compensatory education allotment funding as laid out in the Texas Education Code aligns with the population served by Communities in Schools. Furthermore, the CIS program goals of reducing dropout and improving academic, behavioral, and attendance outcomes for the students served is consistent with the statutorily defined purpose of compensatory education funding. Assuming that the CIS program is an effective means of achieving state compensatory education goals, continuing to provide state funding through a set-aside from the compensatory education allotment would be consistent with the statutory purpose of those funds.

STATE FUNDING LEVELS FOR COMMUNITIES IN SCHOOLS

The $15.8 million in state compensatory education set-aside funds appropriated in fiscal year 2006 represents less than 2 percent of the total compensatory education allotment. The set-aside reduction associated with the CIS program is about $7 per at-risk student on average statewide. CIS programs are in place in districts that serve about 50 percent of students identified as at-risk in all grades and about 46 percent of at-risk students in grades 9 through 12. CIS serves just over 3 percent of the population of at-risk students with state funds as case-managed students. A much larger population of students is served with local funds as both case-managed and non-case-managed students. A count of all students who received some type of CIS service during the 2004–05 school year was nearly 334,000. **Figure 4** shows the number of students served as state funded case-managed students and the total number of students receiving any type of CIS services since fiscal year 2002.

With less than 2 percent of total compensatory education funding serving over 3 percent of the population of at-risk students, the funding level is not disproportionate to the population served. As such, the current state funding level is

FIGURE 4
CIS STATE-FUNDED CASE-MANAGED STUDENTS AND STUDENTS RECEIVING ANY CIS SERVICES, FISCAL YEARS 2002 TO 2005

FISCAL YEAR	STATE FUNDED CASE-MANAGED	TOTAL SERVED
2002	64,069	332,000
2003	65,039	486,694
2004	64,690	447,235
2005	66,719	333,680

SOURCE: Texas Education Agency.

appropriate in the context of state compensatory education funding as a whole.

EVALUATION OF PROGRAM EFFECTIVENESS

Given that the state funding source and the level of state funding for CIS services are not inappropriate to the population served, the question becomes whether or not Communities in Schools is effective in providing the services prescribed by the statutory basis of the compensatory education allotment and is, therefore, an effective use of state funds. Anecdotal evidence on the effectiveness of the program is positive, and research supports a coordinated-services approach like the CIS case-management model in other areas of social services.

The state's Program Operation Requirements for local CIS programs stipulates that student success will be measured based on three objectives: helping students to stay in school, student improvement, and student graduation. **Figure 5** shows the outcome measures CIS uses to gauge success in meeting these objectives and provides 5 years of outcome data.

These measures exceed the target performance stipulated by the state CIS office and point to positive outcomes for students served by CIS programs. However, although CIS case-managed students exhibit positive outcomes, determining program effectiveness accurately would require an independent evaluation with a quasi-experimental design that uses comparison groups or a comparable statistical model. The comparison groups should be as similar as possible in terms of student, campus, and district characteristics with the exception that one group (the "treatment group") receives CIS services and the comparison group does not. Such a comparison would allow an approximation of what the outcomes would have been for CIS students if they had not received those services.

Texas has not conducted an independent evaluation of CIS since 1993. The 1993 evaluation uses a more descriptive approach to analyzing the characteristics of CIS students, and its methodology was not designed to allow accurate analysis of program effectiveness.

The CIS national organization is currently undertaking a nationwide evaluation of the CIS model; and CIS Central Texas (Austin ISD in particular) has been selected as one of the sample sites for the "experimental" portion of the review, aimed at determining the effectiveness of the CIS model. The study will begin in January 2007, and the estimated completion date is 2010. The goal of the study is to determine the characteristics and contributions of national, state, and local CIS offices and to make inferences regarding CIS program effectiveness. Though this study should provide information regarding the effectiveness of the model as a whole, and provide a basis for comparing the structure and function of Texas's programs, it does not include a broad enough study group of Texas school districts to provide a large-scale determination of CIS program effectiveness in Texas.

Recommendation 1 would include a rider in the 2008–09 General Appropriations Bill that directs TEA to conduct an independent evaluation of CIS in Texas with a valid research methodology designed to determine the effectiveness of CIS programs in achieving program goals. The evaluation should be based on a quasi-experimental design comparing students receiving CIS services with similar students in similar educational settings who do not receive CIS services to approximate as closely as possible the isolated effect of CIS services.

Presuming that the results of this evaluation support the continued funding of CIS, additional evaluations should be conducted periodically to measure continued effectiveness.

FIGURE 5
COMMUNITIES IN SCHOOLS, PERFORMANCE DATA, FISCAL YEARS 2001 TO 2005

OUTCOME	2001	2002	2003	2004	2005
Percentage of case-managed CIS participants remaining in school	90%	92%	98%	99%	99%
Percentage of CIS case-managed students improved in academics, attendance, or behavior	84%	90%	91%	95%	96%
Percentage of CIS case-managed eligible seniors who graduated or received a GED	81%	90%	89%	86%	85%

SOURCE: Texas Education Agency.

FISCAL IMPACT OF THE RECOMMENDATION

Assuming a January 2009 delivery date, TEA estimates the cost of a statewide evaluation with an appropriately designed methodology, conducted by an independent contractor, to be $300,000.

These funds could be appropriated as a one-time increase in the set-aside for CIS for no net fiscal impact to the state. School districts would experience a proportional decrease in compensatory education allotment funds of $300,000 statewide.

The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendation 1.

STATE FORMULA FUNDING FOR DEVELOPMENTAL EDUCATION AND COLLEGE READINESS AND TEXAS SUCCESS INITIATIVES

The enactment of the College Readiness Initiative by the Seventy-ninth Legislature, Third Called Session, 2006, and the Texas Success Initiative in 2003 emphasizes the need for effective developmental education in Texas. Despite the significant changes addressed in these initiatives (and legislative appropriations totaling $206 million in General Revenue Funds for the 2006–07 biennium), the state funding formula that drives the achievement of those goals has not changed. Proper alignment of state resources with these initiatives mitigates potential barriers to students' postsecondary success and ensures that state resources are allocated effectively. However, limited statewide data exists to provide an accurate picture of the total costs incurred by institutions to remediate these students. A Legislative Budget Board study currently in progress, *The Cost of Developmental Education in Texas*, addresses these issues and is scheduled for release in January 2007.

FACTS AND FINDINGS

- Legislation passed in 2003 and 2006 encourages more effective developmental education. Texas Success Initiative authorizes the Texas Higher Education Coordinating Board to adjust state formula funding to improve student success; however no changes have been made since fiscal year 2003.
- Research shows that "one size does not fit all;" non-course-based programs can be more effective than traditional course-based developmental education for certain students.
- The current formula funding process does not distinguish between non-course-based and traditional course-based developmental education.
- Identification of costs, and any additional institutional administrative support, related to non-course-based programs would enable the Texas Higher Education Coordinating Board to adjust the formula to promote student success by aligning funding with more effective delivery methods and student interventions.
- The Legislative Budget Board, Texas Higher Education Coordinating Board and the University of Texas at Austin – Charles A. Dana Center have undertaken the task of identifying all of the costs associated with developmental education delivery.

DISCUSSION

Legislation passed by the Seventy-ninth Legislature, Third Called Session, 2006, (House Bill 1), established a new College Readiness Initiative to improve Texas' education system. This legislation requires that the P–16 Council (which is responsible for creating stronger links between preschool, public education, and higher education programs) develop a college readiness and success strategic action plan (House Research Organization, 2006). The plan intends to increase student success and decrease the number of students requiring developmental education coursework at higher education institutions.

If Texas is to achieve the goals of the Texas Higher Education Coordinating Board's (THECB) strategic plan *Closing the Gaps*, developmental education must fulfill its role by efficiently and effectively preparing students for college-level work. The P–16 Council defines developmental education as "a continuum of undergraduate courses and services ranging from tutoring and advising to remedial coursework and other instruction designed to prepare students for college-level (and therefore work-ready) courses and continued academic success." American College Testing, in the 2004 report *Crisis at the Core: Preparing all Students for College and Work*, estimates that as many as five out of six ACT-tested high school graduates in Texas are not prepared to succeed in college courses, with disproportionate numbers of low income and students of color in this group. The THECB, in the 2005 *Developmental Education Data Profile*, reports that once placed in developmental programs, under-prepared students seldom achieve academic success—20 percent ultimately complete developmental programs and earn baccalaureate degrees.

In 2003, the Texas Success Initiative (TSI), replaced the Texas Academic Skills Program (TASP), established by the Seventieth Legislature, 1988. Both state programs provide the framework for institutional developmental education programs. The THECB report, *Developmental Education in Texas Higher Education – A Comparison of Policies and Practices Fall 2000 and Fall 2004 (April 2005),* states that the difference between the TASP and the TSI is that the TSI

provides more institutional discretion to ensure that students are qualified to do college-level work. The TSI also requires that institutions and students work together to develop an individual plan for the student. The plan may include developmental education instruction that is course-based (traditional lecture) and/or non-course-based programs (tutoring, study skills, computer-based instruction, or other means of advising the student). While an initial assessment examination is still required, institutions are given greater responsibility for addressing the preparedness and success of their students, and students are given more options in addressing their academic deficiencies.

FORMULA FUNDING AND INSTRUCTIONAL TECHNIQUES

A critical component of the College Readiness Initiative and TSI is the effective use of financial resources. As higher education programs are enhanced to support student success, finance mechanisms can be realigned for greater efficiency and effectiveness. Texas relies on the *Instruction and Operations* formula funding process to appropriate general revenue to these initiatives. Texas Education Code 51.3062, allows the THECB to align funding by allowing the Board to "develop formulas to supplement the funding of developmental academic programs… non-course-based programs… and develop a performance based funding formula." However, no new formulas have been developed for developmental education programs since TSI implementation in 2003.

The state's current formula funding process for developmental education supports traditional course-based delivery of developmental education (similar to semester-length academic lecture courses) which is ineffective for many developmental education students. Hunter R. Boylan, in *What Works: A Guide to Research Based Best Practices in Developmental Education (2002)*, found that "students in developmental education courses were likely to be more successful when a variety of instruction methods were used." The report finds that these best practices increased student engagement, retention, and success rates in developmental education courses. However, most of these delivery methods are considered non-course-based programs and are not eligible to receive state formula funding.

According to the THECB, only approved courses in the *Academic Course Guide Manual* (ACGM) are considered course-based and eligible to receive formula funding. Those program offerings by an institution that are not in the ACGM are considered non-course-based and are not eligible to receive state formula funding. Non-course-based programs vary at institutions and can include: computer labs, "bridge programs," tutoring, accelerated learning, refresher courses, and study skills.

Currently, there is no formal definition of non-course-based programs in statute or THECB rule. Therefore, for purposes of this report, the cost of developmental or remedial education is classified into two elements:

1) Course-based instruction;
2) Non-course-based or non-instruction including
   a. academic support (library/learning resources center, academic administration, course and curriculum development, instructional computing support),
   b. student services (admissions, registrar, financial aid, supplemental education, advising/counseling/guidance, testing/assessment),
   c. institutional support,
   d. non-operating expenses.

Funding incentives for institutions to implement non-course-based programs under TSI may be unclear due to the state funding mechanism for traditional course-based developmental education. The THECB report, *Developmental Education in Texas Higher Education – A Comparison of Policies and Practices Fall 2000 and Fall 2004 (April 2005),* finds that TSI resulted in changes at institutions, but those changes were not dramatic. The report concludes that, although a priority, many institutions were slow to adopt non-course-based programs identified as best practices. Many institutions also reduced mandatory advising and developmental education placement which is contrary to the intent of TSI, and is not consistent with the design of quality developmental education programs. Although the report's findings were not specifically attributed to financial resources, funding is a key component of institutional policy development and prioritization.

FORMULA FUNDING AND ACTUAL COSTS

For the 2006–07 biennium, the Texas Legislature appropriated approximately $206 million in General Revenue Funds for developmental education at all higher education institutions (**Figure 1**). More than $152 million (74 percent) of that funding goes to community colleges, where the bulk of developmental education occurs. For the 2006–07 biennium, developmental education appropriations, as a percentage of lower division instruction, were 1.38 percent for universities compared to 9.36 percent for community colleges.

FIGURE 1
DEVELOPMENTAL EDUCATION APPROPRIATIONS AS A PERCENTAGE OF LOWER DIVISION INSTRUCTION, 2006–07 BIENNIUM

UNIVERSITIES	LOWER DIVISION	DEVELOPMENTAL EDUCATION	PERCENTAGE OF LOWER DIVISION
Midwestern State University	$38,563,831	$1,231,576	3.19%
Stephen F. Austin State University	73,656,096	1,284,182	1.74
Texas A&M University System			
Prairie View A&M University	64,268,454	1,444,482	2.25
Tarleton State University	50,666,013	1,293,452	2.55
Texas A&M International University	19,679,255	472,576	2.40
Texas A&M University	379,006,662	4,842	0.00
Texas A&M University at Galveston	12,736,701	0	0.00
Texas A&M University – Commerce	36,932,414	706,152	1.91
Texas A&M University – Corpus Christi	48,772,885	653,400	1.34
Texas A&M University – Kingsville	43,681,083	1,708,336	3.91
Texas A&M University – Texarkana	566,963	0	0.00
West Texas A&M University	42,609,644	1,201,518	2.82
Texas Southern University	89,639,223	4,230,884	4.72
Texas State University System			
Angelo State University	43,007,001	1,267,780	2.95
Lamar University	75,275,905	2,768,640	3.68
Sam Houston State University	88,730,591	1,251,766	1.41
Sul Ross State University	15,296,987	870,408	5.69
Sul Ross State University Rio Grande College	374,620	0	0.00
Texas State University – San Marcos	152,914,186	1,265,816	0.83
Texas Tech University System			
Texas Tech University	214,010,048	290,752	0.14
Texas Woman's University	57,243,696	742,280	1.30
The University of Texas System			
University of Texas at Arlington	157,453,341	1,131,616	0.72
University of Texas at Austin	397,368,499	104,938	0.03
University of Texas at Brownsville	7,535,885	0	0.00
University of Texas at Dallas	69,139,064	170,462	0.25
University of Texas at El Paso	109,338,957	3,260,284	2.98
University of Texas – Pan American	102,941,578	4,521,020	4.39
University of Texas of the Permian Basin	14,585,156	269,528	1.85
University of Texas at San Antonio	151,530,280	2,811,432	1.86
University of Texas at Tyler	27,832,362	0	0.00
University of Houston System			
University of Houston	213,118,922	1,540,404	0.72
University of Houston – Clear Lake	7,327	0	0.00
University of Houston – Downtown	46,184,281	3,495,890	7.57
University of Houston – Victoria	414,337	0	0.00
University of North Texas System			
University of North Texas	192,115,358	1,995,600	1.04
TOTAL*	**$3,037,197,604**	**$41,990,016**	**1.38%**

FIGURE 1 (CONTINUED)
DEVELOPMENTAL EDUCATION APPROPRIATIONS AS A PERCENTAGE OF LOWER DIVISION INSTRUCTION, 2006–07 BIENNIUM

COMMUNITY COLLEGES	LOWER DIVISION	DEVELOPMENTAL EDUCATION	PERCENTAGE OF LOWER DIVISION
Alamo CCD	$130,737,272	$17,414,500	13.32%
Alvin Community College	16,128,596	944,348	5.86
Amarillo College	33,623,370	3,081,169	9.16
Angelina College	16,796,712	1,938,158	11.54
Austin Community College	74,150,242	6,972,731	9.40
Blinn College	38,406,724	2,160,707	5.63
Brazosport College	12,161,304	957,860	7.88
Central Texas College	38,724,256	3,272,312	8.45
Cisco Junior College	10,555,362	560,731	5.31
Clarendon College	4,173,514	292,712	7.01
Coastal Bend College	13,612,444	1,157,961	8.51
College of the Mainland CCD	12,707,408	1,390,304	10.94
Collin County CCD	49,972,012	3,807,786	7.62
Dallas County CCD	172,493,633	17,037,500	9.88
Del Mar College	37,257,542	3,090,225	8.29
El Paso CCD	63,284,766	13,939,376	22.03
Frank Phillips College	5,477,752	298,231	5.44
Galveston College	9,440,802	818,158	8.67
Grayson County College	13,140,810	595,906	4.53
Hill College	11,789,699	882,691	7.49
Houston Community College System	122,466,236	10,929,478	8.92
Howard County Junior College District	21,375,686	466,253	2.18
Kilgore College	20,313,966	1,855,989	9.14
Laredo Community College	25,672,449	2,456,212	9.57
Lee College	20,120,128	993,311	4.94
McLennan Community College	26,555,732	1,641,634	6.18
Midland College	20,931,878	1,154,308	5.51
Navarro College	21,161,052	933,395	4.41
North Central Texas CCD	15,607,812	1,973,458	12.64
North Harris Montgomery CCD	98,310,654	13,342,151	13.57
Northeast Texas Community College	7,673,140	392,052	5.11
Odessa College	17,242,162	1,071,958	6.22
Panola College	6,589,408	274,365	4.16
Paris Junior College	14,999,016	2,381,829	15.88
Ranger College	4,173,512	206,874	4.96
San Jacinto College District	70,334,386	5,910,615	8.40
South Plains College	28,744,516	1,753,214	6.10
South Texas College	47,924,442	6,598,045	13.77
Southwest Texas Junior College	15,505,070	1,676,008	10.81

FIGURE 1 (CONTINUED)
DEVELOPMENTAL EDUCATION APPROPRIATIONS AS A PERCENTAGE OF LOWER DIVISION INSTRUCTION, 2006–07 BIENNIUM

COMMUNITY COLLEGES	LOWER DIVISION	DEVELOPMENTAL EDUCATION	PERCENTAGE OF LOWER DIVISION
Tarrant County College District	$86,744,456	$5,810,889	6.70%
Temple College	12,310,414	627,458	5.10
Texarkana College	17,888,098	1,017,337	5.69
Texas Southmost College	24,578,962	1,802,443	7.33
Trinity Valley Community College	22,142,812	1,090,478	4.92
Tyler Junior College	31,952,506	2,543,415	7.96
Vernon College	10,892,020	349,434	3.21
Victoria College, The	13,618,232	650,014	4.77
Weatherford College	15,465,370	952,184	6.16
Western Texas College	5,433,162	287,597	5.29
Wharton County Junior College	16,225,832	619,889	3.82
TOTAL**	**$1,627,587,329**	**$152,375,652**	**9.36%**
Texas State Technical Colleges			
TSTC – Harlingen	$38,201,688	$3,392,019	8.88%
TSTC – Marshall	9,215,083	603,777	6.55
TSTC – Waco	56,055,016	3,661,870	6.53
TSTC – West Texas	24,966,301	990,408	3.97
TOTAL*	**$128,438,088**	**$8,648,074**	**6.73%**
Lamar State Colleges			
Lamar Institute of Technology	$20,676,432	$1,229,451	5.95%
Lamar State College – Orange	14,318,538	714,468	4.99
Lamar State College – Port Arthur	21,367,205	1,068,761	5.00
TOTAL*	**$56,362,175**	**$3,012,681**	**5.35%**
GRAND TOTAL	**$4,849,585,196**	**$206,026,423**	**4.25%**

*Amounts shown for universities and technical colleges include general revenue appropriations for instruction and operations, teaching experience, and infrastructure.
**Amounts shown for community colleges include general revenue appropriations for administration and instruction.
SOURCE: Texas Higher Education Coordinating Board.

The full costs of developmental education programs including non-instructional costs that extend beyond classroom semester credit or contact hours are unknown. Developmental programs that rely on non-course-based programs may have additional administrative costs above comparable college-level instruction in the subject area. Non-course-based program expenditures, even though deemed critical for student success, are not disaggregated in formula funding rate calculations. There is a need for additional research to provide an accurate picture of the actual total costs incurred by institutions to prepare students for college-level coursework.

The THECB recognized this issue in *Formula Funding Recommendations for the 2008–09 Biennium*, which recommends that a "cost study be conducted to determine the additional differential cost for developmental studies." As a result, through collaborative efforts of the Legislative Budget Board, THECB, and the University of Texas at Austin – Charles A. Dana Center, a supplemental study of *The Cost of Developmental Education in Texas* will provide baseline information for the fiscal analysis study. By using focus groups and a statewide survey, the study will explore the current funding architecture and the allocation of funds (state, federal, local) for developmental education. The report will identify all of the costs associated with the delivery of

developmental education. Actual cost data will inform the adequacy of state funding. This report will also provide the foundation for an approach or method of choosing among alternatives that produce the desired results. The report is scheduled for release in January 2007.

ALIGN ADULT BASIC AND POSTSECONDARY EDUCATION TO MEET STATE GOALS IN THE TEXAS WORKFORCE DEVELOPMENT SYSTEM

The role of adult basic education in the U.S. is an important issue for states because of the correlation between educational attainment and the quality of jobs. As educational attainment increases, so does access to jobs with benefits and employment stability. Texas initiated several efforts to improve adult basic education including the enactment of Senate Bill 280 and 281 during the Seventy-eighth Legislature, Regular Session in 2003, the Tri-Agency Strategic Plan, and the Texas Workforce Development System Strategic Plan. Despite these efforts to improve the adult basic education program, the implementation of these plans is still uncoordinated. Texas continues to have the lowest educational achievement rates for adults over age 25 nationally in 2005. In addition, inaccurate reporting of the federal performance measures resulted in a loss of Federal Funds for fiscal year 2004. Texas can improve its educational achievement rates by developing strategies and coordinated agency action plans to align adult basic education and postsecondary education, and developing data standards to ensure data quality and sharing between agencies.

FACTS AND FINDINGS

- The Seventy-eighth Legislature, Regular Session, 2003, directed the Texas Workforce Investment Council to develop and implement immediate and long-range strategies to facilitate the seamless delivery of integrated workforce services and to identify the state agencies responsible for implementing the strategies.
- One of Texas Workforce Investment Council's long-range objectives addresses the importance of enrolling adult basic education students in postsecondary education programs.
- The strategic plans of the Texas Education Agency and the Texas Higher Education Coordinating Board do not include comprehensive action plans that consider the relationship between the agencies for "encouraging adult education participant postsecondary transitions."
- Inaccurate reporting of the federal Adult Education and Family Literacy Act performance measure regarding "participant placement in postsecondary education or training" resulted in a loss of between $750,000 and $3,000,000 in available Federal Funds related to performance incentives for fiscal year 2004.

CONCERNS

- Although Texas Education Agency and Texas Higher Education Coordinating Board Strategic Plans contain strategies for increased General Education Development attainment and employment success, those plans do not contain coordinated state-level actions to support postsecondary education outcomes for adult basic education participants consistent with Texas Workforce Development System goals.
- Inaccurate reporting of the Adult Education and Family Literacy Act performance measure regarding "participant placement in postsecondary education or training" could continue to jeopardize millions of dollars annually in Federal Funds related to the Workforce Investment Act performance incentive.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the 2008–09 General Appropriation Bill requiring Texas Education Agency and Texas Higher Education Coordinating Board in coordination with Texas Workforce Investment Council, to develop, revise, and implement immediate and long-range coordinated action plans to align adult basic education and postsecondary education.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriation Bill requiring Texas Education Agency and Texas Higher Education Coordinating Board in coordination with Texas Workforce Investment Council, to develop standards to enhance data quality and sharing to ensure eligibility for all available Federal Funds related to the Workforce Investment Act performance incentive.

DISCUSSION

The role of adult basic education (ABE) as a bridge to further education and training is central to the U.S. Department of Education's vision for adult education and is an emerging view across the U.S. Several states such as Kentucky, Washington, and Florida implemented statewide initiatives

that support the positive role of postsecondary education in furthering state economic development. As educational attainment increases, so does access to jobs with benefits and employment stability. According to the College Board, *Education Pays – Second Update*, 2006, the 4.4 percent national unemployment rate in 2005 reflected large differences by educational attainment (**Figure 1**).

FIGURE 1
NATIONAL UNEMPLOYMENT RATES BY EDUCATIONAL ATTAINMENT, 2005

ALL	NOT A HIGH SCHOOL GRADUATE	HIGH SCHOOL GRADUATE	SOME COLLEGE OR ASSOCIATE DEGREE	BACHELOR'S DEGREE OR HIGHER
4.4%	8.8%	5.4%	4.2%	2.3%

SOURCE: College Board.

Education is not only increasingly essential for basic employment, it is also essential for economic prosperity and career advancement. Workers with a bachelor's degree earn an annual income nearly $20,000 higher than workers who have only completed high school.

With current allocated resources, Texas is serving 3.5 percent of the 3.8 million people in need of adult basic education services. Currently 24 Community Colleges, 20 School Districts, 8 Education Service Centers, and 2 local organizations are fiscal agents for these programs. For 2004–05, there were 123 providers with 1,560 sites in Texas. For those same years, 95 percent of students enrolled in ABE programs had less than a ninth-grade education, 20 percent of those students were age 16 to 21, while 62 percent were age 25 to 59. In 2004, 51,872 Texas students completed the battery of General Education Development (GED) tests. However, only 66.5 percent (34,587) of those students passed, which was below the national pass-rate average of 71.2 percent. Earning a GED has a minor effect on income, unless it is used as a key for entry into further education and training. However, The National Center for Public Policy and Higher Education's *Measuring Up 2006 State Report Card* ranked Texas as having "made no notable progress in enrolling students in higher education." Only 3.9 percent of Texas working age adults (age 25 to 59) are enrolled part-time in college level education or training compared to 5.1 percent of working age adults of the report's high performing states.

IMPROVE STUDENT TRANSITION FROM ADULT BASIC EDUCATION TO HIGHER EDUCATION

The Texas Workforce Investment Council (TWIC) was created in 1993 by the Seventy-third Legislature. The TWIC Council is composed of nine partner agencies, which includes: Texas Workforce Commission (TWC), Texas Education Agency (TEA), Texas Health and Human Services Commission (HHSC), Economic Development and Tourism, Texas Department of Criminal Justice, Texas Veteran's Commission, Texas Youth Commission, Texas Association of Workforce Boards, and Texas Higher Education Coordinating Board (THECB). The TWIC also includes several members who represent business and industry, education, organized labor and community-based organizations. One of the Council's key responsibilities is the development of a strategic plan for the Texas Workforce Development System (TWDS). This plan focuses on "the system as a whole and the opportunities and challenges of preparing a skilled workforce for Texas in the twenty-first century." In 2003, the Governor and the Legislature directed TWIC to carry out certain strategic planning and evaluation functions to promote the development of a well-educated, highly-skilled workforce for Texas. Legislation enacted by the Seventy-eighth Legislature, Regular Session, 2003, required TWIC to evaluate adult education programs administered by agencies on the council to identify any duplication or gaps in the services provided by those programs, along with any other problems that adversely affect the seamless delivery of services. Additionally, the legislation directed TWIC to develop and implement strategies to address those issues.

The *TWDS Strategic Plan – 2006 Annual Update* lists one long-term objective directly related to the ABE program, "increase the percentage of ABE students completing the level enrolled from 64 percent to 70 percent by Q4/07." To meet this objective, the plan lists 17 major tasks and milestones, and over 30 tracking measures and interim outputs. Included in those tasks is for THECB and TEA to "develop a plan to encourage ABE participants to pursue postsecondary education opportunities leading to the certificates and degrees," which was completed in fiscal year 2004. Although this task directly correlates with the Adult Education and Family Literacy Act (AEFLA) performance measures and program requirements, it does not appear in TEA or THECB agency strategic plans. However, a parallel task in the TWDS plan for encouraging exiting high school students to pursue academic or technical education resulted in an action plan through the TEA Texas High School Initiative program.

TEA and THECB strategic plans do not include comprehensive strategies that consider the relationship between the agencies for "encouraging adult education participant postsecondary transitions." Neither agency strategic plan has performance measures that support this activity in the TWDS strategic plan or at the agency level. Although alternative secondary education and higher education participation and success are clearly within the statewide missions for TEA and THECB, TEA relies on program-level strategies aligned with federal funding performance measures to drive the success of postsecondary transitions. A formal coordinated action plan that supports transitioning ABE participants into postsecondary education does not exist. This unclear linkage and lack of a coordinated action plan between TEA and THECB prevents the state from realizing its goals to fully promote the development of a well-educated, highly-skilled workforce for Texas.

ADMINISTRATION OF ADULT EDUCATION IN TEXAS

TEA, through the Division of Adult and Community Education, administers the ABE program in Texas, and has done so since its beginning in 1964. The original federal legislation, the Federal Economic Opportunity Act, placed responsibility for adult education programs with the state agency, and the Texas Education Code is consistent with the federal legislation. Under an agreement with TEA, Texas LEARNS program, housed in the Harris County Department of Education, provides nondiscretionary grant management functions, program assistance and other statewide support services to Texas Adult Education and Family Literacy Providers. The TEA Division of Discretionary Grants continues to be responsible for all discretionary, policy, and monitoring functions.

In addition to TEA, Texas Workforce Commission (TWC) and the THECB have an active role in adult education. TEA and TWC are primarily responsible for the administration of ABE state and federal funding and oversight of funded programs across the state. TEA is responsible for ensuring adults across the state receive their entitlement of a quality basic and secondary education. TWC is charged with overseeing and providing workforce development services to employers and job seekers in Texas. THECB coordinates services to undereducated adults through community and technical colleges. Some community colleges serve as fiscal agents for TEA and receive AEFLA funds to support basic education and literacy programs.

At a program level, the *Texas State Plan on Adult Education and Family Literacy*, states that the mission of adult education and literacy is "to ensure that all adults who live in Texas have the skills necessary to function effectively in their personal and family lives, in the workplace, and in the community." Placement in postsecondary is a core indicator of the program. However, the *Texas Education Agency Strategic Plan for the Fiscal Years 2007 to 2011* does not include any specific strategies, programs, or measures that define the ABE pathway into postsecondary education. Although TEA's plan does include a description of AEFLA initiatives to "promote workplace literacy and transition to postsecondary or training for adult education students," none of the five TEA performance measures listed for the program strategy include postsecondary transitions.

Although the THECB has no direct role in the administration of ABE programs, it is clearly involved with ABE programs in two ways:

1. Twenty-seven community colleges are ABE program providers.
2. Many students who are enrolled in ABE programs come to the colleges for services, and some are served by developmental education programs to provide college readiness. By state law, community colleges are open enrollment institutions and must accept students who are 18 regardless of high school achievement.

However, neither the *Texas Higher Education Coordinating Board Strategic Plan for the Fiscal Years 2007 to 2011* or the *Closing the Gaps by 2015* plans include any specific strategies, performance measures, or action plans that encourage ABE postsecondary transitions.

To address programmatic and efficiency barriers through this tri-agency approach, THECB, TWC, and TEA first developed a state-wide plan for adult basic education in 2003, *The Ten – Year State Plan for Improvement of Adult Education Efforts in Texas*. However, budgetary constraints did not allow for the plan's implementation. In 2004, the *Destination 2010: FY 2004 to FY 2009 Strategic Plan* was developed by the Texas Workforce Investment Council and included strategies for the ABE program to "increase results through performance."

CURRENT PROCESS NOT ACHIEVING INTENDED RESULTS

Strong leadership at the state level is necessary to build a cohesive, systemic approach to the delivery of adult education services in Texas. Higher education and the Texas workforce

cannot rely entirely on the current number of high school graduates to meet state goals for increasing student participation and success in college. Therefore, a formal coordinated action plan between TEA and THECB is critical. Statutory references are made to this coordination through the State P–16 Council, however this mechanism although useful, is not effective by itself as state goals are still not being accomplished. There are now 27 ABE programs held on community college campuses; however Fall 2004 enrollment of ABE completers in Texas higher education institutions was only 6,085 students statewide.

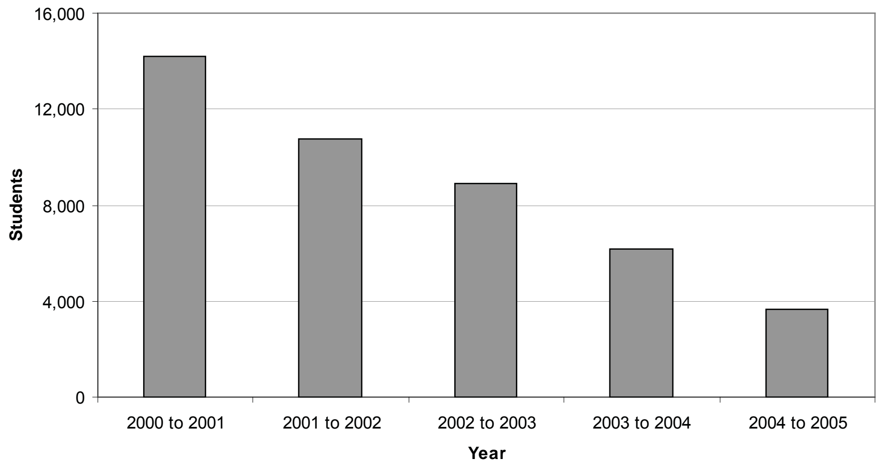
For over 100,000 participants each year, the ABE program provides a potential pathway into higher education that is not maximized to meet the state's educational initiatives. As indicated in the THECB's *Closing the Gaps by 2015: 2006 Progress Report*, July 2006, "Texas is not on track to meet the participation goal of the state's *Closing the Gaps by 2015* higher education plan." The report further states that Texas is 20,500 Hispanic students below the 2005 target of 340,000 students enrolled and overall statewide enrollment increases were the smallest since 2000. Based on new population projections from the Texas State Data Center, Texas must enroll an additional 100,000 Hispanic students by 2015 for a total of 440,000 students or 5.7 percent of the Hispanic population. For the program year 2004–05, there were over 77,000 Hispanic participants in ABE programs to support the achievement of this specific goal. However, very few ABE participants manage to move up.

Current ABE transition rates reflect minimal recruitment of ABE students by higher education institutions. In 2005, of the 3,638 ABE participants with a goal to transition to postsecondary education or training, only 676 (19 percent) were reported by TEA as enrolled in postsecondary education or training after exiting the ABE program. In addition, there has been a 75 percent decrease in ABE participants with a postsecondary goal since 2001 (**Figure 2**).

However, these numbers reflect the ABE participant goals when they enter the program and were not updated throughout the program. Of more than 400,000 ABE participants exiting the program in 2001 through 2004, approximately 6 percent were enrolled in higher education institutions the next fall semester. The consistent 6 percent transition rate each of those years indicates limited success in recruiting of ABE students by higher education institutions statewide. The remaining 94,000 participants each year, who do not transition into higher education, are an "untapped resource" to achieve the state's goals.

Lack of coordination between TEA and THECB resulted in the loss of potential joint opportunities for ABE service providers and community colleges to maximize Federal Funds for these transitions. For example, the U.S. Department of Education's Educational Opportunity Centers (EOC) program (one of the eight federal programs collectively named TRIO) provides counseling and information on college admissions to qualified adults who want to enter or continue a program of postsecondary education. An

FIGURE 2
TEXAS ADULT BASIC EDUCATION STUDENTS WITH POSTSECONDARY EDUCATION OR TRAINING GOALS
PROGRAM YEARS 2000–01 TO 2004–05



SOURCE: Texas Education Agency.

important objective of the program is to counsel participants on financial aid options and to assist in the application process. The goal of the EOC program is to increase the number of adult participants who enroll in postsecondary education institutions. In 2005, only five Texas community colleges had been awarded these Federal Funds.

As noted in Recommendation 1, these issues can be addressed through improved and coordinated agency action plans. Increasing the number of postsecondary outcomes for ABE participants should not end with the TWDS Strategic Plan. The TWDS performance measures should be included in action plans of both TEA and THECB. These action plans should specify how this performance is to be accomplished, what programs are linked to carry out the plan, and the process for evaluation. Action plans are detailed methods specifying how a strategy is implemented. Task specification includes staff assignments, material resource allocation and schedules for completion. Although some action items were noted in the TWDS Strategic Plan, those actions need to be clearly coordinated between TEA and THECB for continuity of services and program evaluation.

The proposed rider language for Recommendation 1 can be found at the end of the Discussion section.

ACCOUNTABILITY OF ADULT BASIC EDUCATION IN TEXAS

The state-administered ABE program, authorized under the federal Adult Education and Family Literacy Act (AEFLA), enacted as Title II of the Workforce Investment Act (WIA) of 1998, is the major source of Federal Funds for adult basic and literacy education programs. In addition, there are other sources of Federal Funds with linkages to adult education and literacy. These sources include the Food Stamps Employment and Training Program, Temporary Assistance for Needy Families/Choices (educational services to welfare recipients), and Trade Adjustment Assistance, all administered by the Texas Workforce Commission. The purpose of the AEFLA grant is to provide educational opportunities to adults age 16 and older, not currently enrolled in school, who lack a high school diploma or the basic skills to function effectively in society, or who are unable to speak, read, or write the English language.

When AEFLA was reauthorized in 1998, Congress made accountability for results a central focus of the new law, setting out new performance accountability requirements for states and local programs that measure program effectiveness on the basis of student academic achievement and employment related outcomes. To define and implement the accountability requirements of AEFLA, the U.S. Department of Education's Office of Vocational and Adult Education (OVAE) established the National Reporting System (NRS).

Since Program Year 2000, the National Reporting System (NRS) has been the accountability system for the adult education program. Texas established a performance accountability system that meets NRS requirements and NRS data are the basis for assessing the effectiveness of states in achieving continuous improvement of adult education and literacy activities to optimize the return on investment of Federal Funds [P.L. 105-220 Section 212(a)]. The AEFLA includes three core indicators:

- Demonstrated improvements in the literacy skill levels in reading, writing and speaking English, English language acquisition, and other literacy skills;
- Placement in, retention in, or completion of postsecondary education, training, unsubsidized employment, or career advancement; and
- Receipt of a secondary school diploma or a recognized equivalent [P.L. 105-220, Section 212(b) (2)].

These indicators are embodied in the NRS five basic core measures that are used to assess state performance:

- Educational gain – of adult learners in basic and English literacy programs, the percentage who acquire the basic or English language skills needed (validated through standardized assessment) to complete the educational functioning level in which they were initially enrolled.
- High school completion – of adult learners with a high school completion goal, the percentage who earned a high school diploma or recognized equivalent.
- Entered postsecondary education – of adult learners who establish a goal to continue their education at the postsecondary level, the percentage that entered postsecondary education or training after program exit.
- Entered employment – of unemployed adult learners with an employment goal, the percentage who obtained a job within one-quarter after program exit.
- Retained employment – of adult learners with a job retention goal, the percentage who entered employment within one-quarter after exiting and, the percentage who were still employed in the third-quarter after program exit.

States also may identify additional performance indicators for adult education and literacy activities and incorporate these indicators, as well as corresponding annual levels of performance, in their state plans.

TEA relies on the federal measure to monitor ABE program performance of transition into postsecondary institutions. **Figure 3** shows that Texas' reported performance was below national averages for the measure "Entered Postsecondary Education/Training" for the program years 2001 to 2003. The ABE service providers and postsecondary institutions are not adequately being held accountable for their role in these transitions.

FIGURE 3
AEFLA PERFORMANCE - ENTERED POSTSECONDARY EDUCATION OR TRAINING, PROGRAM YEARS 2001 TO 2003

PERCENTAGE OF ADULT LEARNERS WITH A GOAL TO CONTINUE THEIR EDUCATION WHO ENTER POSTSECONDARY EDUCATION OR TRAINING AFTER EXITING THE PROGRAM

	2000–01	2001–02	2002–03
Texas	6%	14%	24%
National Averages	25%	29%	30%

SOURCE: U.S. Department of Education.

FEDERAL FUNDS FROM PERFORMANCE INCENTIVES

The federal Adult Education and Family Literacy Act requires that states work with OVAE to determine the levels of performance for the core measures that become baseline performance levels for subsequent decisions related to federal incentives. States that exceed the agreed upon performance levels may be eligible for incentive awards. To qualify for a federal incentive award, a state must exceed performance levels for Title I and Title II of the Workforce Investment Act and for the Carl D. Perkins Vocational and Technical Education Act.

The determination of whether a state exceeded its adjusted levels of performance is based on the state's cumulative achievement across all measures. This is done by calculating the percentage of the state adjusted level achieved for each measure, and then averaging the percent achieved across all measures. When the cumulative average exceeds 100 percent, the state will be determined to have exceeded the overall adjusted performance levels.

WIA section 503 indicates that incentive awards are to be issued in an amount not less than $750,000 and not more than $3,000,000 in Federal Funds, to the extent that funds are available; otherwise, prorated amounts are to be awarded. In program years 2002–03, 47 states exceeded their adult education performance levels. Twenty-three of those states also exceeded WIA Title I and Perkins performance levels and qualified to receive a share of the $25.4 million available for incentive awards for program years 2002–03. In 2004, Texas met WIA Title I and Perkins levels, but did not meet 2004 federal performance targets for its ABE program resulting in the loss of eligibility for WIA Section 503 Performance Incentive funding for the state.

As mentioned in Recommendation 1, TEA and THECB must work together to develop a stronger accountability system for the adult basic education pathway into higher education. Postsecondary institutions and ABE service providers are not adequately held accountable for the transitioning of these students; therefore targets are not consistently met. The TWDS Strategic Plan indicates the need for a coordinated action plan between TEA and THECB required for this activity.

The proposed rider language for Recommendation 1 can be found at the end of the Discussion section.

COLLECTION AND SHARING OF ADULT EDUCATION DATA IN TEXAS

The AEFLA allows states to collect program performance measures through the use of the data match of administrative records or through a follow-up survey. The use of data matching records is clearly preferred because of its greater accuracy and lower cost and is possible in most states for the high school completion measure. For program year 2003–04, 38 states used data matching to determine student outcomes for high school completion and four additional states supplemented data matching with surveys. For entrance to postsecondary education, there are few comprehensive databases available to states for measuring postsecondary enrollment. Consequently, most states must use individual student surveys to collect some or all of the follow-up measures.

Texas uses data matching but not follow-up surveys. The methodology established by TEA uses an automated record match of the Adult and Community Education System student records through a Memorandum of Understanding (MOU) with the THECB to calculate the numbers and percentages of adult education students who enter

postsecondary education, or job training. The population for this measure is the ABE participants that list a goal of "transitioning into postsecondary" upon entrance to the ABE program. Those individuals' social security number (which is not required by federal law) are sent to the THECB and matched to social security numbers of students enrolled in public two-year and four-year institutions. According to TEA, surveying ABE participants would be very time consuming and possibly would not provide optimal results.

Multiple flaws in the data collection and calculation process between TEA and THECB are a significant factor in the quality of results of AEFLA performance measures used for the ABE program accountability. This process does not capture data on students who decide to enter postsecondary after entering the ABE program or those students who do not provide a social security number. TEA did not match ABE participants that transitioned into private institutions and non-credit courses due to lack of consistent communication between TEA and THECB. When TEA reran the data match to include this information, performance increased from 8 percent to 19 percent for program year 2005. However, the result is still inaccurate because there are no established data links to determine the training portion of the measure. Proprietary institutions that provide job training are not required to submit student level data to the THECB. Therefore, Texas has been reporting the transitions into only public postsecondary institutions since 2000. The MOU between TEA and THECB provides the framework for the current data matching process, but it is not updated on a regular basis. Consistent communication between the two agencies is critical to ensure that data needs are met.

Since social security numbers are not a requirement upon entrance into ABE and no secondary identifier has been established between TEA and THECB, the population for data matching is artificially reduced. Between 2001 and 2005, the percentage of total adult education participants without a primary identifier increased from 27 percent to 34 percent (**Figure 4**). For those 48,728 students in 2005, Texas cannot determine the student outcomes of either postsecondary enrollment or employment for approximately $14.7 million of program expenditures ($302.58 per student according to Texas LEARNS) from both state and Federal Funds.

For the sub-group of ABE participants with a postsecondary goal, the percentage without a primary identifier is less than the entire group of ABE participants (**Figure 5**). For program year 2005, 13 percent of students with a goal of higher education or training had not provided a social security number.

Recommendation 2 emphasizes that data quality must be improved. TEA's reliance on AEFLA performance measures for ABE participants transitioning into postsecondary institutions has resulted in inaccurate reporting both nationally and statewide. All systems that support data collection should have effective controls to provide reasonable quality assurance. A secondary identifier must be established to determine program outcomes for all participants. Effective program management will be enhanced at the state and local level as a result.

Texas could achieve stronger coordination between agencies in several ways; in particular, by using existing resources such as the Texas PK–16 Public Education Information Resource (TPEIR) project. This project provides stakeholders in public education with ready access to public primary, secondary, and higher education information for purposes of research, planning, policy, and decision-making. This resource provides a parallel tracking system for monitoring the transition of

FIGURE 4
TEXAS EDUCATION AGENCY ADULT EDUCATION PARTICIPANTS WITH A PRIMARY IDENTIFIER, PROGRAM YEARS 2001-2005

ADULT EDUCATION PROGRAM YEAR	TOTAL ADULT EDUCATION PARTICIPANTS	PARTICIPANTS WITH A PRIMARY IDENTIFIER	PARTICIPANTS WITHOUT A PRIMARY IDENTIFIER	PERCENTAGE OF TOTAL ADULT EDUCATION PARTICIPANTS WITHOUT A PRIMARY IDENTIFIER
7/1/2000 to 12/31/2001	137,164	99,456	37,708	27%
7/1/2001 to 12/31/2002	150,244	106,956	43,288	29%
7/1/2002 to 12/31/2003	156,500	109,987	46,513	30%
7/1/2003 to 12/31/2004	146,388	99,541	46,847	32%
7/1/2004 to 12/31/2005	142,472	93,744	48,728	34%

Sources: Texas Higher Education Coordinating Board; Texas Education Agency.

FIGURE 5
TEXAS EDUCATION AGENCY ADULT EDUCATION EXITERS WITH A POSTSECONDARY GOAL, WITH A PRIMARY IDENTIFIER, PROGRAM YEARS 2001–2005

ADULT EDUCATION PROGRAM YEAR	STUDENTS WITH A POSTSECONDARY GOAL	STUDENTS WITH A POSTSECONDARY GOAL AND A PRIMARY IDENTIFIER	STUDENTS NOT IDENTIFIABLE FOR POSTSECONDARY GOAL	PERCENTAGE OF STUDENTS NOT IDENTIFIABLE FOR POSTSECONDARY GOAL
7/1/2000 to 12/31/2001	14,214	12,641	1,573	11%
7/1/2001 to 12/31/2002	10,771	9,712	1,059	10%
7/1/2002 to 12/31/2003	8,883	8,038	800	9%
7/1/2003 to 12/31/2004	6,153	5,514	639	10%
7/1/2004 to 12/31/2005	3,638	3,156	482	13%

SOURCES: Texas Higher Education Coordinating Board; Texas Education Agency.

high school students into higher education in which adult education students could be added. Managed by TEA and THECB, this project includes an integrated interagency data store containing "raw" data currently collected through several different operational systems and stored in multiple distinct databases. TPEIR's *High school Graduates Enrolled in Higher Education* 2006 report, available on the website at www.texaseducationinfo.org, provides information to both public and higher education on the transitioning of students since 2001.

The following TEA and THECB rider could be included in in the 2008–09 General Appropriations Bill to implement Recommendations 1 and 2:

Align Adult Basic Education and Postsecondary Education.

Out of funds appropriated above, the Texas Higher Education Coordinating Board and the Texas Education Agency shall develop, revise, and implement immediate and long-range coordinated action plans to align Adult Basic Education and postsecondary education. To increase the number, success and persistence of students transitioning, these action plans shall address at a minimum:

a. outreach and advising;
b. assessment, curriculum, and instruction;
c. persistence interventions;
d. state-level accountability systems to monitor performance;
e. service-provider-level performance measures and program evaluation;
f. standards to enhance data quality and sharing among state agencies and service-providers;
g. needs assessment of students and service-providers to identify other structural issues and barriers;
h. grants (including Federal Funds and Other Funds) to maximize effective use of limited General Revenue Funds.

Texas Higher Education Coordinating Board and Texas Education Agency shall develop, and agree to, consistent with Texas Workforce Investment Council provisions under Texas Education Code 2308.1016, a revised memorandum of understanding that establishes the respective responsibilities of each agency for the implementation of action plans necessary to successfully transition students enrolled in adult basic education into postsecondary education. The memorandum of understanding shall establish a point of responsibility and provide sufficient resources within each agency for implementation by that agency of the requirements of the memorandum of understanding. The updated memorandum of understanding must be completed by December 31, 2007.

Texas Higher Education Coordinating Board and Texas Education Agency shall report on the implementation of these provisions to the Texas Workforce Investment Council, the Governor, and the Legislative Budget Board by September 1, 2008.

FISCAL IMPACT OF RECOMMENDATIONS

Recommendations 1 and 2 would have no fiscal impact for the 2008–09 biennium. The introduced 2008–09 General Appropriations Bill includes a rider implementing Recommendations 1 and 2.

RESTRUCTURE HIGHER EDUCATION FINANCIAL AID PROGRAMS TO INCREASE FEDERAL FUNDING AND STUDENT OPPORTUNITIES

Texas is a national leader in linking need-based student financial aid programs to effective preparation in grade K–12 public education. While policies such as the Recommended High School Program have had significant success, state established gift aid programs, such as the "Towards EXcellence, Access and Success" (TEXAS) Grant program, could modify policies and procedures to maximize their efficacy and to secure additional Federal Funds for Texas. Existing inefficiencies are largely created by incongruity between the student-level award of federal aid and the institution-level award of state financial aid. Institutional control over the distribution of state financial aid also creates inequities in funding for similar students in different institutions and diminishes the financial incentives supporting *Closing the Gaps*, the state's initiative for higher education.

Shifting the TEXAS Grant program to a direct grant to students and changing the funding allocation mechanism to average room and board charges as opposed to average tuition and fees could increase the efficiency and equity of state financial aid. These changes would result in an additional $32 million to $42 million in Federal Funds for TEXAS Grant recipients. Further, the TEXAS Grant program could be expanded from $168 million to $314 million without additional state appropriations if funds from two tuition set-aside programs administered by higher education institutions were redirected into the program. This shift would nearly double the amount of need-based student financial aid tied to rigorous preparation in high school.

FACTS AND FINDINGS

- From 1999 to 2005, average tuition and fees in Texas increased at rate of 10.3 percent per year compared to an average increase in room and board of 3.6 percent and a consumer price index increase of 2.9 percent. If current trends persist, average tuition and fees will be greater than the average cost of room and board by 2010.

CONCERNS

- Federal higher education gift aid requires submission of the Free Application for Federal Student Aid, however many students do not complete this form and as a result are ineligible for federal student aid.
- The current institution-based method of awarding TEXAS Grants dilutes the impact of the college-preparation incentive the program is attempting to foster.
- Tuition set-aside funds of $146 million are awarded as financial aid without student performance requirements that support state higher education goals.
- When the benefits of federal education tax-credit programs are fully accounted for, between $32 million and $42 million of the fiscal year 2005 TEXAS Grant appropriation (22 percent to 29 percent) may have provided no net benefit to students. In addition, the rapid growth in state average tuition and fees jeopardizes the scope of the program.

To address these concerns, it is recommeneded that the Texas Higher Education Coordinating Board engage in a set of directed implementation studies to ensure that potential barriers to successful implementation of the initiatives are explored in advance of authorizing legislation. Potential issues include ensuring that any changes are congruent with federal tax regulations, establishing a cost and method for statewide program implementation, and determining the effect of directing funds from existing student populations into the TEXAS Grant award structure.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Higher Education Coordinating Board to study the impact of requiring the completion of the Free Application for Federal Student Aid form as a condition of enrollment in a public institution of higher education in Texas.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Higher Education Coordinating Board to study options for converting TEXAS Grant into a direct educational grant program.
- **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Higher Education Coordinating Board to study

shifting existing tuition set-aside funds from statutory and designated tuition to the TEXAS Grant program.

- ♦ **Recommendation 4:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Higher Education Coordinating Board to study the viability of constraining the future growth of the TEXAS Grant program while enhancing federal education tax-credits by converting the program to a stipend-based aid program linked to state average cost of room and board (or other index of living expenses).

DISCUSSION

The first step in developing a student's financial aid award package is to determine the amount the student or family is expected to contribute to their education. A federal formula on the Free Application for Federal Student Aid (FAFSA) determines this expected family contribution (EFC) amount from income and asset information supplied by the student and his or her family. Financial aid officers have some discretion to modify EFC for changes in family circumstance as a "special condition." These special conditions include: (1) reduction of income due to unemployment or change of profession; (2) experiencing a divorce or separation; (3) reduction of income due to loss of government benefits; (4) child support; (5) non-recurring income in the FAFSA-reported year; or (6) unusually high medical or dental expenses not covered by insurance.

Institutions are required to determine a cost of attendance (COA) for various categories of students (e.g., a full-time student, living on campus). The major categories of expenses included in a COA are: tuition and fees, room and board, and an allowance for books, supplies, transportation, and personal expenses. Institutions have significant flexibility in determining these costs.

The gap between EFC and the COA is referred to as unmet need and financial aid awards are designed to cover some amount of this need. EFC is not affected by the cost of an institution of higher education. Two students with the same income and asset profiles will have the same EFC at Harvard University that they have at South Texas College (unless the COA at the institution is lower than EFC). However, due to the higher COA, unmet need after federal grant aid is larger for more expensive institutions (or institutions in more expensive locales).

Federal financial aid calculations are the basis of college financial award planning because federal support is a large portion of financial aid packages. In fiscal year 2004, for example, 77 percent of student aid ($3.4 billion of $4.4 billion) in Texas was funded with Federal Funds. Students who fail to complete the FAFSA short-circuit the awarding of federal aid at the beginning of the process.

Recommendation 1 would direct the Texas Higher Education Coordinating Board (THECB) to study requiring FAFSA completion as a condition of enrollment for all students attending a public institution of higher education in Texas in an effort to maximize federal education funds for Texas students. Even with significant outreach efforts, many students who are eligible for federal financial aid do not receive it simply because they do not complete this form. All in-state students at a public institution receive some state subsidy for their education through the higher education formula. Requiring FAFSA completion ensures that all students able to access available Federal Funds do so.

STUDENT-DEPENDENT SOURCES OF FEDERAL GRANT AID

Student financial aid is most broadly divided into gift aid (which does not need to be repaid by the student) and loans (which must be repaid). One important, yet largely unspecified distinction among gift aid programs involves the method or formula used to determine whether aid is granted as well as the amount of any award. Student-dependent awards are those which the administering institution does not directly determine the distribution of funds. The lack of institutional control means the programs are more transparent in their operation than institution-directed aid (as any interested student could determine the award they should receive by knowing their financial situation and the calculation used to generate the award amount).

Federal Pell Grant Program: The cornerstone federal financial aid program is the Pell Grant program, with a maximum award of $4,050 per academic year. In fiscal year 2005, $881 million in Pell Grants were awarded to Texas students across all sectors of higher education in the state. To be eligible for consideration for a Pell Grant, students must be U.S. citizens or legal, permanent residents. They must have a high school diploma, passed the General Educational Development Test (GED), or be able to establish "ability to benefit." They must also be working towards their first undergraduate degree and meet satisfactory academic progress as defined by their institution.

If these threshold criteria are met, Pell Grants are then awarded to students with significant financial need under federal guidelines. The amount a student receives as a Pell

Grant is dictated by that student's EFC. A student with zero EFC is fully funded for the first $4,050 of higher education expenses. The award is reduced proportionally at higher levels of EFC. Students with an EFC of over $3,850 receive no award. The minimum Pell Grant is $400.

New Federal Education Grant Programs: There are two new federal grant programs that began in the 2006–07 academic year: the Academic Competitiveness Grant (ACG) program and the National Science and Mathematics to Retain Talent (SMART) Grant program. ACG grants are awarded to full-time, Pell Grant-eligible students who complete a "rigorous high school course of study." A student must also be a U.S. citizen, be a Pell Grant recipient, and be enrolled full-time in a degree program. Currently in Texas, the "rigorous" high school course of study has been determined by the U.S. Department of Education to be the state-established Recommended High School Program or the Distinguished Achievement Plan.

In the first year of higher education, a student eligible to receive an ACG will receive an award of $750. This amount is not adjusted according to EFC. Thus, a first-year student who is ACG-eligible will receive a total federal grant award ranging from $1,150 ($400 Pell Grant plus $750 ACG) to $4,800 ($4,050 Pell Grant plus $750 ACG). In the second year, if the student maintained a 3.0 grade point average (GPA), the ACG award increases to $1,300.

The SMART Grant program provides $4,000 in each of the junior and senior years for students who are enrolled in specific majors. Like the ACG Grant, SMART Grants require that the recipient be a U.S. citizen, be a Pell Grant recipient (of any dollar amount), and be enrolled full-time in a degree program. The grant program does not require completion of a specific course of study in high school; rather, the student must "major in physical, life, or computer sciences, mathematics, technology, or engineering" or "a foreign language that the Secretary [of Education], in consultation with the Director of National Intelligence, determines is critical to the national security of the United States." The student must also have achieved a 3.0 GPA in "coursework required for the major."

Both the ACG and SMART Grant programs are funded by a sum-certain $790 million in Federal Funds in fiscal year 2006. The appropriated amount increases yearly until fiscal year 2010, when it is funded at $1 billion. Texas' share of this appropriation has not yet been determined and will depend on how many students in the state apply for and receive these grants. If the programs are oversubscribed, the grants will be reduced in a pro rata fashion.

Figure 1 shows the potential sources of federal grant funds to students in each of their four years in a university. For students with the greatest need, who enroll in a designated major as a junior or senior, and who maximize their federal grant aid through high school preparation, there is a potential of $26,300 in federal grant funding available over four years.

Figure 2 compares potential federal grant aid to average tuition at a four-year institution in Texas as well as to a transfer path from the average cost community college to the average cost four-year institution. With the exception of freshmen at four-year institutions, potential federal grant aid exceeds Texas' average tuition and fees. However, the limited list of majors eligible for the SMART Grant means that many students cannot take advantage of these funds. Nevertheless, for students with the greatest need, the financial barrier to higher education involves paying for living expenses rather than paying tuition.

INSTITUTION-DEPENDENT GRANT AID

The student-dependent federal grants detailed above represent the core of Federal Funds available for students in higher education. In addition to student-dependent programs, grant aid is provided to higher education institutions from federal and state sources, with institutions given some amount of discretion in the awarding these funds. Because of this

FIGURE 1
POTENTIAL FEDERAL GRANT AID, FULL-TIME STUDENT
PROJECTED 2006-2010 ACADEMIC YEARS

	FRESHMAN	SOPHOMORE	JUNIOR	SENIOR	TOTAL
Pell Grant	$4,050	$4,050	$4,050	$4,050	$16,200
ACG	750	1,350	na	na	2,100
SMART	na	na	4,000	4,000	8,000
TOTAL	**$4,800**	**$5,400**	**$8,050**	**$8,050**	**$26,300**

Source: U.S. Department of Education.

FIGURE 2
POTENTIAL FEDERAL GRANT AID COMPARED TO AVERAGE TUITION AND FEES
TEXAS PUBLIC INSTITUTIONS OF HIGHER EDUCATION
PROJECTED 2006-2010 ACADEMIC YEARS

	FRESHMAN	SOPHOMORE	JUNIOR	SENIOR	TOTAL
Potential Federal Grant Aid	$4,800	$5,400	$8,050	$8,050	$26,300
4-Year Average Tuition and Fees	4,857	4,857	4,857	4,857	19,428
Difference	($57)	$543	$3,193	$3,193	$6,872
	FRESHMAN	SOPHOMORE	JUNIOR	SENIOR	TOTAL
Potential Federal Grant Aid	$4,800	$5,400	$8,050	$8,050	$26,300
Avg. Community College Transfer Tuition and Fees	1,495	1,495	4,857	4,857	12,704
Difference	$3,305	$3,905	$3,193	$3,193	$13,596

SOURCES: U.S. Department of Education; Texas Higher Education Coordinating Board.

discretion, and because institutions do not receive funding proportional to their student population, it is impossible to model the funding that might be available to a student under these institution-dependent programs.

The key federal grant aid program in this category is the Supplemental Educational Opportunity Grant (SEOG). The program provides additional grant support for highly needy students. SEOG awards range from $100 to $4,000 per year. There is no federal calculation that determines the amount for which a specific student is eligible. The program awards a sum-certain amount to higher education institutions, based on a formula that heavily favors institutions that have been long term participants. Texas' share of this federal program in fiscal year 2005 was $48 million in Federal Funds.

In Texas, the most significant state grant aid program under institutional control is the TEXAS Grant. To be eligible for an initial TEXAS Grant, a student must have financial need, complete the Recommended High School Program, and enroll in an institution of higher education three-quarter time within 16 months of high school graduation. For students in four-year institutions the value of the TEXAS Grant is set by statute (Texas Education Code §56.307a) as:

> the average statewide amount of tuition and required fees that a resident student enrolled full-time in a baccalaureate degree program would be charged for that semester or term at general academic teaching institutions.

Students who receive a TEXAS Grant are also exempt from tuition and fees in excess of the statewide average under THECB Rules §22.234b(5) unless the institution provides non-loan awards to make up the difference. This provision allows institutions with tuition above the statewide average to compensate themselves for tuition waivers rather than allowing students to use gift awards (such as Pell Grants) to help defray living expenses.

While the nominal value of the TEXAS Grant is set by the THECB as a statewide average of tuition and fees, the average grant award is significantly lower than this amount. In fiscal year 2005, the average award of dispersed TEXAS Grants across all institution types (public and private) was $2,789 ($168 million in General Revenue Funds distributed among 124,254 students). For students in public four-year institutions in fiscal year 2005, $129 million was dispersed among 39,017 students (average award value $3,301). Awarded amounts are lower than the value set by statute ($4,857) because institutions with lower than average tuition are not required to award TEXAS Grant funds to students in excess of their tuition and fees.

TEXAS Grants are not awarded directly to students. Rather, institutions are given an initial allocation of TEXAS Grant funds to disperse according to institutional financial aid practices. Institutions are to allocate TEXAS Grants as specified in THECB Rules §22.233:

> Priority in Awards to Students
> In determining who should receive an initial year TEXAS Grant, an institution shall give highest priority to students who demonstrate the greatest financial need at the time the award is made.

Figure 3 summarizes EFC data for students awarded initial TEXAS Grants at public four-year institutions in academic year 2005.

In academic year 2005, most four-year institutions in Texas awarded at least one TEXAS Grant to a student who was

FIGURE 3
INITIAL TEXAS GRANT AWARD RECIPIENTS BY EFC OF STUDENT, TEXAS PUBLIC FOUR-YEAR INSTITUTIONS OF HIGHER EDUCATION, ACADEMIC YEAR 2005

	HIGHEST EFC	AVERAGE EFC
Highest Institution	$13,148	$1,399
State Average	5,634	852
Lowest Institution	0	0

SOURCE: Texas Higher Education Coordinating Board.

ineligible for a Pell Grant. This is one indication that the statutory "greatest financial need" criterion is applied unevenly in the current grant allocation system. In addition, the average family contribution of all students awarded TEXAS grants varied significantly by institution, from zero at the bottom of the range to $1,399 at the top.

The data in **Figure 3** suggest that students with identical need profiles are not equally likely to receive a TEXAS Grant and that their award depends on the institution that they attend rather then their need relative to other students in the state. Variation in student EFC by institution is an unintended consequence of an institution-dependent award system for TEXAS Grants. Higher education institutions serve different student populations because they have differing missions and are located in geographical areas with differing demographics. As a result, any award system for TEXAS Grant that is not administered at the state level will create an inequitable distribution of these awards.

Recommendation 2 directs THECB to study options for converting TEXAS Grant funds into a direct grant program, with funds awarded to students up to a set EFC level in any given year (depending on the level of funds appropriated for the program). The study should also examine what student populations lose financial aid award funds as a result of the proposed change and model the effect on statewide higher education facility use from changes in student enrollment arising out of the program.

TUITION SET-ASIDE STATE GRANT PROGRAMS

Texas Public Educational Grants (TPEG) are need-based financial aid awards established under the Texas Education Code §56.031. All institutions of higher education are required to set-aside a percentage out of appropriated tuition (General Revenue–Dedicated Funds) for these grants. The purpose of this program is:

> [T]o supply grants of money to students attending institutions of higher education in Texas whose educational costs are not met in whole or in part from other sources and to provide institutions of higher education with funds to supplement and add flexibility to existing financial aid programs.

In addition, under tuition deregulation institutions are required to set-aside an additional pool of funds out of designated tuition (Local Funds) in return for tuition flexibility (Texas Education Code §56.011):

> The governing board of each institution of higher education shall cause to be set-aside not less than 20 percent of any amount of tuition charged to a resident undergraduate student under Section 54.0513 in excess of $46 per semester credit hour. The funds set-aside under this section by an institution shall be used to provide financial assistance for resident undergraduate students enrolled in the institution.

The distribution of these Local Funds is also specified:

> Priority shall be given to students who meet the coordinating board definition of financial need and whose cost for tuition and required fees is not met through other non-loan financial assistance programs.

Finally, Texas Education Code §56.011(c) also provides wide latitude for institutions in the aid provided by these Local Funds:

> The financial assistance provided under this section may include grants, scholarships, work-study programs, student loans, and student loan repayment assistance.

Total grant funds available to students under tuition set-aside state grant programs are shown in **Figure 4**. (A small amount of tuition deregulation set-aside funds are used to fund 297 work study positions statewide. No funds are used for loans even though this is allowed by statute.)

The $146 million available to higher education institutions under these provisions is similar in scope to the $168 million available as a state appropriation under the TEXAS Grant program. Unlike TEXAS Grant funds, however, there is no uniformity in the award of these funds, their allocation is not tied to *Closing the Gaps* goals for higher education, and students can receive these funds regardless of their level of preparation.

These differences, while enhancing the ability of institutions to fine-tune their financial aid and admission decisions, sharply limit the ability of these funds to influence student preparation in high school. In contrast, the well-marketed and defined TEXAS Grant can affect student behavior

FIGURE 4
TUITION SET-ASIDE STATE GRANT PROGRAM EXPENDITURES
FISCAL YEAR 2005

	TEXAS PUBLIC EDUCATIONAL GRANTS (TPEG)	TUITION DEREGULATION*	TOTAL
Four-Year Institutions	$81,929,905	$33,507,972	$115,437,877
Community Colleges	20,688,592	N/A	20,688,592
Health-Related Institutions	6,869,443	10,750	6,880,193
Public State and Technical Colleges	2,595,501	197,644	2,793,145
Total	**$112,083,441**	**$33,716,366**	**$145,799,807**

* House Bill 3015, Seventy-Eighth Legislature, 2003.
Source: Texas Higher Education Coordinating Board.

because it is linked to high school preparation through its requirement that grantees complete the Recommended High School Program.

An underlying theme that unifies these institution-dependent grant programs is that allocation decisions to students are not made through any transparent process. Institutional rules determine who gets what and students who qualify for one program (for example, a TEXAS Grant) may find themselves eliminated from SEOG or TPEG funding by the institution. As a result, programs like the TEXAS Grant program that are intended to influence student behavior through economic incentives may fail to change student behavior because similar funding is available through programs such as SEOG and TPEG that do not have a qualification tied to student preparation.

Recommendation 3 directs THECB to study the effects of using TPEG General Revenue–Dedicated Funds and tuition deregulation set-asides (Local Funds) to increase the size of the TEXAS Grant program without additional state appropriations. In 2005–06, this shift would have increased the size of the TEXAS Grant program by 87 percent. In addition, merging tuition set-asides into the TEXAS Grant program would significantly increase the transparency of state financial aid awards in Texas and would have the potential to create a clear set of incentives supporting student preparation and success among low-income and minority populations.

RESTRAINING TEXAS GRANT COSTS WHILE MAXIMIZING FEDERAL TAX EFFICIENCY

In contrast to traditional student financial aid administered through institutions of higher education, the federal government also provides a number of financial incentives through the tax system designed to defray college costs. While a potentially significant source of education aid, these tax credit programs require action on the part of students (if they are independent) or their families (if they are dependent). A recent federal study suggests that, as a result, many students who are eligible for this support never receive it.

There are two major federal tax credits, the Hope Credit and the Lifetime Learning Credit. The Hope Credit provides for $1,500 in tax relief for tuition and related expenses arising in the first two years of an undergraduate program. Related expenses do not include charges for room and board or other living expenses. Students must be enrolled at least half-time. This is a credit, not a deduction, and as a result reduces federal tax liability on a dollar-for-dollar basis. In fiscal year 2005, the full $1,500 credit would completely eliminate federal taxes for students with an adjusted gross annual income of $12,400 as a single filer or $14,850 for married filing jointly.

In contrast, the Lifetime Learning Credit is available for all students regardless of their academic status or course load. This credit functions the same way as the Hope Credit, however it is granted for 20 percent of tuition and related expenses; a credit of up to $2,000 is available. (Again, related expenses do not include charges for room and board or other living expenses.) In 2005, the full $2,000 credit would completely eliminate federal taxes for students with an adjusted gross income of $15,750 as a single filer or $18,200 for married filing jointly. Students may choose either the Hope Credit or the Lifetime Learning Credit; they are not eligible for both in the same tax year.

Structuring TEXAS Grants as a tuition and fee-based award reduces the overall federal tax credit subsidy a student can receive through the Hope and Lifetime Learning Credits, as these apply only to tuition and fees. In fiscal year 2005, public institutions (both four-year and two-year) participating

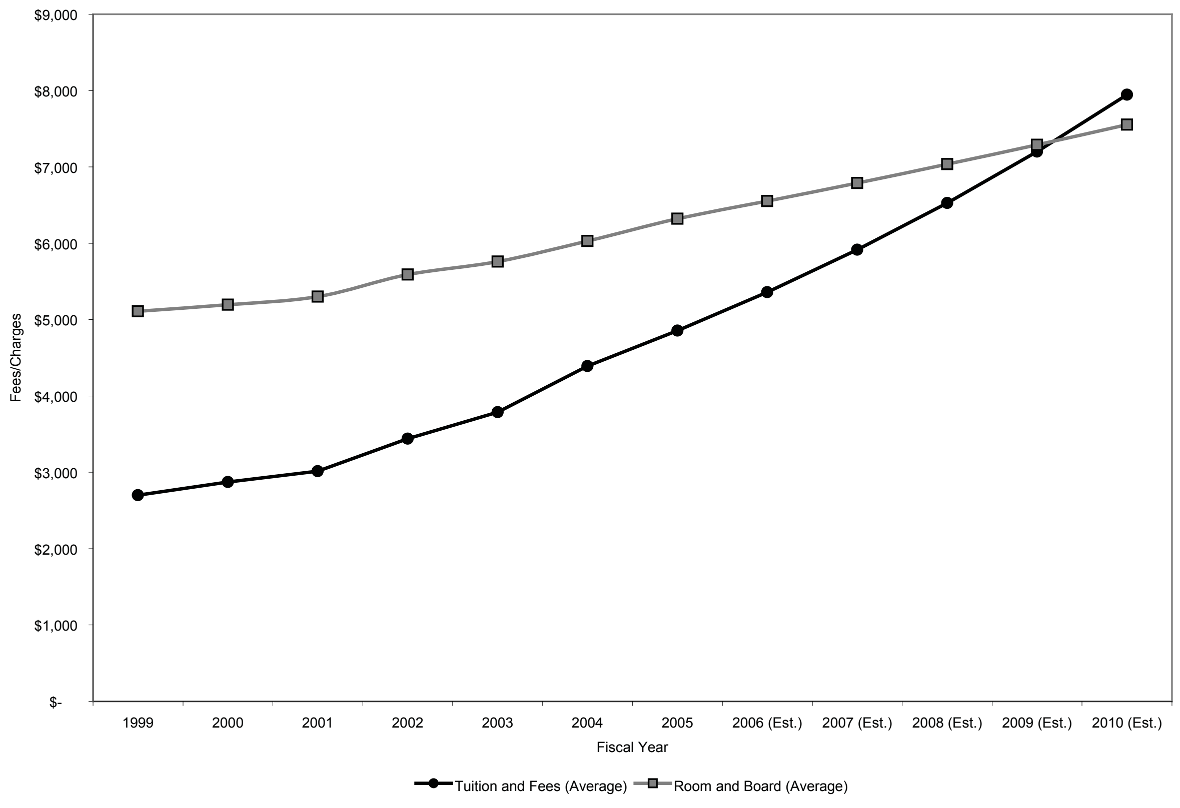
in the TEXAS Grant program received an appropriation of $145 million and served 53,355 students. The value of tuition tax credits for low-income students has been estimated by the U.S. Department of Education at $600 per year, while the average for all full-time undergraduates is $800. If these estimates are correct, between $32 million and $42 million of the fiscal year 2005 TEXAS Grant appropriation (22 percent to 29 percent) provided no net benefit to students receiving the grant (aside from precluding the need to claim the tax credit).

Historically, tying the value of the TEXAS Grant to average tuition made sense because tuition was a relatively small share of the total expenses incurred by students who were attending a university. **Figure 5** compares average tuition and average room and board charges at Texas' public four-year institutions. (While this figure shows room and board, all students are granted a category of "living expenses" as part of their COA.)

From 1999 to 2005, tuition increased at an average rate of 10.3 percent per year. During the same period, room and board increased at a more moderate rate of 3.6 percent per year. The average consumer price index (CPI) increase for this period was 2.9 percent. If current trends continue, by 2010 average tuition and fees at a Texas public four-year institution will exceed average room and board charges.

Recommendation 4 directs the THECB to study the feasibility of delivering TEXAS Grants as a stipend-based award tied to cost of room and board (or other index of living expenses). Student aid that is delivered as a periodic stipend over the course of an academic period prevents those funds from being applied directly to tuition. As a result, a "non-zero" tuition and fee bill is generated, rendering the student eligible to claim the federal education tax credits. Further, basing the TEXAS Grant award amount on room and board as opposed to tuition and fees will naturally constrain the

FIGURE 5
ANNUAL TUITION AND FEES VERSUS ROOM AND BOARD CHARGES
TEXAS PUBLIC FOUR-YEAR INSTITUTIONS
SCHOOL YEARS 1999 TO 2010



NOTE: Fiscal years 2006 to 2010 are projections.
SOURCES: Legislative Budget Board; Texas Higher Education Coordinating Board.

growth of the program to a rate slightly above the historical CPI level.

Converting the TEXAS Grant program to a stipend for room and board has the potential to increase the net cost of higher education for recipients attending a high-tuition institution that awards a waiver of tuition above the state average. A requirement that TEXAS Grant recipients, in addition to a room and board stipend, also receive a tuition and fee waiver at institutions with tuition and fees above the state average would preserve access to higher education for these students.

The following Texas Higher Education Coordinating Board rider provisions could be included in the 2008–09 General Appropriations Bill to implement Recommendations 1 through 4:

Review Structure of State Financial Aid Programs. Out of funds appropriated above, the Texas Higher Education Coordinating Board shall use at least $150,000 to conduct a feasibility study of restructuring state financial aid programs.

At a minimum, the feasibility study shall consist of:

a. An analysis of the effects of requiring completion of the Free Application for Federal Student Aid as a condition of enrollment in a Texas public higher education institution;

b. A proposal for converting the TEXAS Grant program into a direct student grant program based on a uniform assessment of financial need, including an estimate of changes in statewide facility use as a result of changes in student enrollment patterns;

c. An analysis of the effects of using tuition deregulation and TPEG state tuition set-asides as an additional funding source for TEXAS Grants and a projection of the number of additional TEXAS Grants that could be offered with the additional funds;

d. A proposal to convert the index used to establish the value of TEXAS Grants from statewide average tuition and fees to statewide average room and board (or other index of living expenses) and to determine the cost of providing tuition waivers for students at institutions with tuition and fees above the state average;

e. A proposal or proposals for delivering TEXAS Grants as a stipend-based award that would allow students to access higher education tax credits through the federal tax system.

THECB shall report the findings of the study to the Governor and the Legislative Budget Board by July 1, 2008.

FISCAL IMPACT OF RECOMMENDATIONS

Recommendations 1 to 4 would have no fiscal impact for the 2008–09 biennium. The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendations 1 to 4.

APPLY PROPORTIONAL COST-SHARING TO STATE CONTRIBUTIONS FOR COMMUNITY COLLEGE EMPLOYEE BENEFITS

Texas state law requiring state employee benefits be paid in proportion to the funding source of salaries has a significant effect on the state's obligation to fund benefits. For example, without proportional cost-sharing standards, the state would have to increase its current appropriation for higher education group health insurance by almost 80 percent. With the exception of Texas' 50 public community colleges, all state higher education entities apply a uniform standard of proportionality when requesting state contributions for group health benefits. Applying proportional cost-sharing standards to the state's contributions for community college's group health insurance benefits could save Texas approximately $54.2 million in General Revenue Funds for the 2008–09 biennium.

CONCERNS

- ♦ Texas' public community colleges are the only entities receiving significant amounts of General Revenue Funds using a non-standard method of requesting state funding for health insurance benefits.
- ♦ Applying proportional cost-sharing standards to the state's contributions for community colleges' group health insurance benefits could save the state $54.2 million in General Revenue Funds for the 2008–09 biennium and bring community colleges into compliance with current state law.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Apply the common standard of proportional cost-sharing when funding group health insurance contributions with General Revenue Funds for community colleges.
- ♦ **Recommendation 2:** Amend the Higher Education Employees Group Insurance Contributions rider in the 2008–09 General Appropriations Bill to place community colleges in a separate category for health benefits reallocations at the end of each fiscal year.

DISCUSSION

The 50 community college districts in Texas receive significant appropriations of General Revenue Funds for instruction and administration. Community colleges also have access to significant amounts of non-state income, such as property taxes, tuition, fees and a variety of federal funding sources. State General Revenue Funds account for about 30 percent of community colleges' total income (**Figure 1**).

For institutions with differing income sources, the state requires that payments for salaries and associated benefits be proportional to an institution's sources of income. That is, the state's obligation to fund benefits is limited to the portion of salaries supported with state General Revenue Funds, given the total funding sources available to the institution.

State General Revenue Fund appropriations to community colleges for employee benefits are discretionary because community college employees are local, rather than state employees. However, the state has appropriated more than $1.1 billion to community colleges for employee benefits coverage in the last 10 years.

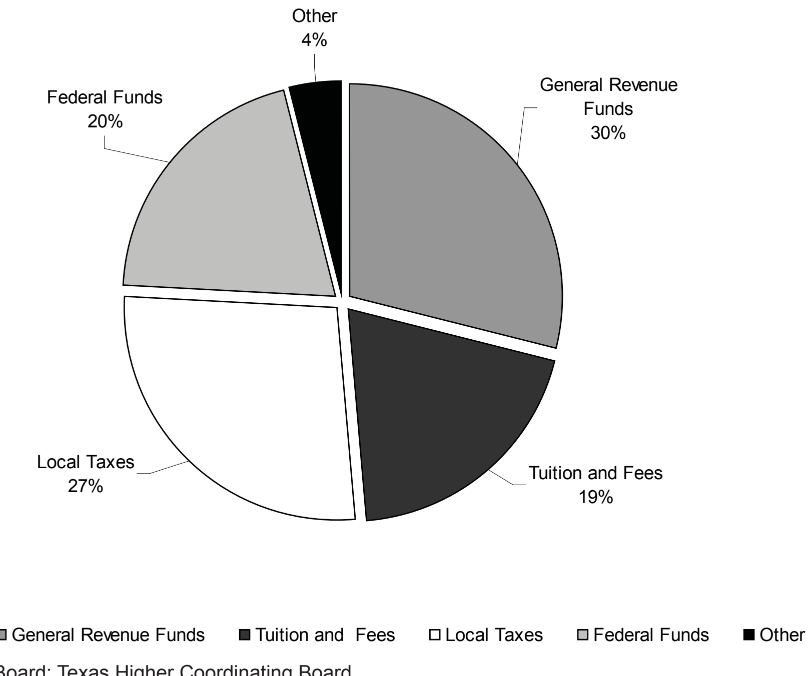
Proportional cost sharing (proportionality) is used to maximize balances in the General Revenue Fund through the alignment of salary funding source with benefits funding source. The Texas Legislature generally limits state General Revenue Fund contributions for benefits only to those employees having salaries paid with General Revenue Funds. Current rider language relating to proportionality in Section 6.11, Article IX, of the 2006–07 General Appropriations Act, reads in part as follows:

> **Sec. 6.11 Salaries to Be Proportional by Fund.**
>
> (b) Unless otherwise authorized by this Act, the funds appropriated by this Act out of the General Revenue Fund may not be expended for employee benefit costs, or other indirect costs, associated with the payment of salaries or wages, if the salaries or wages are paid from a source other than the General Revenue Fund…

In the past, Texas has not applied proportional cost-sharing to fund its share of community college employee benefits.

With the exception of public community colleges, all public institutions of higher education and state agencies use Accounting Policy Statement 011 (APS 011), a report filed annually with the Texas Comptroller of Public Accounts, to determine the proportional cost-sharing "split" in a standardized methodology. This document provides a

FIGURE 1
COMMUNITY COLLEGE INCOME SOURCES (ESTIMATED)
FISCAL YEAR 2006



Sources: Legislative Budget Board; Texas Higher Coordinating Board.

structure by which state and local contributions are "settled up" considering the fiscal year's fund proportionality.

ANALYSIS OF PROPORTIONAL COST SHARING

In 2006, Legislative Budget Board (LBB) staff conducted a review of state proportional cost sharing. The review sought to (1) examine the community colleges' benefits reporting processes, (2) confirm the validity of community college benefits data submitted to state entities, and (3) solicit community college input on proportionality to better understand how it relates to their overall funding.

As part of the review, LBB staff:

- Visited the campus of Stephen F. Austin University, Texas State Technical College at Waco and four community college districts for on-location process reviews of benefits data submitted to state entities;
- Met with staff from the Employee Retirement System (ERS), the Teacher's Retirement System and the Comptroller of Public Accounts for detailed discussions on each agency's role in the provision of health and retirement benefits to community colleges;
- Analyzed detailed community college health and retirement benefits data based on information submitted to state agencies by community colleges, including an LBB staff request to each community college district to provide salary detail in support of each district's previous health benefits enrollment submission;
- Participated in several meetings with community college associations, including the Texas Association of Community Colleges and the Texas Association of Community College Business Officers and distributed a voluntary survey to all 50 districts intended to gather information on proportionality-related issues; and
- Created six different "models" (based on differing numerators and denominators) of realizing proportionality.

In the preliminary 2006 group health insurance enrollment census, community colleges reported 36,409 active and retired employees enrolled in the ERS's Group Benefit Plan. Retired enrollees and active enrollees respectively accounted for 20.7 percent and 79.3 percent of this census.

Community colleges were instructed to categorize enrollees as being either "General Revenue Fund" (i.e., able to receive state contributions for health benefits) or "non-General Revenue Fund" (i.e., where premiums are paid by the district). Enrollees categorized as General Revenue Fund

receive contributions for their health benefits from General Revenue Funds. Community colleges reported 84.1 percent of their active enrollment and 92.9 percent of their retiree enrollment as being able to receive General Revenue Fund contributions.

This analysis assumes all enrollees reported as "General Revenue Fund" are "General Revenue eligible," which means the contribution from General Revenue Funds is paying all the enrollee's salary. For example, if a district reports 90 percent of its total health insurance enrollment is eligible for contributions funded from General Revenue Funds, then approximately 90 percent of the total salary pool for all those enrollees are paid with contributions from General Revenue Funds.

If a community college's appropriation of General Revenue Funds is equal to or greater than the district's total salary pool for those enrollees reported as being eligible for health benefit contributions from General Revenue Funds, then the district is requesting state benefit funding in a manner proportional to how it pays salaries. Conversely, if the district's funding from General Revenue Funds is significantly less than the district's total salary pool for those enrollees eligible to receive state-supported health benefits, then it is possible the district is over-reporting its enrollment of employees eligible for health insurance contributions paid with General Revenue Funds.

Using fiscal year 2005 data collected from community college districts and ERS, this analysis uses the following six steps to determine proportional community college retirement contributions:

1. List the total salary amount of those district employees eligible to receive benefit contributions funded from General Revenue Funds using data from each district's fiscal year 2005 Benefits Proportional by Fund report.
2. Use each district's total fiscal year 2005 formula appropriation to determine each district's maximum amount of unrestricted General Revenue Funding.
3. Determine the percentage each district's unrestricted General Revenue Fund contribution was of its General Revenue Fund eligible salary pool.
4. Calculate each district's proportional state group insurance contribution amount by multiplying the district's total group health insurance costs by the percentage determined above in step 3.
5. Subtract each district's actual group health insurance state from the proportional health insurance contribution amount to determine the degree, if any, of over/under funding.
6. Derive a percentage of over/under funding by dividing each district's over/under funded total by the actual state contribution. If necessary, this multiple could be used to adjust each district's proportional state health insurance 2008–09 contribution level.

Using this approach, **Figure 2** shows an over-funding level of \$27.1 million in fiscal year 2008, which is about 17.6 percent of the total fiscal year 2008 recommended state group health insurance contribution to community colleges. There is significant variation in the over/under funding level among the 50 districts. Over-funding ranges from about 45 percent to 0 percent of the total state contribution. Larger districts are significantly more likely to be over funded.

Assuming the adoption of the LBB's 2008–09 recommended funding levels, the state could reduce its contribution to the community colleges' group health insurance appropriation by approximately \$54.2 million over the biennium (\$27.1 million in fiscal year 2008 and \$27.1 million in fiscal year 2009). These savings are the basis of Recommendation 1, which is to apply the common standard of proportional cost sharing when funding group health insurance contributions with General Revenue Funds for community colleges and are not incorporated into the community college portion of the LBB's recommendations for higher education group insurance.

Recommendation 2, which would amend the Higher Education Employees Group Insurance Contributions rider in the 2008–09 General Appropriations Bill to place community colleges in a separate category for health benefits reallocations at the end of each fiscal year, was based on analysis of ERS processes for providing health benefits to higher education employees. The review revealed there are three points where proportionality is manifested in the draw-down cycle of state-funded health benefits contributions. These points are shown in the highlighted areas of **Figure 3**.

The first such point begins with institutions submitting estimated health enrollment data in August 2004. The second point where proportionality is applied is when this estimated enrollment data is updated with actual enrollment counts in December 2004 to January 2005. In both, the preliminary enrollment submission and the update several months later, institutions are obligated to sort their enrollees by method of

FIGURE 2
RECOMMENDED AND PROPORTIONAL CONTRIBUTION AMOUNTS

	A 2008 GENERAL REVENUE REC.	B ADJUSTMENT MULTIPLE	C REVISED 2008 GENERAL REVENUE REC. A * B	D 2009 GENERAL REVENUE REC.	D REVISED 2009 GENERAL REVENUE	E BIENNIAL TOTAL, REVISED	F TOTAL REDUCED AMOUNT
Alamo Community College	$11,079,138	0.68	$7,491,197	$11,079,138	$7,491,197	$14,982,394	($7,175,882)
Alvin Community College	1,743,554	0.95	1,657,531	1,743,554	1,657,531	3,315,062	(172,046)
Amarillo College	3,989,607	0.89	3,547,874	3,989,607	3,547,874	7,095,748	(883,466)
Angelina College	1,405,021	1.00	1,405,021	1,405,021	1,405,021	2,810,042	-
Austin Community College	7,248,134	0.58	4,215,963	7,248,134	4,215,963	8,431,926	(6,064,342)
Blinn College	3,167,592	1.00	3,167,592	3,167,592	3,167,592	6,335,184	-
Brazosport College	1,443,187	0.69	999,624	1,443,187	999,624	1,999,248	(887,126)
Central Texas College	2,626,045	1.00	2,626,045	2,626,045	2,626,045	5,252,090	-
Cisco Junior College	963,002	1.00	963,002	963,002	963,002	1,926,004	-
Clarendon College	486,167	1.00	486,167	486,167	486,167	972,334	-
Coastal Bend College	1,368,536	1.00	1,368,536	1,368,536	1,368,536	2,737,072	-
College of the Mainland	2,196,117	0.61	1,339,479	2,196,117	1,339,479	2,678,958	(1,713,276)
Collin Cty Community College	3,378,103	0.74	2,516,666	3,378,103	2,516,666	5,033,332	(1,722,874)
Dallas Cty Community College	15,590,838	0.84	13,057,824	15,590,838	13,057,824	26,115,648	(5,066,028)
Del Mar College	4,059,839	0.94	3,796,979	4,059,839	3,796,979	7,593,958	(525,720)
El Paso Community College	6,507,506	0.74	4,830,507	6,507,506	4,830,507	9,661,014	(3,353,998)
Frank Phillips College	590,916	0.83	489,938	590,916	489,938	979,876	(201,956)
Galveston College	857,107	0.96	819,289	857,107	819,289	1,638,578	(75,636)
Grayson County College	1,569,472	1.00	1,569,472	1,569,472	1,569,472	3,138,944	-
Hill College	970,525	1.00	970,525	970,525	970,525	1,941,050	-
Houston Community College	10,264,822	0.55	5,600,481	10,264,822	5,600,481	11,200,962	(9,328,682)
Howard College	1,600,663	1.00	1,600,663	1,600,663	1,600,663	3,201,326	-
Kilgore College	2,353,916	1.00	2,353,916	2,353,916	2,353,916	4,707,832	-
Laredo Junior College	3,456,133	0.85	2,943,283	3,456,133	2,943,283	5,886,566	(1,025,700)
Lee College	2,110,012	0.89	1,871,184	2,110,012	1,871,184	3,742,368	(477,656)
McLennan Community College	3,400,126	0.82	2,802,452	3,400,126	2,802,452	5,604,904	(1,195,348)
Midland College	2,152,568	0.84	1,809,731	2,152,568	1,809,731	3,619,462	(685,674)
Navarro College	1,550,182	1.00	1,550,182	1,550,182	1,550,182	3,100,364	-
NorthCentralTexasCollege	1,408,009	1.00	1,408,009	1,408,009	1,408,009	2,816,018	-
North Harris Montgomery Community College	9,403,944	0.86	8,106,319	9,403,944	8,106,319	16,212,638	(2,595,250)
Northeast Tx Community College	950,337	1.00	945,818	950,337	945,818	1,891,636	(9,038)
Odessa College	2,114,532	0.85	1,801,912	2,114,532	1,801,912	3,603,824	(625,240)
Panola College	891,100	0.74	661,608	891,100	661,608	1,323,216	(458,984)
Paris Junior College	1,329,747	1.00	1,329,747	1,329,747	1,329,747	2,659,494	-
Ranger Junior College	392,835	1.00	392,835	392,835	392,835	785,670	-

FIGURE 2 (CONTINUED)
RECOMMENDED AND PROPORTIONAL CONTRIBUTION AMOUNTS

	A 2008 GENERAL REVENUE REC.	B ADJUSTMENT MULTIPLE	C REVISED 2008 GENERAL REVENUE REC. A * B	D 2009 GENERAL REVENUE REC.	D REVISED 2009 GENERAL REVENUE	E BIENNIAL TOTAL, REVISED	F TOTAL REDUCED AMOUNT
San Jacinto College	$6,720,130	0.76	$5,113,084	$6,720,130	$5,113,084	$10,226,168	($3,214,092)
South Plains College	3,462,745	1.00	3,462,745	3,462,745	3,462,745	6,925,490	-
South Texas Community Col.	4,104,184	0.83	3,408,724	4,104,184	3,408,724	6,817,448	(1,390,920)
Southwest Texas Junior College	1,362,795	0.86	1,177,376	1,362,795	1,177,376	2,354,752	(370,838)
Tarrant County Junior College	9,146,077	0.79	7,251,474	9,146,077	7,251,474	14,502,948	(3,789,206)
Temple Junior College	1,317,617	0.77	1,010,297	1,317,617	1,010,297	2,020,594	(614,640)
Texarkana College	1,668,485	1.00	1,668,485	1,668,485	1,668,485	3,336,970	-
Texas Southmost College***	-	1.00	-	-	-	-	-
Trinity Valley Community College	1,736,732	1.00	1,736,732	1,736,732	1,736,732	3,473,464	-
Tyler Junior College	3,400,979	1.00	3,400,979	3,400,979	3,400,979	6,801,958	-
Vernon Regional Junior College	1,174,168	1.00	1,174,168	1,174,168	1,174,168	2,348,336	-
Victoria College	1,559,987	1.00	1,559,987	1,559,987	1,559,987	3,119,974	-
Weatherford College	1,481,012	1.00	1,481,012	1,481,012	1,481,012	2,962,024	-
Western Texas College	716,076	0.94	672,006	716,076	672,006	1,344,012	(88,140)
Wharton County Junior College	1,844,950	0.85	1,564,214	1,844,950	1,564,214	3,128,428	(561,472)
	$154,315,269		**$127,178,654**	**$154,315,269**	**$127,178,654**	**$254,357,308**	**($54,273,230)**

SOURCE: Legislative Budget Board.

finance. That is, institutions are expected to apply proportionality to their reported enrollment data.

The third point where proportionality is evident occurs toward the end of the yearly budget cycle, when institutions are obligated to submit the Accounting Policy Statement 011 Benefits Proportional by Fund (APS 011) report to the Comptroller of Public Accounts. ERS uses these APS 011 documents to allocate unused state funding among those higher education institutions whose state funding contributions did not pace their actual premiums. The use of APS 011 in this regard provides ERS with an objective means of apportioning unused state health benefits contributions among those institutions complying with proportionality (i. e., using APS 011 as a "settle-up" mechanism).

Instead of using APS 011 as a tool to reallocate unused state funds, in late winter of each year, ERS sends each community college district an email requesting the previous fiscal year's actual amount of premiums that were eligible to be paid from the state's General Revenue Fund. No detail is provided to districts on how to calculate such costs in a standard manner.

ERS uses each under-funded entity's share of the total under-funded amount as the mechanism to allocate the pool of unused state funds. The larger an entity's reported "actual" cost over its appropriated state contribution, the greater the share that entity receives of the reallocated total. While APS 011 compliant entities are subject to a standardized methodology in determining their respective actual costs, community colleges simply report what their state contribution should have been.

FIGURE 3
PROCESS FOR DETERMINING STATE HEALTH BENEFIT CONTRIBUTIONS FOR HIGHER EDUCATION EMPLOYEES

August 2004
Institutions submit census data to LBB in LARs.

November 2004
Application of Proportionality
LBB uses census data to generate recommendations.
College enrolls new hires online with ERS, then determine eligibility.

January 2005
Institutions submit revised census data to LBB.

May 2005
Texas Legislature determines funding level, whether to use updated census data.

July 2005
ERS sets up original Fiscal Year 2006 Appropriations in USAS

September 2005
ERS sets up ongoing 1/12 monthly allocation system which defines Local Funds as dollars in excess of monthly allocation of General Revenue Funds. ERS transacts monthly with college for billing.

February 2006
Application of Proportionality
CPA provides ERS with summary of previous fiscal year's APS 011 data (excludes community colleges).
ERS asks community colleges to report the amount of contributions that were "eligible" to be paid with General Revenue Funds for the previous fiscal year.

May 2006
"SETTLE-UP"
ERS uses CPA and community college data to derive dollar reallocation of the previous fiscal years's unused appropriations.

Source: Legislative Budget Board.

A consequence of this process is community colleges appear to be under-funded to a far greater degree than APS 011 compliant higher education entities, meaning community colleges receive a larger share of unused state funds. Examples of this consequence are summarized in **Figure 4**.

In fiscal year 2005, only four institutions—Texas Tech University, University of Houston, Texas Woman's University and Central Texas College—were over-funded by $3.9 million. The three general academic institutions contributed over 99.9 percent of this over-funding total. Every other higher education entity reported some level of under-funding.

ERS' APS 011 compliant higher education entities constituted about 46.0 percent (or $96.3 million) of the state contribution for ERS' higher education employees. Community colleges composed the remaining portion of the state appropriation (about $113.1 million).

The APS 011 compliant entities reported a total of $4.0 million under-funding, which was about 4.2 percent of their state appropriation. However, for the same year, community colleges reported a total of $25.1 million under-funding, which was about 22.2 percent of their state appropriation. In other words, for fiscal year 2005 community colleges reported to ERS an under-funding level over 530 percent greater than the under-funding level reported by APS 011 compliant higher education entities.

A consequence of this under-funding level between community colleges and APS 011 compliant entities is that ERS' reallocation of funds disproportionately goes toward community colleges. In fiscal year 2005, APS 011 compliant entities provided almost all the $3.9 million for reallocation, of which they received $0.5 million, or about 12.8 percent, while community colleges provided practically no over-funding dollars and absorbed the remaining $3.4 million. Similar results are evident for fiscal years 2003 and 2004.

Because of the disparity in ERS' reallocation methodology, the ERS should be required to separate community colleges into their own category of higher education entities for purposes of reallocation. That is, any unused state contributions among the 50 districts would be reallocated only among the under-funded districts. The unused state funds for the other higher education entities would be first reallocated among themselves to offset under-funded institutions' shortfalls. If any unused funds remain after this reallocation, the balance may be applied to community colleges.

IMPLICATIONS FOR STATE FUNDING

The state can realize savings by applying standardized proportionality to its contributions for community college health benefits. **Figure 5** shows these savings.

FIGURE 4
EMPLOYEES RETIREMENT SYSTEM HIGHER EDUCATION GROUP INSURANCE REALLOCATION (IN MILLIONS)
FISCAL YEARS 2003 TO 2005

FISCAL YEAR	APS 011 COMPLIANT AND COMMUNITY COLLEGES	HEGI APPROPRIATION TOTAL	OVER-FUNDED AMOUNT	UNDER-FUNDED AMOUNT	PERCENT UNDER-FUNDED	FUNDS REALLOCATED*	PERCENTAGE REALLOCATION FUNDS PROVIDED	PERCENTAGE REALLOCATION DOLLARS RECEIVED
2003	APS 011 Compliant	$107.6	$4.3	$2.1	2.0%	$0.7	91.5%	14.9%
	Community Colleges	128.9	0.4	12.2	9.5%	4.0	8.5%	85.1%
2004	APS 011 Compliant	95.6	3.4	3.0	3.1%	0.4	100.0%	11.8%
	Community Colleges	110.1		22.9	20.8%	3.0	0.0%	88.2%
2005	APS 011 Compliant	96.3	3.9	4.0	4.2%	0.5	100.0%	12.8%
	Community Colleges	113.1		25.1	22.2%	3.4	0.0%	87.2%

*In fiscal year 2004, several institutions opted to UB their unused General Revenue Funds into fiscal year 2005. The total unused amount was $0.4 million.
SOURCE: Legislative Budget Board.

FIGURE 5
ESTIMATED SAVINGS BY APPLYING PROPORTIONALITY (IN MILLIONS)

FISCAL YEAR	NO REDUCTION	REDUCTION	DIFFERENCE
2008	$154.3	$127.2	$27.1
2009	$154.3	$127.2	$27.1
Totals	**$308.6**	**$254.4**	**$54.2**

SOURCE: Legislative Budget Board.

FISCAL IMPACT OF RECOMMENDATIONS

Implementing Recommendation 1 would reduce the appropriation of General Revenue Funds to public community colleges' group health insurance contributions by $27.1 million in fiscal year 2008 and $27.1 in fiscal year 2009. The fiscal impact of this recommendation on community colleges would depend on the extent community colleges are brought into compliance with proportionality, and whether some or all of the reductions resulting from any application of proportionality are restored to community colleges in direct formula funding.

Implementing Recommendation 2 would allow ERS institutions of higher education other than community colleges to restore a significant portion of their under-funding for group health insurance. The fiscal impact of this recommendation for community colleges would depend on the dollar value ratio of individual community college districts reporting over-funding to the districts reporting under-funding.

The introduced 2008–09 General Appropriations Bill does not address Recommendations 1 and 2.

PREPARING FOR REAL ID PROGRAM IMPLEMENTATION AND OPERATIONAL COSTS

In May 2005, the U.S. Congress passed the REAL ID Act, an antiterrorist and immigration reform bill that will have significant budget ramifications for states over the next 10 years. The term "REAL" in the title refers to the intention of the act that all states participating in the REAL ID program will be able to verify driver's license data and the accuracy of the cardholder's "real" identity in "real" time. The bill establishes stringent federal standards for issuing state driver's licenses and state identification cards that states must implement by May 2008. The U.S. Department of Homeland Security recently stated that it will not be ready to release REAL ID standards until early part of fiscal year 2007 and may grant an extension to the May 2008 implementation deadline to allow states more time to meet the required standards. Furthermore, information-sharing technology and policies that would help states comply with REAL ID provisions are not fully established among all 50 states and territories of the United States.

The Texas Department of Public Safety initiated a Driver's License Reengineering project in fiscal year 2004, before the passage of REAL ID. Since then, the state appropriated $39.5 million in State Highway Funds to the Department of Public Safety for the Reengineering project. Although recent improvements bring driver's licenses and ID cards in line with some of the REAL ID requirements, the agency estimates additional costs to implement the REAL ID program will be significant due to new data verification requirements, specialized card technology, and increased personnel and space needs. An increase in fees for driver's licenses and identification cards could mitigate REAL ID costs.

CONCERNS

- ♦ A joint study conducted by the National Conference of State Legislatures, National Governors Association and American Association of Motor Vehicle Administrators estimates the cost of implementing REAL ID over 10 years at approximately $11 billion.
- ♦ The federal government allocated only $6 million for pilot programs in two states, out of a $40 million appropriation in fiscal year 2006 for the implementation of REAL ID. There are no additional funds appropriated for fiscal year 2007.
- ♦ States that participate in the REAL ID program must be ready to issue federally certified driver's licenses and identification cards beginning in May 2008. States then have five years to issue the new cards to all licensed drivers and identification card holders. Beginning May 2013, federal agencies may not accept a state's non-federally certified driver's license or personal identification card for official federal purposes anywhere in the United States or abroad.
- ♦ The Department of Public Safety's projected cost for REAL ID is $167.4 million for the first year of implementation, with ongoing annual operating expenses of $101.3 million per year. The agency submitted a request for the 2008–09 biennium totaling $268.7 million.
- ♦ Recent improvements to the Texas driver's license and identification card program will not meet all REAL ID requirements. Additional document verification systems will also have to be implemented.
- ♦ According to the agency, the REAL ID program will require an additional 149 commissioned employees and 588 non-commissioned employees for a total of 737 new full-time employees plus related capital expenses at a cost of over $66.5 million for the 2008–09 biennium. New buildings and building renovations will cost $51.4 million for the 2008–09 biennium.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Petition the U.S. Congress to appropriate federal funds for state implementation of the REAL ID program and grant more flexibility and time for states to implement their programs.
- ♦ **Recommendation 2:** Reduce Department of Public Safety full-time employee costs for the 2008–09 biennium to coincide with the actual timeframe for implementation of REAL ID and require the Department of Public Safety to phase out employees, leases and contractors for functions that the agency will reduce once it completes the REAL ID reenrollment in 2013.

- ♦ **Recommendation 3:** Reduce the Department of Public Safety's building acquisition and major renovation estimates for the 2008–09 biennium by using general obligation bonds and/or additional leasing of office space.
- ♦ **Recommendation 4:** Amend Chapter 521 of the Texas Transportation Code to increase the driver's license and identification card application and renewal fees (to no more than $15 per license or identification card) to generate enough revenue to cover ongoing costs of the REAL ID program that are not reimbursed by the federal government.
- ♦ **Recommendation 5:** Require the Texas Department of Public Safety to provide a progress report to the legislature on implementation of the REAL ID program by January 1, 2009.

DISCUSSION

The federal REAL ID Act creates a national standard for driver's licenses and other state-issued identification cards. Individual states will continue to issue driver's licenses. The legislation does not stipulate which technologies to use, but the U.S. Department of Homeland Security (DHS) is expected to publish rules and requirements early in 2007. States that choose to participate in REAL ID must have their programs federally approved by May 2008. States will then have five years to issue new licenses and identification cards (IDs) to their residents. All residents who can verify that they have legal status for being in the United States can be issued a license or ID. Effective May 2013, state licenses and IDs that do not meet the federal standard will not be acceptable for official federal purposes, which could include access to federal buildings and boarding commercial airliners.

According to the Department of Public Safety (DPS), recent improvements to the Texas driver's license and identification card program will be insufficient to meet REAL ID requirements. Under the REAL ID statute, minimum requirements for federal certification of a state driver's license or ID card are as follows:

- person's full legal name,
- person's date of birth,
- person's gender,
- driver's license/ID number,
- person's address of legal residence,
- person's signature,
- digital photograph, and
- physical security features designed to prevent tampering, counterfeiting or duplication for fraudulent purposes in a common machine-readable technology with defined data elements.

Texas driver's license and ID cards do not currently contain all of the enhanced security fatures anticipated in the DHS design and technology requirements. The agency's estimate for the new specialized cards is $105.7 million for the 2008–09 biennium. Document verification and data sharing standards are anticipated to be more stringent under REAL ID, and DPS estimates those additional costs at $12.2 million for the 2008–09 biennium.

The REAL ID Act also establishes standards for verification of identity. At a minimum, an applicant for a driver's license must present (and states must verify): (a) a photo identity document (or a non-photo identity document if it includes a person's legal name and date of birth); (b) documentation showing birth date; (c) proof of Social Security number (or verification that the person is not eligible for one); and (d) documentation showing the person's name and address of primary residence. States must verify U.S. citizenship or the lawful status of applicants. States may not accept any foreign documents other than an official passport, and may not issue a driver's license or ID to anyone holding a driver's license or ID from another state, without confirmation that the person is terminating or terminated the other state's license or ID. Information contained in the motor vehicle database in each state must be electronically accessible to all other states. Also, the REAL ID Act establishes a maximum period of license or ID validity at eight years.

In September 2006, a joint study conducted by the National Conference of State Legislatures, National Governors Association, and American Association of Motor Vehicle Administrators reported the national estimates for implementation of the REAL ID program The study estimates the implementation and operational cost of REAL ID for states at approximately $11 billion nationwide over 10 years. Some states calculated their anticipated costs for the new program. California estimates it will cost nearly $400 million to $600 million to implement REAL ID in its state. Virginia officials report an estimate of $169 million to implement REAL ID technology and the issuance of new licenses and IDs for its state.

Congress appropriated $40 million for REAL ID as part of an amendment to House Resolution 2360, the federal Homeland Security appropriations bill for federal fiscal year 2006. DHS has the authority to use the appropriation to issue grants to states. States may use the grants to conform to the minimum federal standards of REAL ID, including the integration of hardware, software and information management systems. However, DHS has only granted $3 million each for two pilot programs in New Hampshire and Kentucky. Approximately $34 million in unexpended appropriations for REAL ID remains available. On October 4, 2006, the President signed the 2007 Homeland Security Appropriations Bill. No additional funds for implementation of REAL ID are included.

Recommendation 1 would encourage the Texas Legislature to petition the U.S. Congress to appropriate federal funds for state implementation of the REAL ID program and grant more flexibility and time for states to implement their programs. This could be accomplished by: (1) passing a resolution; (2) directing the Texas Office of State-Federal Relations to establish federal funding for REAL ID state implementation as a priority initiative; (3) directly contacting members of the Texas congressional delegation and members of the Administration; and (4) working with organizations such as the National Conference of State Legislatures and other states seeking similar action.

CURRENT TEXAS DRIVER'S LICENSE AND ID REQUIREMENTS

DPS now separates the REAL ID federal implementation initiative from its Driver's License Reengineering (DLR) project, but there is an understanding that the agency will link the two once Texas incorporates the federal requirements for REAL ID into the driver license and ID card system. In 2003, legislation was enacted which authorized the DLR project. This legislation authorized DPS' effort to upgrade license card technology and data technology before the passage of REAL ID. Subsequently, the Seventy-eighth Legislature, Third Called Session, 2003, appropriated $32 million in State Highway Funds for the DLR project through a $1 increase in the vehicle registration fee, for which the DPS appropriation expired at the end of fiscal year 2005. Approximately $26.5 million of the previously appropriated funding was unexpended at the close of fiscal year 2005 and was appropriated for the 2006–07 biennium for the same purpose. The Seventy-ninth Legislature, Regular Session, 2005, then passed legislation that amended the Texas Transportation Code to allow for implementation of an image verification system and the collection of residency information from applicants for a driver's license or personal ID. To fund the legislation, the Seventy-ninth Legislature, Regular Session, 2005, appropriated an additional $7.5 million (also in State Highway Funds) via Article IX, Section 14.16, of the 2006–07 General Appropriations Act to DPS to allow the agency to implement visual imaging technology for state driver's licenses.

Texas state law requires one or more forms of ID for a U.S. resident or non-resident to receive a state driver's license or state ID card. According to DPS records, as of September 2006, there were over 18.5 million valid driver's licenses and IDs issued in Texas. To verify identity and for security purposes Texas state law requires applicants to provide at least one form of primary identification when they apply, such as a valid Texas driver's license, a U.S. Passport or proof of citizenship documents. If an applicant does not have primary identification, at least two forms of secondary identification are acceptable. Examples of these include a valid out-of-state driver's license, a certified copy of a birth certificate, or a certified copy of a U.S. Department of State certification of birth. When primary and secondary levels of identification are limited, the applicant may present at least one form of secondary identification with two forms of supporting identification such as an insurance policy, military records, or a vehicle title. DPS also takes the applicants thumbprint image at the time of application.

State license renewals must be made in person, unless the person are "invited" to renew on-line, by mail or by phone. Residents may not renew on-line or by mail if their license has been suspended, revoked, denied, or restricted, or if they are applying for commercial, occupational or other provisional licenses. DPS reported in a July 24, 2006 analysis presented to legislative staff that the primary method of verification for most Texas driver's licenses is either the person's Social Security number or birth certificate. New driver's licenses or IDs in Texas currently cost $24, except for persons age 60 or older (whose fee is $5), and are valid for 6 years. Renewal fees are $15.

The legislation that was enacted in 2003 required revenue from driver's license fees to be deposited in the Texas Mobility Fund; however, legislation passed by the Seventy-eighth Legislature, Third Called Session, 2003, redirected the funds to the General Revenue Fund for fiscal years 2004 and 2005. In 2005, legislation was enacted which continued the deposit to the General Revenue Fund until January 1, 2008.

COSTS OF IMPLEMENTATION OF REAL ID IN TEXAS

The DPS anticipates that the existing and planned components of the driver's license and ID issuing system will likely meet many of the REAL ID regulatory requirements. However, based on discussions with DHS and the American Association of Motor Vehicle Administrators, the agency estimates that implementation of other REAL ID requirements could cost up to $167.4 million, with annual maintenance costs of $101.3 million per year. The agency requested $268.7 million for the 2008–09 biennium related to REAL ID costs. **Figure 1** shows DPS' estimated REAL ID implementation and annual operations costs by category.

New federal requirements (to be released in early 2007) could change the implementation costs of issuing new driver's licenses and IDs. For instance, DPS anticipates that federal rules will require an electronically enhanced card with security features, including a two-dimensional barcode and the applicant's digital photograph. The recommended card would be made of a special plastic composite not currently used by DPS. The specialized cards cost $7.25 per card, approximately $5 more than the current card used in Texas. In DPS' request, the agency assumes a cost of $105.7 million over the biennium related to the new cards. If the DHS does not require the new specialized card in the final rules, DPS would be able to continue use of the current card and eliminate $105.7 million or approximately 30 percent of the estimated implementation costs.

It is anticipated that reissued licenses and IDs will have to be processed by DPS in person and more frequently. DPS reported in their July 24, 2006 analysis to legislative staff that nearly 30 percent of driver's license renewals are now conducted online or through the mail. DPS projects a revenue loss of $4.6 million related to discontinuation of online convenience fees. Although DPS states that on-line and mail renewals may eventually be permitted again, on-site renewals will require additional facilities and personnel to process new cards during the DPS' five-year reenrollment period beginning in fiscal year 2009 through fiscal year 2013. DPS estimates that it will require an additional 737 staff to expand the issuance processes for in-office visits due to re-verification of the existing 18.5 million Texas driver's licenses and IDs, resulting in a 48 percent increase in office transactions for the first year of the biennium. DPS estimates

FIGURE 1
DEPARTMENT OF PUBLIC SAFETY ESTIMATED COSTS FOR REAL ID IMPLEMENTATION AND OPERATIONS
FISCAL YEARS 2008 AND 2009

REQUESTED ITEM	IMPLEMENTATION COSTS 2008	ANNUAL OPERATIONS COSTS 2009
Document Requirements	$51,029,134	$54,710,919
Temporary Driver's License/ID Cards	21,782	
Document Verification Data Access	7,442,141	4,833,809
Document Retention	2,870,378	1,996,358
Facial Image Capture	193,170	193,170
Commissioned Full-time Equivalents (FTEs)	19,745,311	9,529,675
Non-Commissioned FTEs	19,423,896	17,901,931
Overtime Pay	9,763,478	9,763,478
New State-Owned Offices (7)	39,693,548	275,940
New Leased Offices (7)	2,376,301	886,000
Remodeled Offices (18)	11,532,896	73,200
Online Expansion	453,400	175,836
Public Education	1,000,000	750,000
Fraudulent Document Training	134,442	38,376
License Validity	54,000	
Non-conforming License	24,000	
Database Requirements	1,699,800	225,200
Total Implementation	**$167,457,677**	
Total Annual Maintenance Costs		**$101,353,892**

SOURCE: Texas Department of Public Safety.

that processing time for all applicants will increase to that of an original applicant due to document verification and scanning time, effectively doubling processing time for all renewals. DPS anticipates that federal requirements for extensive review of documents and fraudulent document incidents will require additional troopers to deter fraud and conduct investigations. The agency estimates employee costs for commissioned officers and non-commissioned staff at $66.5 million for the 2008–09 biennium.

However, according to DPS, the agency will only start issuing the new driver's licenses and ID cards in fiscal year 2009. The agency will not need a fully staffed operation in fiscal year 2008. Therefore, a strategy of incremental hiring and training of new permanent and temporary employees could be implemented in fiscal year 2008 to minimize costs. Temporary positions could expire once the agency completes mandatory reenrollment at the end of fiscal year 2013. Recommendation 2 would reduce DPS full-time employee costs for the 2008–09 biennium to coincide with the actual timeframe for implementation of REAL ID (to be determined by DPS), and to phase out employees, lease space and contractors for functions that the agency will reduce once it completes the REAL ID reenrollment in 2013.

Projected costs for office space could be spread over several years through the issuance of general obligation bonds, reducing costs for building acquisition and major renovations by approximately 90 percent over the 2008–09 biennium. DPS' estimate of $51.5 million for building acquisition and major renovations could be reduced to $7 million in debt service or lower for the 2008–09 biennium. **Figure 2** shows general obligation bond financing estimates for new and remodeled facilities as compared to requested State Highway Fund appropriations during the 2008–09 biennium. Expanded use of leasing would be another alternative. Recommendation 3 is to reduce DPS building acquisition and major renovation estimates for the 2008–09 biennium by using general obligation bonds and/or additional leasing of office space as alternatives to the cash purchase of office space.

The DPS has access to limited data when issuing new licenses or reviewing out-of-state licenses, but costly technological and logistics challenges remain, such as how to communicate birth certificate and criminal data in real-time with other states. The state currently has data-sharing agreements with a few other states and the Federal Bureau of Investigation (FBI), and the federal government is now creating a national data system. Police officers who check a person's driver's license or ID can usually determine if the person has a past criminal history, traffic tickets, outstanding warrants, or is wanted by the FBI or another state. DPS hopes to gain access to the new federal national database that will link all states in the next few years. DPS estimates the cost of verification and data systems for REAL ID at $12.2 million for the 2008–09 biennium. DPS assumptions contain two elements for verification and data systems. One element is installation and setup of the actual systems. The second element is based on a cost per data inquiry when issuing new licenses and IDs. In preparing for reenrollment, the state should expect verification and data systems implementation costs in fiscal year 2008. However, data inquiry costs, which are calculated on a per license or ID card basis, would not be assessed until DPS begins issuing REAL ID compatible driver's licenses and ID cards in fiscal year 2009.

GENERATING FEES FOR REAL ID IMPLEMENTATION

Additional revenue based on increasing driver's license or ID fees could offset costs for implementing REAL ID. Driver's license fees range from $15.60 (valid for 10 years) in Colorado, to $66 to $77 (valid for 6 or 7 years) in Connecticut. There are 29 states with fees higher than Texas, 5 states with the same fee, and 16 states with lower fees. DPS estimates it will issue over 7 million driver's licenses and ID cards in fiscal year 2009, the first full year for REAL ID. Each $1 increase in Texas' driver's license fee would generate approximately $7

FIGURE 2
REQUESTED NEW AND REMODELED BUILDINGS
GENERAL OBLIGATION BOND ESTIMATES FOR THE 2008–09 BIENNIUM (IN MILLIONS)

	FISCAL YEAR 2008	FISCAL YEAR 2009	TOTAL FOR BIENNIUM	TOTAL FOR 19 YEARS
DPS – State Highway Fund 6 Request	$51.2	$0.4	$51.5	
General Obligation Bond Option	$2.5	$4.5	$7.0	$78.0
Difference (Savings Compared to DPS Request)	$48.7	($4.1)	$44.5	($26.8)

SOURCE: Texas Public Finance Authority.

million in revenue. **Figure 3** shows driver's license and ID fees in the United States as of September 2006.

Recommendation 4 would amend Chapter 521 of the Texas Transportation Code to increase the driver's license and identification card application and renewal fees to generate enough revenue to cover ongoing operational costs of the REAL ID program that are not reimbursed by the federal government. The amount of the increase should be capped at $15 per license.

Recommendation 5 is to require the Department of Public Safety to provide a progress report to the Lgegislature on implementation of the REAL ID program by January 1, 2009.

FISCAL IMPACT OF THE RECOMMENDATIONS

The DPS cost estimates for full implementation of REAL ID are significant, totaling $268.7 million for the 2008–09 biennium. The DPS reports that it will only start issuing new driver's licenses and ID cards in fiscal year 2009. The state could achieve considerable cost savings by reducing full-time employee costs accordingly, and relying on general obligation bonds and leasing rather than purchasing office space. Increasing the driver's license and identification card application and renewal fees could generate enough revenue to pay for ongoing operational costs of the REAL ID program that the federal government does not reimburse.

The introduced 2008–09 General Appropriations Bill does not address any of the five recommendations.

FIGURE 3
UNITED STATES DRIVER'S LICENSE AND RENEWAL COMPARISON TABLE, SEPTEMBER 2006

STATE	DRIVER LICENSE FEE	DRIVER LICENSE RENEWAL PERIOD	RENEWAL FEE
Alabama	$23.00	4 years	$23.00
Alaska	$15.00	5 years	$15.00
Arizona	$12.50	5 years	$12.50
Arkansas	$20.00	4 years	$20.00
California	$24.00	5 years	$24.00
Colorado	$15.60	10 years	$15.60
Connecticut	$66.00to $77.00	6 to 7 years	$44.00
Delaware	$12.50	5 years	$12.50
Florida	$20.00	6 years	$15.00
Georgia	$15.00	5 years	$15.00
Hawaii	$3.00 to $18.00	1 to 6 years	$3.00 to $18.00
Idaho	$24.50–$45.00	4–8 years	$24.50 to $45.00
Illinois	$10.00	4 years	$10.00
Indiana	$14.00	4 years	$14.00
Iowa	$8.00to $20.00	2to 5 years	$8.00 to $20.00
Kansas	$31.00	6 years	$31.00
Kentucky	$20.00	4 years	$20.00
Louisiana	$12.50	4 years	$12.50
Maine	$30.00	6 years	$30.00
Maryland	$30.00	5 years	$30.00
Massachusetts	$33.75	5 years	$33.75
Michigan	$25.00	4 years	$18.00
Minnesota	$37.50	4 years	$37.50
Mississippi	$18.00	4 years	$18.00
Missouri	$45.00	6 years	$45.00
Montana	$20.00 to $40.00	4 to 8 years	$20.00 to $40.00
Nebraska	$23.75	5 years	$23.75
Nevada	$20.50	4 years	$20.50
New Hampshire	$50.00	5 years	$50.00
New Jersey	$24.00	4 years	$24.00
New Mexico	$16.00 to $32.00	4 to 8 years	$16.00 to $32.00
New York	$38.50 to $43.00	8 years	$38.50 to $43.00
North Carolina	$17.00	4 years	$17.00
North Dakota	$15.00	4 years	$10.00
Ohio	$23.75	4 years	$23.75
Oklahoma	$23.00	4 years	$23.00
Oregon	$54.50	8 years	$34.50
Pennsylvania	$31.00	4 years	$26.00
Rhode Island	$12.00	5 years	$30.00
South Carolina	$12.50	5 years	$12.50
South Dakota	$8.00	5 years	$8.00
Tennessee	$41.00	5 years	$41.00
Texas	$24.00	6 years	$15.00
Utah	$20.00	5 years	$20.00
Vermont	$30.00	4 years	$30.00
Virginia	$20.00	5 years	$20.00
Washington	$35.00	5 years	$25.00
West Virginia	$8.00 to $15.00	3 to 7 years	$8.00 to $15.00
Wisconsin	$18.00	8 years	$24.00
Wyoming	$20.00	4 years	$15.00

SOURCE: American Automobile Association.

INCREASE DRIVER RESPONSIBILITY PROGRAM COLLECTIONS AND OFFENDER COMPLIANCE

The state's Driver Responsibility Program assesses surcharges on drivers convicted of certain driving offenses in Texas. The Texas Department of Public Safety administers the program, which applies to offenses committed after September 1, 2003 and has assessed and collected surcharges since September 2004. At the end of fiscal year 2006, the program's overall collection rate was 27.8 percent and its overall compliance rate (which includes not just violators who have paid their surcharge, but also those who are on installment plans and are scheduled to pay their surcharge) was 32.5 percent. Of all surcharges billed, 54.9 percent led to license suspension rather than payment.

Texas could improve Driver Responsibility Program collections by implementing a new collection contract, making payment of certain surcharges more feasible to low-income drivers, and providing additional consequences for noncompliance. The state could improve compliance with laws regarding motor vehicle operation by authorizing alternatives to full surcharge payments with proof of a change in behavior in the offender.

FACTS AND FINDINGS

- ♦ From its inception in September 2004 through August 2006, the Driver Responsibility Program sent 1.5 million notices billing $478.7 million in potential surcharges. During the same period, the revenue collected was $132.8 million. The collection rate for the categories of offense range from 18.8 percent to 51.2 percent.
- ♦ Approximately 50 percent of the monies collected by the Driver Responsibility Program are designated for the state's Trauma Facility and EMS Fund.

CONCERNS

- ♦ The collection contract for the Driver Responsibility Program limits collection methods for pursuing fines.
- ♦ Low-income violators might be unable to pay surcharges without more payment options, leaving them without a valid driver's license.
- ♦ The Texas Department of Public Safety has limited sanction authority for nonpayment, but other states grant more authority to the administrators of their driver responsibility programs.
- ♦ The Driver Responsibility Program imposes surcharges as an incentive for drivers to comply with traffic laws, but does not offer any payment alternatives as a further incentive for drivers to comply with the law.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Transportation Code, Chapter 708 to require the Texas Department of Public Safety to negotiate an additional collection contract including more extensive collection techniques.
- ♦ **Recommendation 2:** Amend Texas Transportation Code, Chapter 708 to make payment of certain surcharges more feasible for low-income drivers, including allowing reinstatement of installment plans for non-payment and periodic amnesty programs.
- ♦ **Recommendation 3:** Amend Texas Transportation Code, Chapter 708 to allow additional consequences for nonpayment of certain surcharges, such as liens on personal property.
- ♦ **Recommendation 4:** Amend Texas Transportation Code, Chapter 708 to provide incentives for bad drivers to change their behavior through a reduction in surcharges or the number of years the surcharges are collected.

DISCUSSION

Legislation enacted by the Seventy-eighth Legislature, Regular Session, 2003, established the Driver Responsibility Program (DRP) and became effective on September 1, 2003. Under the DRP, certain traffic violators pay an annual surcharge for three years, following final conviction of certain traffic offenses, if committed on or after September 1, 2003:

- Points: accumulating six or more points from specific moving violations;
- Driving while Intoxicated (DWI): failing a blood alcohol test;

- License Invalid/No Insurance (LINI): either driving while license invalid (DWLI), meaning that the license is suspended or revoked, or failing to maintain financial responsibility (having no insurance); or
- No License (NL): driving with no license or an expired license.

Figure 1 shows each type of violation and its surcharges.

DEMOGRAPHIC OVERVIEW OF DRIVER RESPONSIBILITY PROGRAM VIOLATORS

According to data provided by the Department of Public Safety (DPS), the majority of DRP violators live in urban counties, are either Caucasian or Hispanic, are male, and are between the ages of 22 and 39. The following data is from the program's inception in September 2003 to September 22, 2006.

The 10 counties with the highest total numbers of assessed drivers comprise 60.6 percent of all assessments. **Figure 2** shows the number of violations by category, the total number of offenses, the percentage of total violations, and the percentage of total population for each of the top 10 counties.

The racial breakdown of DRP violators, according to DPS's currently collected data categories, is Caucasian (including Hispanic) 70.3 percent, African-American 18.2 percent, Asian 0.8 percent, and Native American 0.3 percent, and all other 10.5 percent. The gender profile is 30.6 percent female, 68.9 percent male, and 0.6 percent unknown.

The age category of DRP violators with the largest number of offenses was between age 22 and 29 with 35.8 percent of all offenses. Another 26.2 percent were between age 30 and 39. **Figure 3** shows the distribution of DRP violations by age categories.

REVENUE ALLOCATION AND COLLECTIONS

One percent of DRP revenue collected in fiscal years 2004 and 2005 was directed to the General Revenue Fund for program administration. The remainder (99 percent) was divided equally (49.5 percent) between the Designated Trauma Facility and EMS Fund (General Revenue–Dedicated Funds) and the Texas Mobility Fund (General Revenue Funds).

Starting in fiscal year 2006, the 49.5 percent of funds previously deposited to the Texas Mobility Fund were deposited in the General Revenue Fund instead. These funds will be directed back to the Texas Mobility Fund only if combined deposits to the General Revenue Fund from DRP funds and $30 State Traffic Fine funds meet an annual $250 million limit. **Figure 4** shows this relationship.

Total surcharges collected as of the end of fiscal year 2006 were $132.8 million of $478.7 million assessed. As **Figure 5** shows, the Texas Comptroller of Public Accounts' Biennial Revenue Estimate (BRE) for DRP collections was $36.0

FIGURE 1
VIOLATIONS RESULTING IN DRIVER RESPONSIBILITY PROGRAM SURCHARGES

VIOLATION	DETAIL	SURCHARGE (PER YEAR FOR THREE YEARS)
6 or more points (Points)	2 points per moving violation; 3 points per moving violation resulting in an accident; Exempt: speeding less than 10 percent over posted speed limit, unless in school zone, and other specific traffic infractions	$100 for 6 points $25 for each additional point
Driving while Intoxicated (DWI)		$1,000 for first offense $1,500 for subsequent offense $2,000 for offense with blood alcohol test of 0.16 or more
License Invalid/No Insurance (LINI), includes: • Driving While License Invalid (DWLI) • Driving Without Financial Responsibility (No Insurance)	DWLI is driving with a suspended or revoked license.	$250
Driving Without A License (NL)	Not having a license or driving with an expired license	$100

Source: Legislative Budget Board.

FIGURE 2
TOP 10 COUNTIES WITH DRIVER RESPONSIBILITY PROGRAM OFFENSES, 2003 TO 2006

COUNTY	POINTS	DRIVING WHILE INTOXICATED	NO INSURANCE / DRIVING WHILE LICENSE INVALID	NO DRIVER LICENSE	TOTAL VIOLATORS (DISCOUNTS MULTIPLE VIOLATIONS)	PERCENTAGE OF TOTAL VIOLATIONS	PERCENTAGE OF TOTAL POPULATION
Harris	1,692	24,219	84,744	42,924	123,293	16.5%	16.2%
Dallas	1,595	13,549	76,093	38,879	101,507	13.6%	10.1%
Bexar	1,063	10,494	33,312	14,552	47,909	6.4%	6.6%
Tarrant	608	9,231	31,794	15,522	45,871	6.1%	7.1%
El Paso	1,396	1,784	30,503	20,574	41,152	5.5%	3.2%
Travis	693	7,416	19,501	10,859	31,562	4.2%	3.9%
Hidalgo	525	4,825	11,973	7,572	21,413	2.9%	3.0%
Denton	918	2,457	10,154	4,181	15,082	2.0%	2.4%
Collin	1,030	2,461	9,063	3,522	13,533	1.8%	2.9%
Galveston	277	1,549	8,458	4,073	11,460	1.5%	1.2%

SOURCE: Legislative Budget Board.

FIGURE 3
AGE OF DRIVER RESPONSIBILITY PROGRAM VIOLATORS, 2003 TO 2006

AGE	PERCENTAGE OF TOTAL	DRP VIOLATORS
15 or younger	0.03%	192
16 to18	2.1	15,433
19 to 21	11.6	86,706
22 to 29	35.8	267,116
30 to 39	26.2	195,923
40 to 49	16.1	120,097
50 to 59	6.3	47,122
60 to 69	1.5	11,031
70 or older	0.4	3,018
Total	**100.0%**	**746,638**

SOURCE: Legislative Budget Board.

million in fiscal year 2005 and $76.4 million in fiscal year 2006. Actual DRP collections met or exceeded the BRE in both years.

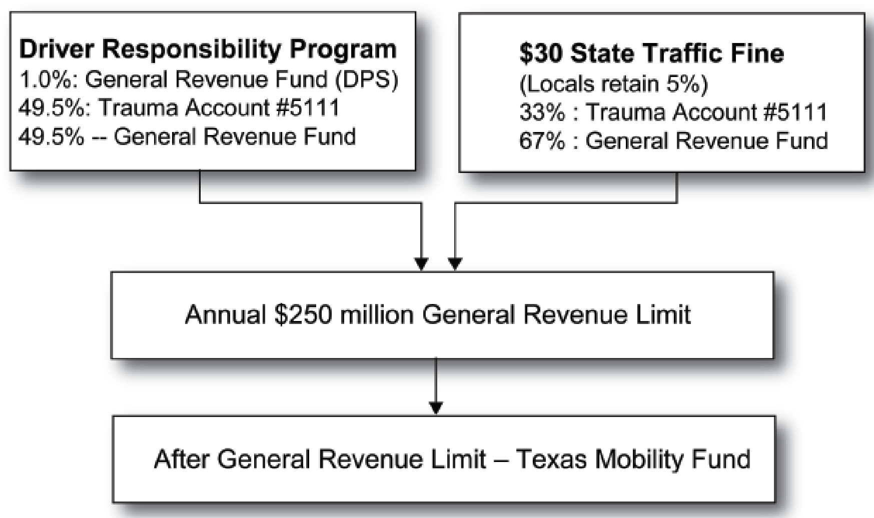
However, the collection estimates in the fiscal note for the bill that created the DRP were higher. DPS projected that the DRP would have a 66 percent collection rate. This collection rate was based on a program with fees lower than the proposed DRP surcharges. Using DPS projections, the fiscal note projected that the DRP would assess $181.5 million in fiscal year 2004 and collect surcharges of $119.8 million. The fiscal note further estimated $344.5 million in assessments in fiscal year 2005, with $227.4 million in collections, and, in each subsequent year, $507.7 million in assessments and $335.1 million in collections.

CURRENT DEPARTMENT OF PUBLIC SAFETY COLLECTION EFFORTS

Statute allows DPS to enter into a contract with a vendor for collection of DRP surcharges and limits compensation to the vendor to 30 percent of the amount of surcharges and related costs collected. DPS awarded a contract to the vendor on August 26, 2004, for the collection of surcharges. The vendor is allowed to collect 4 percent over the surcharge amount as base compensation. Other compensation includes fees on transactions made by phone, credit card transactions, and installment plans. The vendor began to collect surcharges for the state on September 30, 2004, and deposited the first revenues in the state treasury in November 2004. The contract is valid from September 28, 2004, through September 28, 2008, with an option to renew for a five-year period with the same terms, costs, and conditions.

As required by statute, the vendor mails violators notices regarding surcharges, giving them 30 days to pay or enter into an installment payment agreement. The address used in the mailing is the address DPS has on file for the violator. DPS suspends the license of violators who do not make payment arrangements. As of the end of fiscal year 2006, 54.9 percent of all notices resulted in license suspension. As **Figure 6** shows, these suspension rates were similar for all categories of offenses other than points. The percentage of cases in compliance and percentage of cases suspended do

FIGURE 4
ANNUAL DRIVER RESPONSIBILITY PROGRAM FUND ALLOCATION, FISCAL YEARS 2006 TO PRESENT



SOURCE: Legislative Budget Board.

FIGURE 5
ALLOCATION OF DRIVER RESPONSIBILITY PROGRAM COLLECTIONS (IN MILLIONS), FISCAL YEARS 2005 AND 2006

	2005		2006	
FUND	ACTUAL	BRE	ACTUAL	BRE
General Revenue Funds	$0.4	$0.4	$49.7	$38.6
Trauma Account #5111	18.2	17.8	48.7	37.8
Mobility Fund #365	18.2	17.8	0	0
Total	**$36.8**	**$36.0**	**$98.3**	**$76.4**

SOURCE: Legislative Budget Board.

FIGURE 6
SUSPENSION AND COMPLIANCE RATES BY CATEGORY OF OFFENSE, 2003 TO 2006

NOTICES	POINTS	DRIVING WHILE INTOXICATED	LICENSE INVALID / NO INSURANCE	NO LICENSE	TOTAL
Total Notices Mailed	28,333	183,446	904,135	395,183	1,511,097
Surcharge Notices in Compliance (Paid or with installment agreement)	17,190	67,852	317,492	88,854	491,388
Compliance Percentage	60.7	37.0	35.1	22.5	32.5
Surcharge Notices resulting in Suspension	7,135	100,699	494,689	226,360	828,883
Cases Suspended Percentage	25.2	54.9	54.7	57.3	54.9

SOURCE: Department of Public Safety.

not equal 100 percent because some cases are still within 30 days of notice or are being processed.

Collection rates similarly vary by category of offense. As of the end of fiscal year 2006, the overall collection rate was 27.8 percent, but within categories, as shown in **Figure 7**, collections ranged from 18.8 percent to 51.2 percent.

DPS limits the vendor's collection efforts to mailing notification letters and receiving incoming calls from violators. Other state agencies that collect debts use more extensive collection strategies. For instance, to collect and distribute child support payments, the Texas Office of the Attorney General sends automated letters, makes outbound calls, and follows leads on inbound calls. When DPS solicited bids for the contract, three other vendors bid and offered a

FIGURE 7
COLLECTION RATES BY CATEGORY OF OFFENSE, 2003 TO 2006

NOTICES	POINTS	DRIVING WHILE INTOXICATED	LICENSE INVALID/ NO INSURANCE	NO LICENSE	TOTAL
Billed Surcharges	$3,054,966	$191,332,900	$238,459,780	$45,857,175	$478,704,791
Collected Revenue	$1,565,156	$52,693,831	$69,962,561	$8,620,797	$132,842,306
Percent Collected	51.2	27.5	29.3	18.8	27.8

SOURCE: Texas Department of Public Safety.

variety of services, including multiple notification letters, outbound collection calls, automated dialer campaigns, and credit bureau reporting. The proposed fees ranged from 5.9 percent to 30 percent, and included tiered-fee structures where the rate increased as the receivable aged and collection efforts mounted.

Recommendation 1 would amend the Texas Transportation Code, Chapter 708 to require DPS to negotiate an additional collection contract including more extensive collection techniques. More extensive collection techniques could result in higher collection rates. DPS should also consider establishing a tiered compensation methodology for an increase in collection rates for delinquent debts. According to the debt-collection industry, the probability of collecting a debt decreases with the length of time the debt is outstanding.

Collection contracts typically allow for greater payment rates with the greater effort involved in collection of older accounts. As DPS's current contract limits collection techniques in pursuit of surcharges, the statute would direct DPS to establish an additional contract for further collection efforts using more extensive collection techniques and allowing a greater payment rate for the greater effort involved. This way, the current contract would act as a first round of collection, and the additional contract would be able to improve collections rates for more difficult cases. The statute should permit the current vendor to bid for the additional contract, which may be addressed as an amendment to current contract. The statutory cap of 30 percent on compensation rates would apply to the compensation of both contracts.

INCOME ANALYSIS OF DRIVER RESPONSIBILITY PROGRAM OFFENSES

DRP offenses and assessment rates vary among income levels for Points, license invalid/no insurance (LINI), and no driver's license (NL) violators.

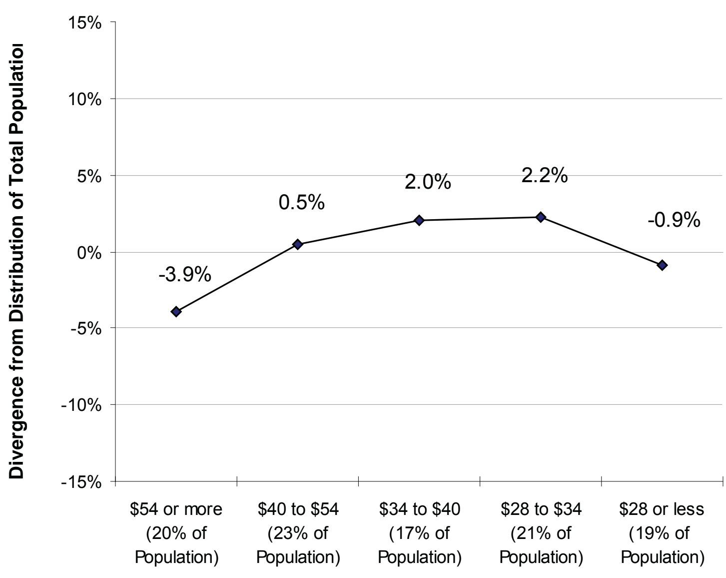
DPS does not collect income information about DRP violators. Legislative Budget Board staff compared violators' zip code data with the U.S. Census Bureau's mean household income per zip code, as provided by the Texas State Data Center, as a proxy for individual income. The analysis found that the LINI and NL offenses occur more frequently in lower-income areas than Points or DWI offenses. Income does not appear to affect the DWI category, and middle-income areas are more likely to have Points offenses. The following analysis has not employed standard statistical tests and did not consider the standard deviation for any given zip code, nor for the study as a whole. The data includes all DRP offenses between September 2003 and September 2006.

Figure 8 through **Figure 11** show the divergence between the distribution of DRP violations and the distribution of the population as a whole. If the DRP violations were evenly distributed over each income strata, the percentage of violations would be equal to the percentage of the total population, and the line would be flat at the 0 percent line. Any divergence shows the relationship between income and DRP violations when holding all other variables constant.

As shown in **Figure 1**, Points violations are moving vehicle violations. A complete list of Points violations appears in Texas Administrative Code, Title 37, §15.89(b). With a 51.2 percent collection rate, violators earning 6 or more Points are the most compliant category of DRP violators in terms of paying assessments. However, only 2.6 percent of all DRP assessments are a result of Points offenses. **Figure 8** shows that Points violators tend to fall into the middle brackets of household income, showing a positive violation-to-population difference for those earning between $28,001 and $54,000.

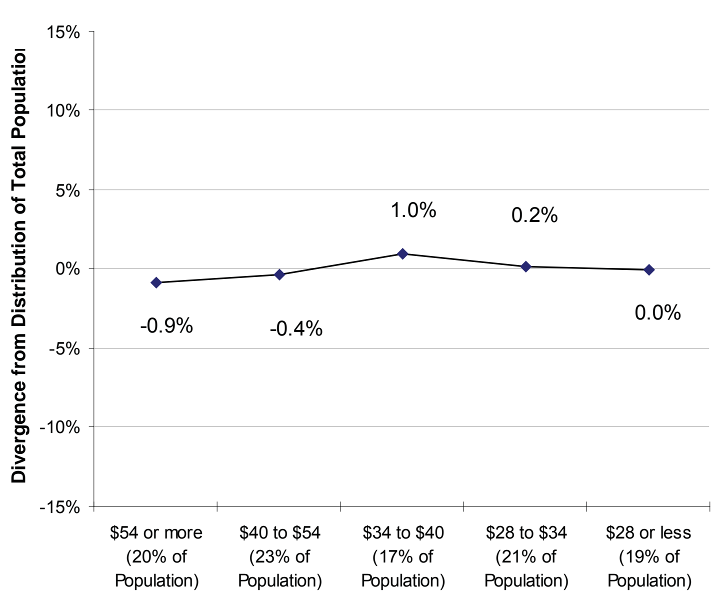
Driving while intoxicated (DWI) violators have a 27.5 percent collection rate and comprise 12.9 percent of all DRP assessments. **Figure 9** shows that the divergence among income categories for DWI violators ranges from minus 1.1 percent to plus 1.0 percent. DWI violators have an income distribution closer to even with the population as a whole than any other category of DRP violators. The relationship

FIGURE 8
PERCENTAGE POINT DIFFERENCE BETWEEN DISTRIBUTION OF POINTS VIOLATORS AND POPULATION, 2003 TO 2006



SOURCE: Legislative Budget Board.

FIGURE 9
PERCENTAGE POINT DIFFERENCE BETWEEN DISTRIBUTION OF DRIVING WHILE INTOXICATED VIOLATORS AND POPULATION, 2003 TO 2006

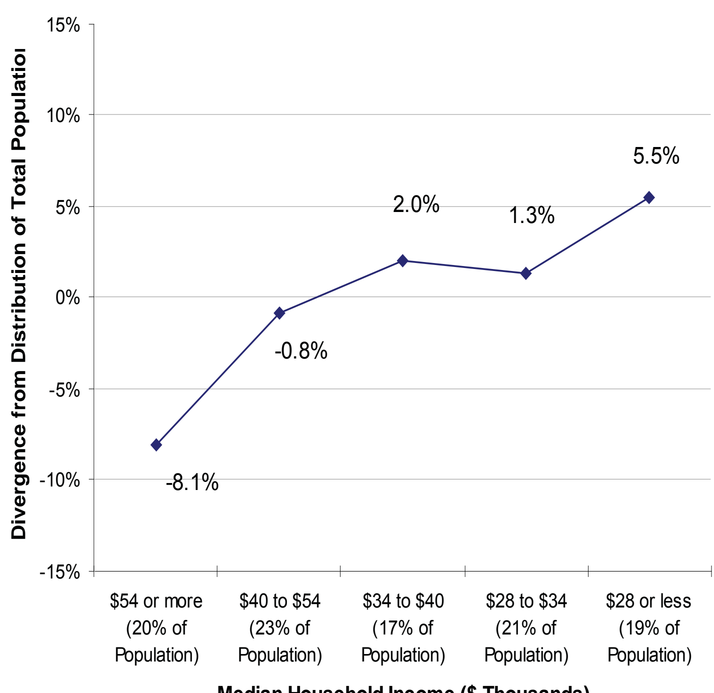


SOURCE: Legislative Budget Board.

between income and DWI violations does not appear to be as strong as in the other categories.

DRP violators convicted of driving with license invalid or having no insurance (LINI) have a 29.3 percent collection rate and represent 57.0 percent of all DRP assessments. **Figure 10** shows that the divergence among income categories

FIGURE 10
PERCENTAGE POINT DIFFERENCE BETWEEN DISTRIBUTION OF LICENSE INVALID/NO INSURANCE VIOLATORS AND POPULATION, 2003 TO 2006



SOURCE: Legislative Budget Board.

for the distribution of LINI violators is much more significant than the divergence among income categories for points or DWI violations, ranging from minus 8.1 percent to plus 5.5 percent. LINI violations tend to fall disproportionately on areas with lower median household income.

Violators convicted of driving without a license (NL) have an 18.8 percent collection rate and constitute 27.5 percent of all DRP assessments. **Figure 11** shows that the divergence among distribution over income categories is even greater for NL violations than the divergence among income categories for LINI violations, ranging from minus 10.2 percent to plus 9.0 percent. NL violations trend strongly towards areas with lower median household incomes.

ECONOMIC CONSEQUENCES OF DRP SURCHARGES

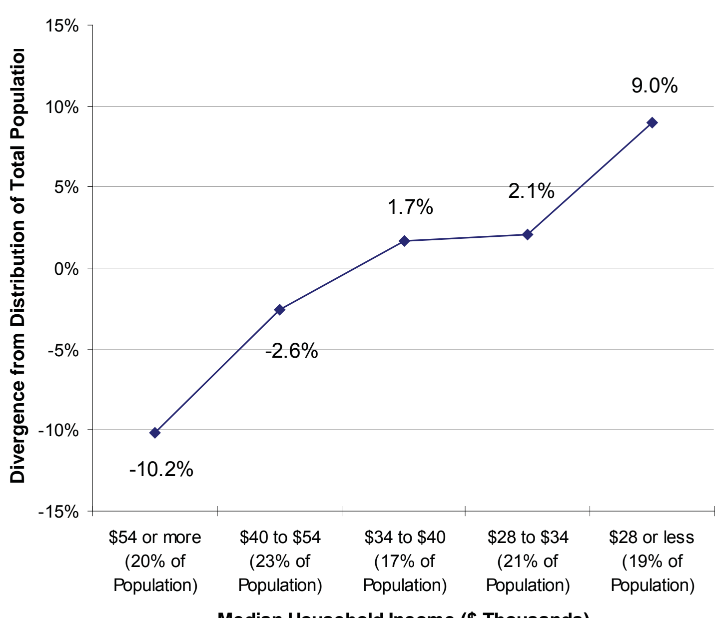
New Jersey's driver responsibility program is similar to the DRP in Texas, but it has a higher collection rate. New Jersey's overall collection rate for assessed surcharges is about 36 percent. New Jersey's collection rates per category are 71 percent for Points violations, 35 percent for DUI offenses, and 25 percent for LINI and NL offenses. New Jersey's program was created in 1983 and is the oldest in the United States.

In February 2006, the State of New Jersey's Motor Vehicles Affordability and Fairness Task Force released its Final Report (New Jersey Report) which included a survey of drivers with suspended licenses. Their results generally found a disproportionate impact of New Jersey's program on low-income people. **Figure 12** shows the reported economic impacts of license suspensions across income groups.

The New Jersey Report further included a summary of public testimony gathered during the course of its study, including:

- the negative effects of license suspension on other members of the family;
- the budget concerns of paying surcharges on a limited income, even when paying on installment;
- an increase in auto insurance costs;
- an inability to maintain insurance because of fines, fees, and surcharges;

FIGURE 11
PERCENTAGE POINT DIFFERENCE BETWEEN DISTRIBUTION OF NO LICENSE VIOLATORS AND POPULATION, 2003 TO 2006



SOURCE: Legislative Budget Board.

FIGURE 12
ECONOMIC EFFECTS OF LICENSE SUSPENSION ACROSS INCOME GROUPS IN NEW JERSEY

ECONOMIC EFFECT	LOW INCOME (UNDER $30,000) (N=102)	MIDDLE INCOME ($30,000 - $100,000) (N=174)	HIGH INCOME (OVER $100,000) (N=52)
Job status: Not able to keep job after suspension	64%	33%	17%
Job search: Unable to find new job after suspension (if not able to keep job after suspension)	51%	37%	13%
Job performance: Suspension negatively affected job performance	66%	50%	60%
Insurance costs: Not able to pay increased insurance costs	65%	48%	21%
Other costs:			
Experienced other costs related to suspension	64%	61%	51%
Not able to pay other costs?	90%	68%	33%

SOURCE: State of New Jersey.

- a negative effect on available labor for the labor force as a whole, either through lack of transportation or on-the-job screening for a valid driver's license;
- decreased tax revenue for gas, auto services, and insurance; and
- increased public assistance.

PAYMENT OPTIONS FOR THE DRIVER RESPONSIBILITY PROGRAM

The income analysis shows that DRP violators in the LINI and NL categories tend to live in zip codes with low-income median household incomes, and DRP violators in the points and DWI categories are distributed in low-income zip codes at the same or almost the same frequency as the population as a whole. The cost of DRP surcharges may prevent some low-income violators from complying with the law, leaving them without a valid driver's license. Because of this, violators should have various methods to pay DRP assessments, such

as allowing reinstatement of installment plans for non-payment, allowing other fees payable to DPS to be combined with the same installment plan, and periodic amnesty programs.

Recommendation 2 would amend Texas Transportation Code, Chapter 708 to make payment of surcharges more feasible for low-income drivers by allowing DPS to employ these payment options in its contract with the collections vendor.

The same section of the Texas Transportation Code allows DPS to promulgate rules declaring the balance of the installment plan immediately due and payable for non-payment. This provision could have a negative effect on collections. If, for instance, a low-income person who has been paying his or her surcharge on an installment plan has an unforeseen income problem in one month, this provision would nullify the installment plan and give this person the choice of paying the remainder immediately or being noncompliant. A credit card company in a similar position typically either increases the finance charge or provides leniency if in their best interest to do so. Rather than cancelling the installment plan and possibly forgoing the remainder of the surcharge, DPS should be allowed to establish a new installment plan on different terms.

In addition to DRP surcharges, violators must pay court costs and fees and other fees payable to DPS, such as a license restoration fee. The total costs and fees assessed to convicted DRP violators vary greatly. As **Figure 13** shows, DRP violators convicted of a Class C offense with 6 points on their records would pay between a minimum of $405 and a maximum of $838 over three years due to the varying required and optional court costs. A felony conviction for a DWI with a blood alcohol test (BAT) of 0.16 would require payments of an estimated $6,603 over three years.

DPS should also have the authority to create a periodic amnesty program for drivers with surcharges, with specific consideration to limiting participation based on the seriousness of the offense. A periodic amnesty program would give violators with unpaid surcharges the opportunity to mend their records and become compliant with the law. New Jersey offered a 60-day amnesty in 2003 for all surcharged violators other than those with DWI convictions. During that time, the state collected 74,139 payments for $17.5 million in revenue on amnesty-eligible accounts.

ADDITIONAL CONSEQUENCES FOR NON-PAYMENT OF SURCHARGES

The only sanction authority for non-payment of DRP surcharges that statute currently grants DPS is license suspension. As of September 1, 2006, DPS suspended 828,883 licenses, which constitutes 54.9 percent of all DRP surcharge notices, for failure to comply with the DRP. The overall compliance rate with the DRP is 32.5 percent.

However, New Jersey's driver responsibility program, which has a compliance rate of 36 percent, allows for liens on personal property and wage garnishment for outstanding debts. In Texas, the Office of the Attorney General (OAG)

FIGURE 13
COST PER DRIVER RESPONSIBILITY PROGRAM CONVICTION

OFFENSE LEVEL	REQUIRED AND OPTIONAL COURT COSTS AND FEES*	DRP FEES (OVER 3 YEARS)	TOTAL
Six Points: Class C, Minimum	$105.00	$300.00	$405.00
Six Points: Class C, Maximum	537.50	300.00	837.50
Six Points: Class A or B	552.50	300.00	852.50
Driving While Intoxicated 1st, Class A	552.50	3,000.00	3,552.50
Driving While Intoxicated 2nd, Class B	552.50	4,500.00	5,052.50
Driving While Intoxicated 3rd, Felony	602.50	4,500.00	5,102.50
Driving While Intoxicated 0.16 BAT, Felony**	602.50	6,000.00	6,602.50
License Invalid/No Insurance, Class B (DWLI)	552.50	750.00	1,302.50
License Invalid/No Insurance, Class C, Maximum	537.50	750.00	1,287.50
No License, Class C, Maximum	537.50	300.00	837.50

*Optional fees include assumptions regarding typical charges. Not all optional fees necessarily apply.
**Chart assumes felony conviction to demonstrate maximum DRP penalty, but 0.16 blood alchohol test DWI is not necessarily a felony.
Source: Legislative Budget Board.

can file liens against property or other assets, garnish wages, intercept Internal Revenue Service refunds and lottery winnings, suspend licenses, deny passports, order credit bureau reports, place non-payers on probation, and request jail time in seeking child support payments. About 70 percent of the OAG's collected child support comes from garnished wages, also known as income withholding, but Article 16 of the Texas Constitution prohibits wage garnishment except to enforce court-ordered child support payments or spousal maintenance.

Recommendation 3 would amend Texas Transportation Code, Chapter 708 to allow additional consequences for nonpayment of certain surcharges. However, given the higher incidence of LINI and NL violations among people living in lower-income areas, additional collection methods in these categories may cause unintended additional economic impacts on low-income people. Even though the collection rate may increase in the aggregate through liens on personal property, these unintended additional economic impacts discussed in the New Jersey Report could reduce the ability of some low-income people to comply with the DRP and lead to more unlicensed drivers and a reduced collection rate among certain income classes. Because of this, Recommendation 3 would be more effective if applied to points and DWI violators only.

BEHAVIOR MODIFICATION OF VIOLATORS

The number of license suspension cases in the misdemeanor court system has risen significantly over the last three years. Some of the low-income DRP violators lose their licenses for non-payment and may be unable to pay the surcharges, fines, and fees necessary to restore their licenses. Although Recommendations 1 and 3 may increase collections from DRP violators in higher income brackets, some low-income DRP violators would not be able to pay their surcharges despite increased collection efforts or additional consequences for non-payment of surcharges. For instance, a family of four at the 2006 Federal Poverty Level (i.e., annual income of $20,000) would have an income of $1,667 each month before taxes. If one of the drivers were to receive a LINI violation for driving without insurance, which is a Class C misdemeanor, the offense would cost the family almost a whole month's pay. The consequence of non-payment would be a suspended license. Any next violation would be a LINI offense for driving with license invalid, a Class B misdemeanor carrying a maximum of 180 days in jail and a $2,000 fine, as well as the surcharge and court costs.

Recommendation 4 would amend Texas Transportation Code, Chapter 708 to provide incentives for bad drivers to change their behavior through a reduction in the number of years surcharges are collected. For instance, if a DWI offender provided proof of stay in a rehabilitation clinic and ongoing rehabilitation efforts, DPS or the courts could reduce the surcharge to $500 for three years or $1,000 for two. If LINI and NL violators acquire insurance or a valid license within a certain number of days, DPS or the courts could reduce their surcharges or the life of their surcharges.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 and 3 would likely increase collections, but the amount to which they would do so cannot be estimated. Recommendations 2 and 4 would potentially also increase collections, but, at the same time, could decrease the amount billed. This might affect total revenues. Given the potential for increased collections to be offset by decreased assessments, no fiscal impact is anticipated from these recommendations.

The introduced 2008–09 General Appropriations Bill does not address these recommendations.

IMPLEMENT AN ANNUAL PAROLE SUPERVISION PROGRAM TO REDUCE THE COST OF SUPERVISING LOW-RISK OFFENDERS

Texas' parole population is over 76,000 and is one of the largest in the nation. Additionally, more than one-third of the state's parole population has been on supervision for three years or longer. According to a 2004 study conducted by George Washington University, violation of parole supervision terms is more likely to occur during the first 12 months of release, and few offenders violate parole supervision after three years. This finding is consistent with a similar 2001 study commissioned by the Texas Board of Pardons and Paroles. Implementing an annual parole supervision program would reduce the resources needed to supervise low-risk offenders, which would save $3.8 million in General Revenue Funds in the 2008–09 biennium.

CONCERN

- ♦ Texas does not currently have an active annual supervision program for low-risk offenders. As a result, low-risk offenders are monitored through regular supervision, a more costly program.

RECOMMENDATION

- ♦ **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill limiting the use of $2.2 million of the Texas Department of Criminal Justice's parole appropriation for an annual parole supervision program which would reduce the resources needed to supervise low-risk offenders.

DISCUSSION

The Parole Division of the Texas Department of Criminal Justice (TDCJ) is responsible for the supervision of offenders released to parole or mandatory supervision.

The Parole Division is also responsible for promoting public safety and positive offender change through effective supervision. The Board of Pardons and Paroles (BPP) is responsible for decisions regarding parole release, parole revocation, or special conditions of parole. However, the Parole Division works closely with the BPP and provides the necessary documentation to assist BPP members with their decisions.

In 2001, consultants hired by BPP indicated that most offenders who will violate their terms of parole will do so during the first 12 months of supervision, and few will violate supervision after three years of being on parole. In 2004, a study by George Washington University of the state's parole supervision and violation practices reported similar findings. The study found 49 percent of the released offenders violated their parole terms during the first 12 months of supervision, and 15 percent violated their parole terms after three years of supervision.

TYPES OF RELEASE

The three types of release to supervision include parole, mandatory supervision, and discretionary mandatory supervision:

- Parole: The release of an offender by decision of the BPP, which has complete discretion to grant or deny parole.
- Mandatory Supervision: The automatic release to supervision provided by law for certain offenders when time served and good time credit equals the length of their sentence. This type of release does not require BPP approval and applies to offenders whose offense was committed prior to September 1, 1996.
- Discretionary Mandatory Supervision: The BPP can grant or deny an offender's release to supervision for offenders eligible for mandatory supervision if the offense was committed on or after September 1, 1996.

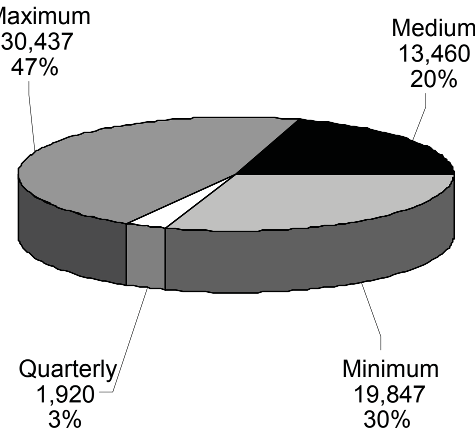
The BPP sets conditions of release for parole and mandatory supervision releasees. Offenders released on parole and mandatory supervision must serve the remainder of the sentence under supervision, and are subject to sanctions or revocation of parole for violation of parole conditions.

LEVEL OF SUPERVISION

Once the BPP approves an offender's release and, if applicable, assigns conditions of release, Parole Division staff determine the level of supervision. The staff assign the level of supervision based on the releasee's risk to re-offend and a needs assessment. The risks and needs assessments determine if offenders released will be assigned to a regular or specialized caseload. Specialized caseloads include Sex Offender, Special Needs, Therapeutic Community, District Resource Center, Super-intensive Supervision, and Electronic Monitoring. In June 2006, the active parole population was over 76,000 of which

65,664 offenders were on regular supervision (monthly and quarterly reporting) and approximately 10,650 were either in custody with parole not revoked or pending arrival to parole supervision. **Figure 1** shows the June 2006 parole population by level of supervision.

FIGURE 1
PAROLE POPULATION BY LEVEL OF SUPERVISION



SOURCES: Texas Department of Criminal Justice; Texas Sunset Advisory Commission.

Currently, the levels of supervision for regular reporting require the releasee to contact a parole officer monthly in addition to complying with basic guidelines, such as, providing verification of employment or counseling, and residence. The levels of supervision for regular reporting and their respective contact requirements are:

- Minimum: One contact with the offender each month.
- Medium: One office contact each month and an offender contact at every other month.
- Maximum: One office contact each month and an offender contact each month.

Releasees who have been on supervision a minimum of five years and meet the following criteria are allowed to report quarterly:

- Do not have instant offenses or prior convictions that include a violent or sex offense;
- Have a risk assessment score of minimum supervision status;
- Are current on fees;
- Are current and remain current on restitution;
- Are in compliance with all special conditions; and
- Have had no warrant issued during the current period of supervision.

In 2006, 1,920 releasees, 3 percent of the parole population, were reporting quarterly. Offenders who meet the criteria for quarterly reporting are required to report once each quarter; the contact must be an office visit in person.

ANNUAL PAROLE SUPERVISION PROGRAM

Texas does not currently have an active annual supervision program, although the state used an annual reporting status program in the late 1980s. This program consisted of an annual mail-in form and a criminal-history check. Releasees could obtain annual status in one year if they were current on their fees and assessed to be at minimum risk. However, TDCJ staff found this system too lenient and with few controls, so the agency has not assigned any offenders annual reporting status since 1995.

An annual parole supervision program can include more controls than those used by Texas in its previous program. Recommendation 1 would require TDCJ to develop an annual parole supervision program that adequately monitors low-risk offenders. TDCJ would develop criteria for program participation, which the Texas Board of Criminal Justice would approve.

Based on the studies discussed previously, TDCJ could consider the eligibility criteria and reporting requirements for annual parole supervision status shown in **Figure 2**.

FIGURE 2
ANNUAL PAROLE SUPERVISION PROGRAM ELIGIBILITY AND REPORTING REQUIREMENTS

ELIGIBILITY CRITERIA	REPORTING REQUIREMENTS
• Have been on supervision for at least three years; • assessed minimum risk for one year; • current on fees and restitution; and • gainfully employed, if applicable.	• Report in person annually to a parole officer; • urinalysis; • continued fee payments; and • annual review of criminal history.

SOURCE: Legislative Budget Board.

The following rider could be included in the 2008–09 General Appropriations Bill to implement Recommendation 1.

> **Annual Parole Supervision.**
> Out of funds appropriated above in Strategy E.2.1, Parole Supervision, an amount of $2.2 million in General Revenue Funds may be expended only for the purpose of supervising low-risk offenders in an annual parole supervision program in the 2008–09 biennium.

TDCJ could incorporate the program into a step-down model of supervision of non-violent offenders where the offender reports monthly and quarterly for certain periods before being considered for annual reporting status. This step-down method provides assurance that sufficient controls are in place to ensure public safety and the appropriate level of supervision. A progression to this step-down approach to supervise low-risk offenders may include early termination for an offender that has been on annual supervision for a certain period. Under early termination, offenders are released from supervision, but remain under TDCJ jurisdiction until the completion of their sentence. In an October 2006 report, the Texas Sunset Advisory Commission staff recommended that TDCJ implement an early release program for low-risk offenders.

SAVINGS FROM ANNUAL PAROLE SUPERVISION

Through implementation of an annual parole supervision program, the TDCJ Parole Division could move approximately 5,400 low-risk eligible offenders to annual reporting status. This would reduce the number of parole staff required to supervise low-risk offenders by 51 full-time equivalent (FTE) positions by the end of the 2008-2009 biennium. As a result, the TDCJs Parole Division appropriation for Strategy E.2.1, Parole Supervision could be reduced by $1.6 million in General Revenue Funds in fiscal year 2008 and $2.2 million in General Revenue Funds in fiscal year 2009.

FISCAL IMPACT OF THE RECOMMENDATION

The recommendation to implement an annual supervision program would realize a net savings of $3.8 million in General Revenue Funds in the 2008–09 biennium.

These savings would be realized by implementing annual supervision of low-risk offenders at a cost of $1.15 per day compared to the cost of regular supervision at $3.15 per day.

The estimated number of releasees includes releasees who currently meet the criteria for quarterly reporting (must have been under supervision for five years) plus releasees who would otherwise meet criteria for quarterly reporting but have been under supervision for three years. TDCJ estimates the associated staff cost is $56,611 per FTE for salary plus benefits. As a result, when the program is fully implemented in 2010, the full-time equivalent reduction would be 70. **Figure 3** shows the net savings of partial program implementation in fiscal years 2008 and 2009 and complete program implementation by fiscal year 2010.

FIGURE 3
FISCAL IMPACT OF RECOMMENDATION

FISCAL YEAR	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS	CHANGE IN FULL-TIME EQUIVALENTS COMPARED TO 2006–07 BIENNIUM
2008	$1,618,761	(38)
2009	$2,188,325	(51)
2010	$2,997,705	(70)
2011	$2,997,705	(70)
2012	$2,997,705	(70)

SOURCE: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill does not address Recommendation 1.

REHABILITATE DWI OFFENDERS AND CONSERVE PRISON CAPACITY BY CREATING MORE DWI COURTS

Despite the construction of 70 new prisons in the 1990s at a cost of $2.3 billion, Texas prison populations are expected to exceed operating capacity by 7,328 inmates by the end of the 2008–09 biennium. Without policy changes that reduce prison populations, the state will have to continue to contract with counties to house additional state inmates in county jails. Housing inmates in contracted county beds is projected to cost the state $173.8 million by the end of the 2008–09 biennium.

Drug, DWI, and other problem-solving courts have been found to be cost-effective alternatives to incarceration. These courts combine judicial supervision with immediate sanctions and mandated treatment to ensure public safety and to rehabilitate offenders. Despite the demonstrated success of specialized courts, Texas had only 54 drug courts, some of which accepted DWI offenders, but only four DWI courts as of November 2006. Encouraging the creation of more DWI courts could help rehabilitate these offenders and divert them from prison.

CONCERNS

- Prison populations are currently exceeding capacity, with five-year projections showing that population growth will continue. Non-violent DWI offenders made up 4 percent, or 5,486, of the incarcerated population as of August 2005. Projections indicate an increase in the number of such offenders.
- Even though it costs 78 percent less to send a felony drunk-driver to a DWI court involving active judicial supervision, mandatory treatment, and immediate sanctions than it does to incarcerate them, little has been done to encourage the implementation of these courts.
- DWI court judges and other judges interested in presiding over DWI courts report that a lack of incentives for participation hampers their ability to engage offenders in this program. As a result, few DWI courts have been established and participation is often low because eligible offenders opt for incarceration or basic community supervision (probation).
- While the number of drug courts in Texas increased significantly since 2001 legislation that requires larger counties to establish a drug court, state appropriations specifically for drug court operations have not increased from the biennial $1.5 million originally allocated.

RECOMMENDATIONS

- **Recommendation 1:** Amend Chapter 469 of the Texas Health and Safety Code to require all Texas counties with drug courts to serve felony DWI offenders or to create DWI courts that serve drunk-driving repeat offenders with a misdemeanor second DWI or felony third DWI offense using the nationally recognized drug court model.
- **Recommendation 2:** Amend Chapter 42 of the Texas Code of Criminal Procedure and Section 521.242 of the Texas Transportation Code to provide judges with the discretion to suspend certain restrictions placed on DWI offenders to provide participants with incentives.
- **Recommendation 3:** Amend Section 17.42 of the Texas Code of Criminal Procedure to require county courts in counties with established drug courts to assess a $20 or 6 percent personal bond fee of the amount of bail fixed for the accused, whichever is greater, to provide drug and DWI courts with a funding mechanism. One-half of the revenue generated would go to defray the costs of the personal bond office, as currently mandated in statute.
- **Recommendation 4:** Include a contingency rider for the Department of Criminal Justice in the 2008–09 General Appropriations Bill to transfer $270,000 in General Revenue Funds per fiscal year out of Strategy C.1.10, Contracted Temporary Capacity, into Strategy A.1.2, Diversion Programs, for the expansion and operation of DWI courts.

DISCUSSION

As Texas seeks ways to assure public safety while controlling the growing prison population and reducing recidivism, several counties in the state implemented innovative ways to address these issues and found cost-effective alternatives to incarceration. One such approach is establishing drug courts. This court, with its combined judiciary supervision, immediate sanctions, and mandated treatment, was first

established in Miami-Dade County in 1989. Typically, the drug court program is offered to first time offenders who have been arrested for low-level drug possession or non-violent crimes related to drug use as an alternative to probation or incarceration. Under this model, successful completion of the drug court program often results in dismissed charges or reduced probation sentences.

The success of drug courts led to the emergence of other problem-solving courts that specifically address issues such as drunk driving, domestic violence, mental health, and prostitution. This same court model can be applied to address drunk-driving offenders who directly contribute to prison population growth and the overall cost of Texas' prison system.

DWI OFFENDERS IN PRISON AND STATE JAILS

Currently, judges and prosecutors without dual drug/DWI courts or DWI courts in their counties have limited options when handling DWI offenders. **Figure 1** shows sentencing options, fees, fines and other sanctions for DWI offenders.

Although misdemeanor and felony DWI offenders can be diverted from prison to probation, they are ineligible for deferred adjudication, unlike other offenders committing misdemeanors or felonies.

While the amount of DWI offenders is not the major cause of prison population growth, they contribute to it by occupying limited space that can otherwise be used for higher risk violent offenders. Even with the increased capacity of the 70 new prisons built in the 1990s, state prison populations continue to exceed available capacity. By 1999, the construction costs of the 108,597 additional prison beds totaled $2.3 billion. In July 2005, the state resumed contracting with counties for space. The number of county contracted beds totaled 575 in July 2005, a year later, the amount more than doubled to 1,418 county contracted beds.

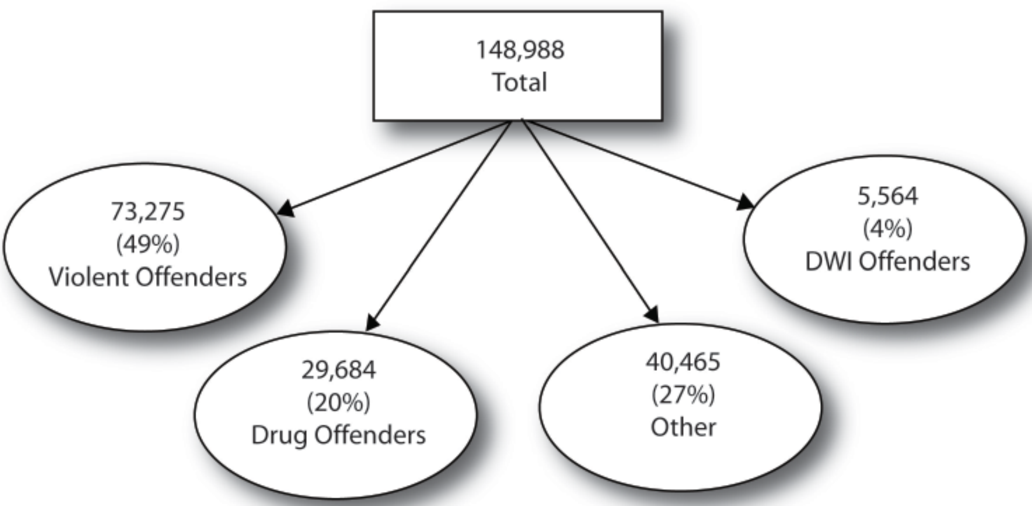
As of August 31, 2005, there were 148,988 offenders in prison and state jail. While almost half of the prison and state jail population is made up of violent offenders, non-violent offenders, including drunk-driving offenders, make up 51 percent of the incarcerated population shown in **Figure 2**.

FIGURE 1
DWI SANCTIONS AND LAWS

OFFENSE	FIRST DWI OFFENSE CLASS B MISDEMEANOR	SECOND DWI OFFENSE CLASS A MISDEMEANOR	THIRD DWI OFFENSE THIRD DEGREE FELONY
Fine	Up to $2,000	Up to $4,000	Up to $10,000
Driver Responsibility Program Surcharge	$1,000 annual charge for 3 years, or $2,000 for 3 years if blood-alcohol level is more than 0.16	$1,500 annual charge for 3 years, or $2,000 for 3 years if blood-alcohol level is more than 0.16	$1,500 annual charge for 3 years, or $2,000 for 3 years if blood-alcohol level is more than 0.16
Punishment Range	72 hours to 180 days in jail; may be probated for up to 2 years	30 days to 1 year in jail; may be probated for up to 2 years (with a minimum of 3 days in jail as a condition of probation)	2 to10 years in prison; may be probated for 2 to 10 years (with a minimum of 10 days in jail as a condition of probation)
Driver's License Suspension	Automatic suspension-90 days to 1 year	Automatic suspension- 180 days to 2 years (or 1 year to 2 years if the prior offense was within 5 years of the new offense)	Automatic suspension-180 days to 2 years (or 1 year to 2 years if the prior offense was within 5 years of the new offense)
Community Service	Mandatory 24 hours to 100 hours	Mandatory 80 hours to 200 hours	Mandatory 160 hours to 600 hours
Special Car Ignition Switch	Not required as a condition of release from jail on bond – required for at least half the time on community supervision (probation) if blood alcohol level was 0.15 or higher	As a condition of release from jail on bond- needed for at least half of the time on community supervision (probation)	As a condition of release from jail on bond-needed for at least half of the time on community supervision (probation)

Note: This table does not include the monthly probation fees required for those serving community supervision sentences, court costs or program fees, if applicable, for participation in treatment programs.
Source: Legislative Budget Board.

FIGURE 2
PRISON AND STATE JAILS POPULATION, AUGUST 31, 2005



SOURCE: Legislative Budget Board.

The total number of incarcerated drunk driving offenders remained relatively stable since 2003. While this population has not grown, drunk-driving offenders continue to use resources that could more effectively be focused on offenders who present greater public safety risks.

Figure 3 shows that the total prison population will continue to grow. By the end of fiscal year 2011, there will be a need for over 11,000 additional beds, 465 of which are projected to be for DWI offenders.

CRIMINAL JUSTICE SPENDING IN TEXAS

Based on August 2005 population numbers, the state spent almost $76.5 million in General Revenue Funds in fiscal year 2005 to incarcerate drunk-drivers. A total of 1,765 offenders admitted to prison in fiscal year 2005 for a DWI offense came from nine counties with populations of more than 550,000 people. There is increasing evidence that incarcerating substance abuse offenders is not the most effective means of reducing recidivism. **Figure 4** shows the average annual cost per offender at a state jail and prison, and the number of drunk-driving offenders as of August 31, 2005. The annual cost for incarceration of drunk-driving offenders is between $12,000 and $14,000 per offender.

Overall incarceration costs are expected to grow by 2011 due to the projected growth in the adult incarcerated population. The state currently contracts with counties for beds at $40 per day. At a daily cost of $40 per offender, an increase of the 306 new DWI offenders by the end of the 2008–09 biennium estimated in **Figure 3** will cost the state an additional $7.2 million. The total cost of the projected prisoners over capacity for that same period is estimated to be $173.8 million in General Revenue Funds by the end of fiscal year 2009.

FIGURE 3
TEXAS PRISON POPULATION PROJECTIONS, FISCAL YEARS 2007 TO 2011

FISCAL YEAR	POPULATION	POPULATION OVER CAPACITY	PERCENTAGE OF POPULATION OVER CAPACITY	DWI OFFENDERS IN OVER CAPACITY POPULATION
2007	153,935	3,101	2.1%	129
2008	156,620	5,786	3.8%	241
2009	158,162	7,328	4.9%	306
2010	160,448	9,614	6.4%	401
2011	161,990	11,156	7.4%	465

SOURCE: Legislative Budget Board.

FIGURE 4
COST OF PRISON AND STATE JAIL POPULATION BY DRUNK-DRIVING OFFENSE, FISCAL YEAR 2005

FACILITY	PRISON	STATE JAIL
Annual Cost per Offender	$13,771	$12,330
DWI Offenders	5,486	78
Total Annual Cost	**$75,547,706**	**$961,740**

Source: Legislative Budget Board.

NATIONAL EXPERIENCE WITH DWI AND DRUG COURTS

Several states followed Florida's lead and initiated the use of drug courts and other problem-solving courts as a way to divert offenders from jails and prison. According to the National Association of Drug Court Programs (NADCP), as of late 2005, there are more than 1,600 drug courts operating or being planned in the United States. A reported 225 DWI courts and dual drug/DWI courts currently exist nationwide. **Figure 5** shows the 10 key components of the drug court model as identified by the U.S. Department of Justice.

FIGURE 5
THE 10 KEY COMPONENTS OF A DRUG COURT

- Integration of treatment services and criminal justice system
- Coordinated effort between prosecutor and defense counsel
- Immediate screening, assessment and placement of participants
- Continuum of treatment and rehabilitative services
- Frequent drug testing (daily to weekly)
- Coordinated response for compliance and noncompliance (including incentives and sanctions)
- Active judicial supervision (anywhere between weekly and monthly court appearances)
- Monitoring and evaluation of program
- Continuing education for program staff
- Community partnerships among treatment providers, criminal justice agencies, and community based organizations

Source: U.S. Department of Justice.

Because of the nature of the offense and the issues of public safety with drunk-driving offenders, DWI courts typically take only post-adjudication cases. This model won the support of the nationally recognized Mothers Against Drunk-Driving (MADD) organization. Unlike the pre-adjudication cases taken in drug courts, charges cannot be dropped or records expunged as an incentive to complete the program. Instead, DWI offenders may be offered only incentives that can reduce their time on probation, reduce fees, or other tokens of progress. Several existing drug courts and DWI courts have indicated that mandatory sentencing laws and other requirements specific to DWI offenders make it more challenging to find incentives that are appealing to this population.

One of the oldest and most successful DWI courts is in Albuquerque, New Mexico. Since its inception in 1997, only 123 of the total 1,054 graduates have been rearrested for drunk driving, which reflects an 11.7 percent recidivism rate. Studies have shown that participants who do not complete traditional treatment programs relapse within a year, and that traditional programs retain only 10 to 20 percent of entering participants. Retention rates for court mandated treatment are significantly higher as indicated by the 69 percent retention success that the DWI court in New Mexico has shown since its inception.

Many studies provide strong evidence that drug courts and substance abuse treatment, the model upon which DWI courts are based, produce lasting changes in participants, persisting beyond program enrollment:

- In February 2005, the U.S. General Accountability Office published an extensive review of drug court research that established the efficacy of drug court programs. It concluded, among several things, that there was a reduction in recidivism (both rearrest and conviction) and that it was maintained for substantial intervals of time by participants completing drug court programs as compared to control groups. It also found a positive cost/benefit ratio for participants, criminal justice systems and society, as a whole.

- A 2003 National Institute of Justice recidivism report entitled, *Recidivism Rates For Drug Court Graduates: National Based Estimates*, found that recidivism rates for a sample representative of 17,000 drug court participants was 16.4 percent one year after graduation and 27.5 percent after two years. The same report found that 38 drug courts had recidivism rates lower than 10 percent one year after graduation, which is significantly lower than the national recidivism average of 48 percent.

- According to a 2006 University of California at Los Angeles report, a statewide program which offers first and second time drug-related offenders the choice between prison time or probation and drug treatment, substantially reduces incarceration costs and saves taxpayers millions. The report finds that taxpayers save

nearly $2.50 for every dollar expended on the program, largely as a result of reduced criminal justice costs. Since its inception in 2000, the drug treatment alternative saved about $800 million, with $140.5 million being saved the first year.

While evidence shows that drug courts can reduce recidivism, few dedicated funding streams exist for these efforts. For federal fiscal year 2007, $69.9 million in Federal Funds for drug courts nationwide was included in the President's budget proposal, but Congress has yet to approve the appropriation. If both houses agree to this amount, it would be a significant increase from the previous year's allocation of $10 million. However, even with an increase in Federal Funds, funds are still limited since the number of problem-solving courts eligible for this funding has also grown.

Nationally, state appropriations for drug courts, are also sparse. States surveyed mentioned that the limited funding available in their states forced their drug courts to be resourceful in funding their programs. They reported several funding sources, including Federal Funds, state grants, local funds, participant fees, and private donations. Local funding, through shared staff, probation officers, office space, and other in-kind services, covers a large portion of program expenses. Michigan partially funds DWI courts from revenues collected from court filing fees. Missouri allows for Medicaid reimbursement for drug court mandated treatment services provided under the Medicaid system.

TEXAS' DRUG COURT EXPERIENCE

Section 469 of the Texas Health and Safety Code requires all counties with a population over 550,000 to establish a drug court if they can obtain Federal Funds for implementation or if the legislature appropriates money for drug-court programs. The bill lays out guidelines that limit participation to non-violent offenses where alcohol or a controlled substance is involved.

As of October 2006, according to the Criminal Justice Division of the Governor's Office, there were 54 drug courts, some of which accepted DWI offenders, and only four DWI courts. These problem-solving courts serve a total of 40 counties. Prior to the legislation, Dallas, Tarrant and Travis Counties had drug courts. El Paso began operating a drug court in 2001. In addition, as a result of the legislation, Bexar, Harris, and Hidalgo counties were required to establish drug courts. The legislature appropriated $1.5 million for drug courts in the 2002–03 biennium. The money had to be supplemented with Local or Federal Funds to provide complete funding for these programs.

Although the number of drug courts in Texas has grown since September 2001, specific state appropriations for drug courts have remained constant at $750,000 per year in grants through the Governor's Office. As mentioned earlier, community supervision departments are often a part of the unique partnership that make up the drug court program. The Community Justice Assistance Division (CJAD) within the Texas Department of Criminal Justice (TDCJ) identified $2.1 million in basic supervision funds, community corrections funds and diversion program grants that local probation departments used to augment their drug court programs in fiscal year 2006. However, other basic supervision and operation funds provided to local probation departments may also indirectly be supporting the infrastructure of drug and DWI courts, as is the case in other states.

Funding challenges are not the only similarities between Texas drug courts and other drug courts across the country. Texas drug courts have shown the same encouraging results that have been found nationwide. In January 2003, the Texas Criminal Justice Policy Council completed the first outcome evaluation of the Dallas, Jefferson, and Travis County Drug Courts. The agency tracked 501 offenders entering the drug court programs in these counties between 1998 and 1999. The evaluation showed 52 percent completed the programs within an average of 15 months. A control group of 285 offenders who were eligible for drug courts but did not enter the program were also tracked. The following are some of the findings:

- Offenders who graduated from drug court programs had a 28.5 percent re-arrest rate three years after entry compared to 56.8 percent of the control group;
- Offenders who graduated from drug court programs had a 3.4 percent incarceration rate three years after entry compared to 26.6 percent of the comparison group; and
- Nine to 11 percent of the offenders participating in the program tested positive for illicit drugs at some time during the program participation compared to more than 50 percent of offenders arrested in Texas sites covered by the Arrestee Drug Abuse Monitoring program of the U.S. Department of Justice in fiscal year 2000.

In addition to these outcomes, there are other indirect societal benefits of the courts. These benefits can translate into

increased worker productivity of treated participants, reduced medical costs for participants, and costs avoided by potential victims. According to the National Highway Transportation Safety Administration (NHTSA), 46 percent of total traffic deaths in Texas for 2004 were alcohol related. Based on a study sponsored by NHTSA in 1999, the economic costs of one fatal alcohol related car crash in Texas was estimated at $3.3 million—$1.1 million in monetary costs and $2.2 million in quality of life costs having to do with worker productivity and loss in tax revenue. The average cost of an alcohol related car crash injury was $96,000. DWI courts can help curb these costs by reducing the incidence of offenders driving while intoxicated. A cost-benefit analysis of the Dallas County drug court conducted by Southern Methodist University found that every $1 invested in drug courts yields $9 in savings to the criminal justice system.

The benefits of these courts are further demonstrated by the difference in the cost to incarcerate DWI offenders and the cost to discipline them through DWI courts. **Figure 6** shows that drug and DWI courts cost $6,000 for the average program length of stay per participant, a 78 percent difference in costs.

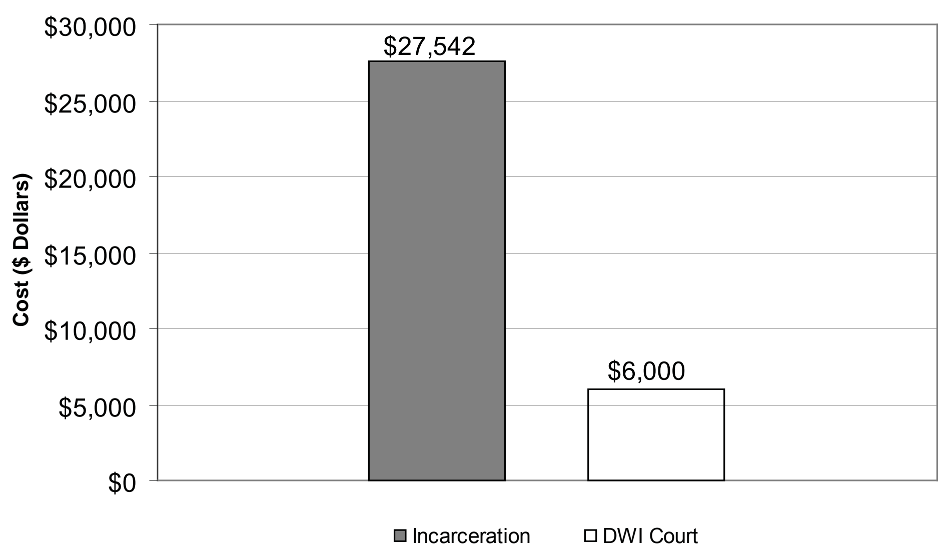
Six Texas counties now operate a DWI or dual DWI/drug court—Bexar, Collin, Denton, El Paso, Ft. Bend, and Tarrant. In summer 2005, MADD Texas and NHTSA partnered to provide training to counties interested in developing DWI Courts. As a result, another two counties are either developing or planning to develop a DWI court. The delay in developing these courts is due to funding issues, judge availability, or a lack of district attorney support. **Figure 7** shows a summary of Texas DWI courts.

ENCOURAGE THE CREATION OF MORE DWI COURTS

Providing resources and establishing standards for the operation of DWI courts in Texas would divert lower-risk offenders from prison and provide more opportunities for rehabilitation.

Recommendation 1 would amend Chapter 469 of the Texas Health and Safety Code to create a section to statutorily recognize DWI courts and apply the existing requirements for drug courts to DWI courts. Some exceptions to the requirements would apply. For example, counties with populations over 550,000 would have the option of accepting DWI offenders in their existing drug court programs or create a separate DWI court. Due to higher costs, the required minimum of participants at one time for DWI courts would be set at 50 participants versus the 100 required of drug courts. While the creation of DWI courts would be contingent upon funding, all operating drug courts in counties without a separate DWI court would be required to allow second or third DWI offenders in the drug court program, drawing upon resources and the existing infrastructure to divert these offenders.

FIGURE 6
COST COMPARISON OF INCARCERATION AND DWI COURT PER OFFENDER, FISCAL YEAR 2005



Note: Based on average length of prison stay of 24 months, and 18 months of DWI Court participation per offender.
Source: Legislative Budget Board.

FIGURE 7
SUMMARY OF TEXAS DWI COURTS, FISCAL YEAR 2006

COUNTY	DWI COURT?	LEVEL OF OFFENSE	CHALLENGES
Bexar	Yes-hybrid	Second DWI	Lack of judicial and attorney support, lack of incentives. Is still very interested in implementing a separate DWI court.
Collin	Yes- hybrid	Second DWI	Funding, lack of incentives for participants.
Dallas	In development	Multiple 1st, Second DWI	Funding, lack of incentives for participants, (has applied for governor's grant to begin program).
Denton	Yes	Second and third DWI	Lack of attorney support, funding, lack of incentives for participants.
El Paso	Yes	Second and third DWI	Transportation for offenders, lack of incentives for participants.
Ft. Bend	Yes	Second DWI	Funding, lack of incentives for participants.
Tarrant	Yes	Third DWI	Lack of dedicated funding.

Source: Legislative Budget Board.

Recommendation 2 addresses the lack of incentives that DWI court judges are currently allowed to offer participants. In order for DWI courts to have similar outcomes to drug courts, comparable incentives that encourage participation should be allowed for this offender population. Chapter 42 of the Texas Code of Criminal Procedure and Section 521.242 of the Texas Transportation Code should be amended to provide DWI court judges the discretion to suspend certain restrictions placed upon DWI offenders. As previously shown, Texas law mandates that a judge order DWI offenders to complete a minimum amount of community service. Temporarily suspending or waiving community service minimum requirements may work as an incentive to draw DWI offenders with time constraints into the programs. Offenders charged with a second or third DWI are also required to install an alcohol detecting device on their vehicle's ignition. There is a one-time installation fee and a monthly fee offenders must pay. Furthermore, DWI participants submit to regular drug and alcohol testing and are often monitored by 24 hour personal alcohol devices, making the ignition lock requirement unnecessary for a compliant participant.

Recommendation 2 also addresses the inefficiency in obtaining an occupational driver's license by amending Section 521.242 of the Texas Transportation Code to permit a presiding judge of a DWI court to order an occupational license as a condition of probation. An occupational license allows a participant to drive to and from designated points like work, court, and treatment meetings. Currently, a defendant must file a separate civil petition for an occupational driver's license, which is neither timely nor cost effective. The occupational driver's license would become part of the DWI court itself, as opposed to it being filed as a separate civil action. Adding this provision to the Texas Transportation Code would not only serve as an incentive to the participant who needs immediate access to a vehicle to comply with regular court appearances and drug testing, but also allow the judge to easily order an occupational license, thereby lowering costs and time involved in its preparation.

The limited funding available to drug and DWI courts has made it difficult for counties to implement or expand these types of courts in their areas. Amending Article 17.42 of the Code of Criminal Procedure to assess a personal bond fee of $20, or 6 percent, whichever is greater, on the bail fixed for the accused with one-half of the personal bond fee collected going to dual drug/DWI courts or DWI court programs would create a funding mechanism. Recommendation 3 would require a county court, in a county with an established drug or DWI court, to assess a personal bond fee. Currently, courts are required to assess a personal bond fee of $20 or 3 percent, whichever is greater, on the amount of bail fixed for an accused. The fees must be used to defray costs of the bond office. Courts in a county with no drug or DWI courts would not be affected by this recommendation.

Recommendation 4 also provides a partial funding source for DWI courts by directing a transfer of funds within appropriations for TDCJ in the 2008–09 General Appropriations Bill. The recommendation would include a rider in the 2008–09 General Appropriations Bill that would reallocate $540,000 in General Revenue Funds for the expansion of DWI courts, contingent upon enactment of legislation removing barriers to the use of DWI courts.

The following TDCJ rider should be included in the 2008–09 General Appropriations Bill:

> **Contingency Transfer of Appropriations.** Contingent on the enactment of legislation by the Eightieth Legislature, Regular Session, 2007, or similar legislation relating to the establishment of DWI Courts, the Department of Criminal Justice shall transfer $270,000 in General Revenue Funds each fiscal year out of Strategy C.1.10, Contracted Temporary Capacity, into Strategy A.1.2, Diversion Programs, for the purposes of providing grants to DWI courts or dual DWI/drug courts in accordance with the definition laid out in Health and Safety Code Chapter 469. Counties receiving these grants shall be required to report historical and annual information on DWI offenders to the Community Justice Assistance Division. The Community Justice Assistance Division shall create a uniform data collection instrument to track the offenders and shall submit a report on the implementation and effectiveness of the programs to the Legislative Budget Board and Governor's Office by December 1st of each year.

This provision of funding, coupled with the expected revenue to counties from the personal bond fee, would provide DWI courts with a total of $1.5 million in funding for the 2008–09 biennium. This funding should be adequate to cover 50 percent of the estimated operating expenses for DWI/drug courts to assist counties in meeting the requirements in Recommendation 1. **Figure 8** shows the estimated budget to operate a DWI/drug court in a county with a population over 550,000.

The annual $4,000 cost is based on operating costs used by different studies and provided by local DWI/drug courts and others located in different states. The estimate adjusts for other costs that DWI courts may incur because of the more sophisticated alcohol testing devices that may be necessary to effectively monitor offenders.

Currently, there are nine counties in the state with populations over 550,000. Providing these funding streams to DWI court programs would provide these nine counties with much needed assistance. Under Recommendation 1, these same nine counties would also be required to expand their drug court programs or create separate DWI courts. Assuming five of the nine counties choose to develop a separate DWI court, a greater portion of the grant money would go to them to help fund start-up costs. The remaining four counties choosing to expand their current drug court programs to DWI participants would receive assistance to help pay the additional costs of serving this new population. This would mean that $1.5 million, $540,000 in General Revenue Funds and $960,000 in fees on bail bonds, could provide the mandated counties choosing to develop a separate DWI court with $100,000 each per year if distributed equally. As shown in figure 8, this amount would cover 50 percent of the total $200,000 in estimated operating costs. The other four counties would be eligible for the remaining $500,000, made up of bail bond fees and General Revenue Funds for the biennium, about $62,500 per year for each court.

In addition to providing funding for DWI Courts, Recommendation 4 would result in a reduction in appropriations of $540,000 for the 2008–09 biennium to TDCJ for contracting capacity. This reduction in appropriation is expected to be offset by diverting DWI offenders from prison, who on average serve 24 months. With the cost of incarcerating a DWI offender in a contracted county jail at $14,600 per year, diverting at least 19 DWI offenders from prison annually would make Recommendation 4 cost-neutral. This means that only 11 percent of the estimated 176 DWI offenders (above capacity) expected to enter prison during the 2008–09 biennium would have to be diverted to offset the cost of this recommendation. With the increased discretion given to judges to provide incentives to DWI offenders in Recommendation 2, this benchmark of diverting 19 DWI offenders per year is realistic. Any offender beyond the nineteenth person diverted would result in cost savings to the state.

FIGURE 8
FUNDING NEEDED TO MEET DWI/DRUG COURT REQUIREMENTS

COUNTY (POPULATION >550,000)	REQUIRED NUMBER OF PARTICIPANTS (AT ONE TIME)	ANNUAL COST PER DWI COURT PARTICIPANT	ANNUAL DWI/DRUG COURT OPERATING COSTS
County A	50	$4,000	$200,000

SOURCE: Legislative Budget Board.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations would result in no net fiscal impact in the 2008–09 biennium.

Recommendations 1 and 2 would have no fiscal impact, and the fiscal impact of Recommendation 3 is local and varies depending on how many personal bonds are issued and in what amounts. Assuming that eight of the 10 largest counties in Texas, all with established drug or DWI court programs, each issue 2,000 personal bonds annually with an average amount set at $1,000, the total revenue generated for these counties would be an estimated $1.92 million per biennium. This revenue gain would provide the counties with $960,000 for their DWI or dual DWI/drug court program biennially.

Recommendation 4 would have no net fiscal impact. Funds would be transferred from one strategy to another in appropriations to TDCJ.

Implementing DWI courts and increasing the amount of funds appropriated to help sustain these prison diversion courts would reduce incarceration costs. Ultimately, the reduction in funding for incarceration would be offset by the savings yielded in not contracting for space in county jails. Expanding DWI courts would reduce costs associated with growing prison populations and would treat offenders who have an alcohol dependency, curbing future incidents of driving while intoxicated, saving both the state and local communities money.

The introduced 2008–09 General Appropriations Bill does not address these recommendations.

IMPROVE THE ACCOUNTABILITY AND SERVICE DELIVERY OF THE RE-INTEGRATION OF OFFENDERS PROGRAM

The "Re-Integration of Offenders" program, or Project RIO, provides employment preparation services to adult offenders and adjudicated youth during and after their incarceration. Project RIO reintegrates ex-offenders and adjudicated youth into the labor force, thus promoting public safety and reducing recidivism. Services are provided before release by the Texas Department of Criminal Justice and the Texas Youth Commission within their correctional facilities. Post-release Project RIO services are provided through cooperative agreements between the Texas Workforce Commission and the 28 Local Workforce Development Boards, which manage more than 270 local workforce centers. Although the program has demonstrated some success in helping ex-offenders secure employment, the Texas Workforce Commission, the Texas Department of Criminal Justice, and the Texas Youth Commission should improve their accountability and delivery of Project RIO services.

CONCERNS

- There is currently no requirement to evaluate the data interface project now under development by the Texas Workforce Commission, the Texas Department of Criminal Justice, and the Texas Youth Commission. The lack of evaluation prevents the agencies from determining if the project has improved communication and delivery of Project RIO services and from identifying additional areas for improvement.
- Project RIO performance data does not measure how long participants retain employment after using Project RIO services.
- The Texas Workforce Commission does not maintain information to identify effective methods (i.e., best practices) used by Local Workforce Development Boards and local workforce centers for delivering post-release Project RIO services, which the program could implement in other areas.
- Despite efforts by the Texas Department of Criminal Justice to ensure that ex-offenders who are unemployed or underemployed are identified and referred to the workforce system to participate in post-release Project RIO services, additional improvements could be made to this process.

RECOMMENDATIONS

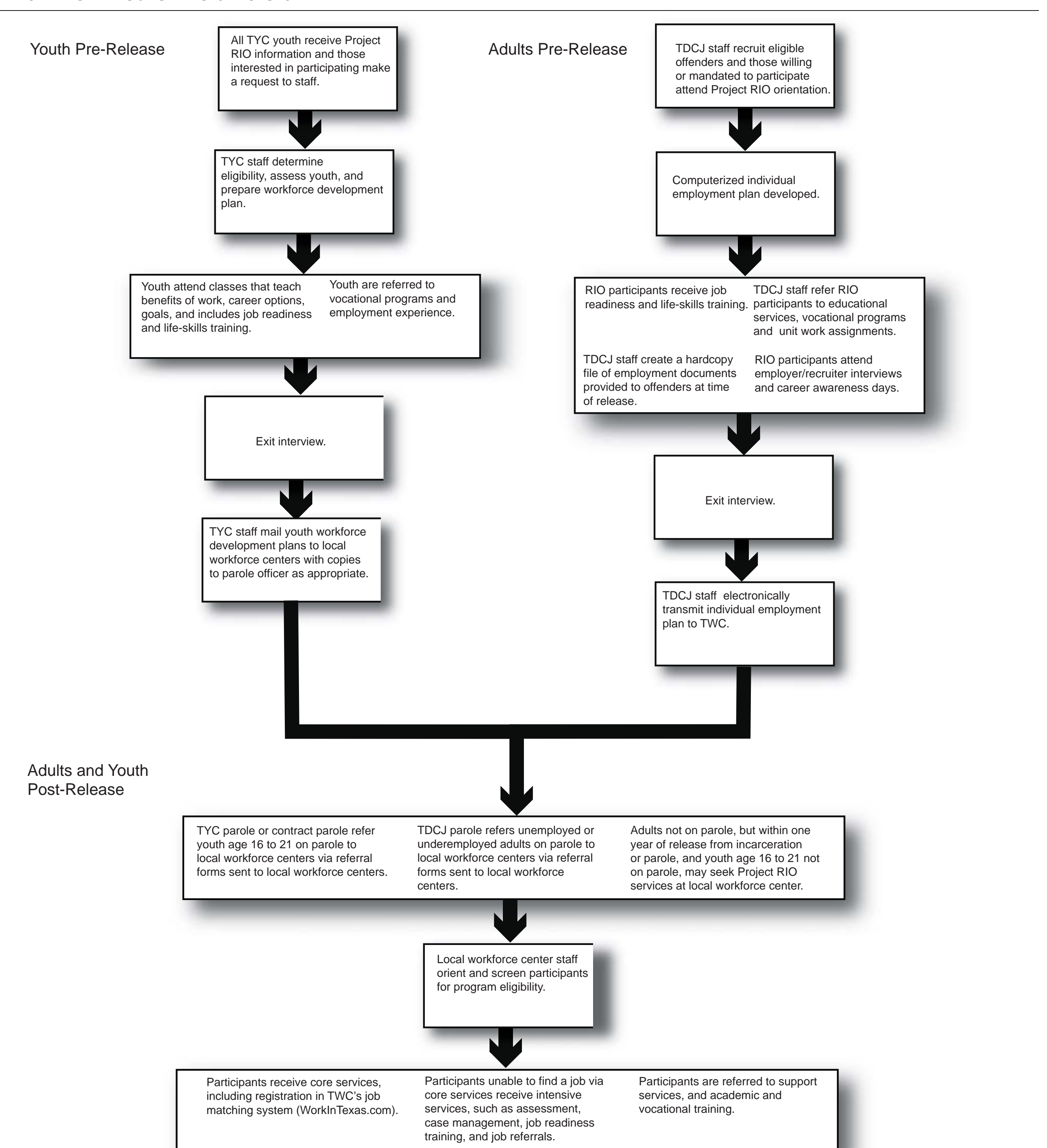
- **Recommendation 1:** Amend the Texas Labor Code to require the Texas Workforce Commission, in consultation with the Texas Department of Criminal Justice and the Texas Youth Commission, to evaluate the impact of the Project RIO data interface project on the delivery of Project RIO services and submit a report to the Governor and the Legislative Budget Board by August 31, 2008.
- **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Workforce Commission to develop a statewide performance measure for employment retention for participants who received post-release Project RIO services for inclusion in the Project RIO Strategic Plan.
- **Recommendation 3:** Amend the Texas Labor Code to require the Texas Workforce Commission to evaluate the delivery of post-release Project RIO services across the Local Workforce Development Boards, including a comparison of performance outcomes and delivery methods, to identify effective strategies that can be implemented in other areas, and require that Local Workforce Development Boards adopt those effective strategies, if appropriate, when providing post-release Project RIO services.
- **Recommendation 4:** Include a rider in the 2008–09 General Appropriations Bill that requires the Texas Department of Criminal Justice to implement methods to ensure that ex-offenders under parole supervision who are unemployed or underemployed are identified and referred to the workforce system to participate in post-release Project RIO services.

DISCUSSION

Project Re-Integration of Offenders (RIO), which began as a pilot program in 1985, is an interagency initiative that provides employment preparation services to adult offenders and adjudicated youth during and after incarceration. Project RIO is intended to reintegrate ex-offenders and adjudicated youth into the labor force, thus promoting public safety and reducing recidivism. Project RIO is jointly operated by the

Texas Workforce Commission (TWC), the Texas Department of Criminal Justice (TDCJ), and the Texas Youth Commission (TYC). Project RIO services are provided before release by TDCJ and TYC within their correctional facilities. Post-release Project RIO services are provided through cooperative agreements between TWC and the 28 Local Workforce Development Boards (LWDBs), which manage more than 270 local workforce centers. **Figure 1** shows the delivery of

FIGURE 1
DELIVERY OF PROJECT RIO SERVICES



SOURCE: Legislative Budget Board.

pre-release and post-release Project RIO services to adults and youth.

PROJECT RIO OPERATIONS AND SERVICES

As of October 2006, Project RIO services were available at 89 of TDCJ's 106 state-operated and private correctional units. The 17 facilities without Project RIO include psychiatric facilities, medical facilities, and certain state jails, transfer facilities, and substance abuse felony punishment facilities. Project RIO is administratively organized within the Windham School District (WSD) under the authority of the Texas Board of Criminal Justice. The Project RIO Administrator reports to the Continuing Education Division at WSD. Project RIO Workforce Specialists are housed at the correctional units and report to the WSD unit principal. Some units also have an administrative clerk assigned to assist the Project RIO Workforce Specialist. Each unit is expected to follow the Project RIO policy and procedures manual established by TDCJ.

Project RIO services are available at nine of the 12 TYC state schools. Project RIO services are also available to youth at two contract-care programs, and one halfway house. Project RIO is organized within the Education Department at TYC. Workforce Development Counselors are housed at the state schools and report to the school principal. Workforce Development Counselors are expected to administer Project RIO in accordance with the Workforce Development Curriculum and standard operating procedures manual established by TYC.

Post-release Project RIO services are provided by local workforce centers managed by LWDBs. TWC awards grants to LWDBs for provision of post-release Project RIO services. Although the grant awards include a statement of work that details general project requirements, each LWDB has discretion on program implementation, including development of standard operating procedures.

As shown in **Figure 2**, Project RIO participation requirements and eligibility criteria vary depending on whether participants

FIGURE 2
PROJECT RIO PARTICIPATION REQUIREMENTS AND ELIGIBILITY CRITERIA

	TEXAS DEPARTMENT OF CRIMINAL JUSTICE PRE-RELEASE SERVICES	TEXAS YOUTH COMMISSION PRE-RELEASE SERVICES	TEXAS WORKFORCE COMMISSION POST-RELEASE SERVICES
Participation Requirements	Voluntary*	Voluntary	Mandatory for unemployed and underemployed adults on parole Voluntary for unemployed or underemployed adults released from incarceration and not on parole Mandatory for youth released to parole who participated in pre-release Project RIO at Texas Youth Commission Voluntary for youth who did not participate in pre-release Project RIO at Texas Youth Commission
Eligibility Criteria	General population status offender unless enrolled in violent offender reentry program Appropriate classification status Willing, eligible, and able to work on assigned tasks Offender plans to reside in Texas post-release No pending felony charges No pending immigration-related deportation orders Be within 18 months of projected release, or within 36 months of projected release if under age 35	Age 16 or older Within 6 months of projected release No existing employment or training opportunities available after release Completed or in the process of completing high school diploma or GED Staff recommendation Facilities may have additional criteria related to safety and security concerns	Adult ex-offenders must be within one year after their release from incarceration or completion of parole term or be currently under parole supervision. Adjudicated youth are eligible until age 21.

*Certain offenders enrolled in academic and/or vocational programs are mandatory RIO participants. Also, refusing participation in Project RIO can have an adverse effect on the offender's parole date.
Sources: Texas Department of Criminal Justice; Texas Youth Commission; Texas Workforce Commission.

receive services at pre-release or post-release and whether the participants are adults or youth.

Project RIO services prepare adult offenders and adjudicated youth to successfully enter the labor force and maintain employment. The program provides a link between education, training and employment during incarceration and job placement and training programs provided through local workforce centers upon an offender's release. **Figure 3** shows the specific services that Project RIO participants may receive at TDCJ, TYC, and/or through the local workforce centers.

In general, the services available to Project RIO participants during their incarceration may include career assessment, development of an Individual Employment Plan, job-readiness training (e.g., interviewing skills), and collection of documents needed for employment (e.g., birth certificate). Post-release services provided by local workforce centers include a graduated level of workforce services to eligible ex-offenders and adjudicated youth based upon needs and barriers. Graduated services may include core, intensive, and training services. Core services are available through self-service or in a group setting, including registration with TWC's online job matching system WorkInTexas.com. Project RIO participants who cannot secure employment through core services receive intensive or training services to assist in obtaining employment. Intensive services may include case management, job counseling, development of an Individual Employment Plan if not previously completed at TDCJ or TYC, job readiness training, and job referrals and placement services. According to TWC, 95 percent of identified RIO participants received intensive services in state fiscal year 2005.

TDCJ and TYC both offer other education and workforce development programs in addition to Project RIO. Offenders housed at TDCJ have access to educational programming and services offered through the Windham School District. They may also participate in occupational training provided through the Career and Technology Education program and may obtain skills while performing jobs, such as in Texas Correctional Industries' manufacturing facilities and through the Prison Industry Enhancement Program. Similarly, incarcerated youth at TYC participate in year-round educational programs. TYC youth also have access to vocational and skills development through the Career and Technology Education program and employment experience through Campus Work Programs and the PIE Program.

FIGURE 3
PROJECT RIO SERVICES

TEXAS DEPARTMENT OF CRIMINAL JUSTICE PRE-RELEASE SERVICES	TEXAS YOUTH COMMISSION PRE-RELEASE SERVICES	TEXAS WORKFORCE COMMISSION POST-RELEASE SERVICES
Vocational aptitude and interest assessment Development of an Individual Employment Plan Job readiness training, such as resume development, job search skills, and interviewing skills Participation in Career Awareness Days Coordinate employer/recruiter interviews Life skills training Referrals to TDCJ educational, vocational, and job assignments Assistance with WorkInTexas.com registration Information about fidelity bonding and tax credit programs Development of a hardcopy file of employment documents provided to offenders at the time of release	Vocational aptitude and interest assessment Development of an Individual Employment Plan Job readiness training, such as resume development, job search skills, and interviewing skills Career and educational exploration, including career fairs Life skills training Information about fidelity bonding and tax credit programs Development of a hardcopy file of employment documents provided to youth at the time of release	Core services generally accessed through self-service or in a group setting, including registration with TWC's job matching system WorkInTexas.com Intensive services for Project RIO job seekers unable to secure employment through core services, such as: • Case management • Job counseling • Development of an Individual Employment Plan if not previously completed at TDCJ or TYC • Job readiness training, such as resume development, job search skills, and interviewing skills • Job referrals and placement services • Referrals to support services, and academic and vocational training Information about fidelity bonding and tax credit programs

Sources: Texas Department of Criminal Justice; Texas Youth Commission; Texas Workforce Commission.

Project RIO services are intended to complement these other education and workforce programs. For example, Project RIO staff at TDCJ refer offenders to educational services, vocational programs, and unit work assignments. Also, TDCJ work site supervisors contact Project RIO staff for assistance with identifying offenders whose skills match job site requirements. Project RIO helps incarcerated adults and youth compile their academic achievement, acquired vocational skills, and work experience and learn how to sell those skills to an employer or apply them to further training and/or education.

Post-release Project RIO services are fully integrated within the local workforce centers' service delivery system. LWDBs are required to ensure that other non-Project RIO employment and training activities available through the workforce service delivery system are provided to Project RIO participants as deemed appropriate by the local center. Local workforce centers may co-enroll adults and youth in both Project RIO and other appropriate programs, such as TANF CHOICES, Food Stamp Employment and Training, and Workforce Investment Act programs.

Funding for Project RIO is appropriated to TWC who retains a portion of the funding for post-release services and distributes funds through interagency contracts to TDCJ and TYC for pre-release services. As shown in **Figure 4**, the budget for Project RIO totaled $15.6 million for the 2006–07 biennium, including $14.7 million in General Revenue Funds and $0.9 million in Federal Funds. Of that amount, about $8.2 million was retained by TWC for post-release services, $6.5 million was allocated to TDCJ for pre-release services for adult offenders, and $0.9 million was allocated to TYC for pre-release services for adjudicated youth. Overall, Project RIO funding decreased slightly between the 2002–03 and 2006–07 biennia; however, TWC funding increased slightly during this period while the amounts allocated to TDCJ and TYC through interagency contract decreased.

According to TDCJ, funding reductions have resulted in a loss of full-time equivalents and reduced staffing levels at TDCJ correctional units with Project RIO services. Reduced staffing levels prevent all eligible offenders from participating in Project RIO and increase caseload size. TDCJ estimates there were 11,977 offenders released during the first six months of 2006 from both correctional units with and without Project RIO services who were eligible for Project RIO services, but did not receive services during incarceration due to limited resources. According to TDCJ, there are six state-operated correctional units where Project RIO services are appropriate, but are not available due to funding limitations. Similarly, TYC reports an inability to provide Project RIO services to all eligible youth due to funding limitations. Project RIO services are not available at three of the 12 TYC state schools.

As shown in **Figure 5**, 44.7 percent of adults released from TDCJ and 23.7 percent of youth released from TYC in state fiscal year 2005 participated in Project RIO while incarcerated. Reasons for non-participation include ineligibility, program refusals, and limited service provision due to resource limitations.

Figure 6 shows performance data for Project RIO reported in the Project RIO strategic plan during state fiscal year 2005. The number of Project RIO adult participants served by TDCJ in 2005 (i.e., 69,720) is greater than the number of releases served (i.e., 32,861) reported in **Figure 5** because the data in **Figure 6** includes persons who received services, but were not necessarily released during 2005. The number of Project RIO adults and youth registered at local workforce centers includes participants who self-registered, those who received assistance from local workforce center staff in registering, and those who had another external entity (e.g., TDCJ staff) assist with registration.

FIGURE 4
PROJECT RIO FUNDING 2002 TO 2007

	2002–03 BIENNIUM	2004–05 BIENNIUM	2006–07 BIENNIUM	FUNDING CHANGE FROM 2002–03 TO 2006–07
Total Budgeted	$15,675,261	$15,516,788	$15,599,379	($75,882)
Texas Workforce Commission	$8,003,845	$8,383,114	$8,187,409	$183,564
Texas Department of Criminal Justice Contract	$6,735,694	$6,302,816	$6,519,470	($216,224)
Texas Youth Commission Contract	$935,722	$830,858	$892,500	($43,222)

SOURCE: Legislative Budget Board.

FIGURE 5
PROJECT RIO PRE-RELEASE PARTICIPATION RATES, 2003 TO 2005

TEXAS DEPARTMENT OF CRIMINAL JUSTICE	ADULTS RELEASED	RELEASES SERVED	PARTICIPATION RATE
2003	72,666	27,823	38.3%
2004	75,931	35,458	46.7%
2005	73,525	32,861	44.7%
TEXAS YOUTH COMMISSION	**YOUTH RELEASED**	**RELEASES SERVED**	**PARTICIPATION RATE**
2003	3,949	1,113	28.2%
2004	3,413	995	29.2%
2005	3,523	835	23.7%

SOURCES: Texas Department of Criminal Justice; Texas Youth Commission.

FIGURE 6
PERFORMANCE DATA FOR PROJECT RIO REPORTED IN PROJECT RIO STRATEGIC PLAN, FISCAL YEAR 2005

ADULT OFFENDERS	2005
Project RIO adult participants served by Texas Department of Criminal Justice	69,720
Project RIO adult participants registered at local workforce centers	24,777
Percentage of Project RIO adult participants who obtained a job	76%
ADJUDICATED YOUTH	
Project RIO adjudicated youth served by Texas Youth Commission	835
Project RIO youth participants registered at local workforce centers	260
Percentage of Project RIO youth participants who obtained a job	80%

SOURCE: Texas Workforce Commission.

An analysis of Project RIO's effectiveness conducted by TWC found that adult ex-offenders that participated in Project RIO had higher rates of employment and lower rates of recidivism as compared to non-participants. The best outcomes were for adult ex-offenders who participated in Project RIO both during incarceration and after release. As shown in **Figure 7**, 40.3 percent of adult ex-offenders who participated in Project RIO during and after incarceration were employed five years after release as compared to 24 percent of adult ex-offenders who did not participate in Project RIO. Similarly, only 6 percent of adult ex-offenders who participated in both pre- and post-release Project RIO services recidivated three years after release compared to 25.4 percent of non-RIO participants. Although the analysis conducted by TWC is encouraging, the lack of a control group in the evaluation design makes it difficult to infer that the improved outcomes were causally linked to Project RIO participation.

FIGURE 7
PROJECT RIO EFFECTIVENESS AMONG ADULT OFFENDERS: 2001, 2003, AND 2005

	EMPLOYMENT RATE			RECIDIVISM RATE		
CATEGORY	2001	2003	2005	2001	2003	2005
Post-Release: Received Project Rio services only after release	49.5%	34.7%	34.0%	7.6%	11.7%	Not available
Pre-Release: Received Project Rio services only during incarceration	44.8%	33.7%	30.8%	4.6%	9.4%	Not available
Pre and Post: Received Project RIO services both before and after release	63.1%	46.0%	40.3%	2.1%	6.0%	Not available
Non-RIO: Did not receive Project RIO Services	32.3%	22.4%	24.0%	10.3%	25.4%	Not available

NOTE: TWC conducted the analysis based on data received from TDCJ on the total population released from TDCJ correctional units between July 1, 2000 and June 30, 2001 with valid social security numbers (i.e., approximately 49,000 records).
SOURCE: Texas Workforce Commission.

IMPROVE THE ACCOUNTABILITY AND SERVICE DELIVERY OF PROJECT RIO

There are four areas where the participating agencies could improve accountability and delivery of Project RIO pre- and post-release services: (1) data sharing; (2) performance reporting; (3) evaluation of post-release services; and (4) identification and referral of ex-offenders to the workforce system.

Data Sharing: Legislation passed by the Seventy-ninth Texas Legislature, Regular Session, 2005, directed TWC, TDCJ, and TYC to establish a data interface to allow the agencies to exchange detailed information about Project RIO participants. The intent of the improved data interface is to improve communication between the workforce and criminal justice systems. The data interface is under development and implementation is scheduled for completion by February 2007.

There is no requirement to evaluate the impact of the data interface project on the delivery of Project RIO services. The agencies are designing the data interface to address previously identified inefficiencies in program delivery. For example, under the current system, ex-offenders released from TDCJ who are not under supervision would have to self-identify as RIO participants. The data interface project will allow TWC to have electronic data on all ex-offenders. As a result, TWC anticipates serving ex-offenders not previously identified for Project RIO services. The lack of evaluation prevents the agencies from determining if the data interface project has improved communication and delivery of Project RIO services and from identifying additional areas for improvement. Recommendation 1 would amend the Texas Labor Code to require TWC, in consultation with TDCJ and TYC, to evaluate the impact of the Project RIO data interface project on the delivery of Project RIO services and submit a report to the Governor and the Legislative Budget Board by August 31, 2008.

Performance Reporting: Performance data reported in the Project RIO strategic plan and reported to the Legislative Budget Board includes data that allows for tracking the number of persons served and the number of persons who obtained employment. Project RIO performance data does not measure how long participants retain employment after using Project RIO services. Employment retention measures are reported for most programs administered through TWC, including TANF CHOICES, Employment Services, Trade Adjustment Assistance Program, and the Skills Development Fund. TWC asked LWDBs through cooperative agreements to report on employment retention for Project RIO for program year 2007. Recommendation 2 would include a rider in the 2008–09 General Appropriations Bill that requires TWC to develop a statewide performance measure that captures the employment retention rate for participants who received post-release Project RIO services, and to report on the employment retention rate in the Project RIO strategic plan.

The following Texas Workforce Commission rider language could be included in the 2008–09 General Appropriations Bill to implement Recommendation 2:

> **Project RIO Employment Retention Performance Measure.**
>
> The Texas Workforce Commission shall develop a statewide performance measure that captures the employment retention rate for participants who received post-release Project RIO services and report on the employment retention rate performance measure in the Project RIO strategic plan.

Evaluation of Post-Release Services: TWC enters into cooperative agreements with each of the 28 LWDBs for the delivery of post-release Project RIO services. The LWDBs operate post-release Project RIO services under broad administrative rules provided by TWC. Under the rules, the LWDBs determine the specific manner to deliver services. As a result, there is variation in the delivery of services across LWDBs. For example, a LWDB may develop standard operating procedures and forms specifically for use at the local workforce centers under its authority. Local control allows each LWDB to tailor the delivery of Project RIO services to accommodate local priorities and conditions. TWC does not track how Project RIO is implemented in each local area.

Certain LWDBs may have developed effective methods for delivery of post-release Project RIO services that could be replicated in other areas. However, TWC does not maintain information to identify effective methods for delivering post-release Project RIO services. Recommendation 3 would amend the Texas Labor Code to require TWC to evaluate the delivery of post-release Project RIO services across LWDBs, including a comparison of performance outcomes and delivery methods, to identify effective strategies that can be implemented in other areas, and require that LWDBs adopt those effective strategies, if appropriate, when providing post-release Project RIO services.

Identification and Referral of Ex-Offenders to the Workforce System: Participation in post-release Project RIO services is mandatory for all ex-offenders who are under supervision at a TDCJ District Parole Office and who are either unemployed, underemployed, or with special employment needs. Determination of underemployment is under the discretion of local parole management; however, once a determination of underemployment has been made, the local parole office is mandated to refer the ex-offender to the local workforce center.

TDCJ has taken steps to ensure that ex-offenders under parole supervision who are unemployed or underemployed are referred to the workforce system to receive Project RIO services. For example, unit supervisors and TDCJ's Internal Review section periodically conduct quality reviews to determine if staff have followed policy. TDCJ indicates that they are also in the process of developing reports to help ensure that ex-offenders are referred to Project RIO. Recommendation 4 would include a rider in the 2008–09 General Appropriations Bill that requires TDCJ to implement methods to ensure that ex-offenders under parole supervision who are unemployed or underemployed are identified and referred to the workforce system to participate in post-release Project RIO services. This recommendation will help ensure that TDCJ implements reports currently under development and implements additional controls to identify unemployed and underemployed ex-offenders. For example, TDCJ could consider developing and implementing a standard assessment instrument for use in determining if an ex-offender is underemployed.

The following Texas Department of Criminal Justice rider language could be included in the 2008–09 General Appropriations Bill to implement Recommendation 4:

> **Project RIO Referrals.**
>
> The Texas Department of Criminal Justice shall implement methods to ensure that offenders under parole supervision who are unemployed or underemployed are identified and referred to local workforce centers to participate in post-release Project RIO services.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations in this report have no direct impact on General Revenue Fund appropriations during the 2008–09 biennium. The recommendations direct TWC, TDCJ, and/or TYC to implement improvements to improve accountability and delivery of Project RIO pre- and post-release services. The intent of the recommendations is to improve the operation of Project RIO, thus contributing to higher post-confinement employment rates, reduced recidivism, and long-term cost savings. It is estimated that the recommendations would have no significant fiscal impact because they could be implemented using existing resources.

The introduced 2008–09 General Appropriations Bill includes riders to implement Recommendations 2 and 4. The introduced 2008–09 General Appropriations Bill does not address Recommendations 1 and 3.

UPDATE ON JUVENILE JUSTICE ALTERNATIVE EDUCATION PROGRAMS

The Seventy-fourth Legislature, Regular Session, 1995, created juvenile justice alternative education programs to address serious juvenile behavioral problems in Texas public schools. These programs provide educational services to juvenile offenders and at-risk youth who are expelled from regular or disciplinary alternative education program classrooms. Program participants include mandatory, discretionary, and other expulsions. The state provides funding for mandatory students in the programs at $59 per student attendance day.

FACTS AND FINDINGS

- ♦ Texas Education Code, Chapter 37.011, requires a juvenile justice alternative education program to focus on English, language arts, mathematics, science, social studies, and self-discipline. Most programs provide additional services which vary among school districts. These services include family, group and individual counseling, military-style training, substance abuse counseling, and parenting classes for parents of program youth.

- ♦ Juvenile justice alternative education programs are mandated in counties with populations greater than 125,000. There are mandatory programs in 27 Texas counties. Counties with populations between 72,000 and 125,000 have the option of operating voluntary or mandatory programs. Counties with a population less than 72,000 may only operate voluntary programs. If a less populous county operates a voluntary program, it is not subject to Juvenile Probation Commission approval, nor held to the same standards as mandatory programs. Voluntary programs are also not eligible for funding at $59 per student attendance day, but may receive state grant funding. During the 2005–06 school year, seven counties operated voluntary programs.

- ♦ The state provides funding for mandatory students in mandatory juvenile justice alternative education programs at $59 per student attendance day. The Juvenile Probation Commission reports that actual costs ranged from $69 to $254 per student attendance day during the 2004–05 school year. The average was $126 per student attendance day.

- ♦ During the 2004–05 school year, mandatory students in juvenile justice alternative education programs were 59 percent Hispanic, 24 percent white, 15 percent black, and 2 percent other race/ethnicity. Students were 78.5 percent male and 21.5 percent female. Felony drug offenses accounted for 48 percent of mandatory participants. Eighteen percent were expelled for possession of prohibited weapons; 3 percent for possession of firearms; and 31 percent for all other offenses. Thirty-four percent of students were mandatory expulsions, 59 percent were discretionary expulsions, and 7 percent were in the program for other reasons.

- ♦ The mandatory juvenile justice alternative education program student population grew every year since the 1998–99 school year, when 1,207 juveniles were placed in these programs. The amount more than doubled by the 2004–05 school year to 2,445. Overall, the mandatory student population increased by an average of 11.7 percent since the 1998–99 school year. The mandatory student population is expected to increase from 2,593 in the 2005–06 school year to 3,280 in the 2010–11 school year. During the projection period, the population of mandatory students is projected to increase each school year from 2006–07 through 2010–11 at an annual rate of 4.8 percent.

- ♦ The juvenile justice alternative education program mandatory student attendance days increased from 67,878 in the 1998–99 school year to 128,057 in the 2005–06 school year, a difference of 88.7 percent. Mandatory student attendance days are projected to increase to 131,153 in the 2006–07 school year, and gradually increase to 140,478 by the 2010–11 school year at an annual rate of 1.9 percent.

DISCUSSION

The Seventy-fourth Legislature, Regular Session, 1995, created juvenile justice alternative education programs (JJAEPs) to address serious juvenile behavioral problems in Texas public schools. JJAEPs provide educational services to juvenile offenders and at-risk youth expelled from regular or disciplinary alternative education program classrooms. Texas Education Code, Chapter 37.011, requires a JJAEP to focus

on English, language arts, mathematics, science, social studies, and self-discipline. Most JJAEPs provide additional services which vary among school districts. The primary academic and programmatic standards that must be followed by all JJAEPs are shown in **Figure 1**.

The Texas Education Code mandates that the juvenile board of a county with a population greater than 125,000 develop a JJAEP subject to the approval of the Juvenile Probation Commission (JPC). Counties with a population less than 125,000 have the option of creating a program.

Students in a JJAEP fall into one of three categories of placement: mandatory expulsion, discretionary expulsion, and other students. The Seventy-fifth Legislature, Regular Session, 1997, outlined criteria for mandatory and discretionary expulsion from public schools. "Mandatory" expulsion occurs when a student engages in serious criminal offenses on school property or at a school-related function. "Discretionary" expulsion occurs when a student engages in less serious criminal offenses on school property or at a school-related function, or serious criminal offenses that occur off school property. "Other" students attend JJAEPs because they were either ordered to do so by a juvenile court judge or placed there through an agreement with the local school district. The *Juvenile Justice Alternative Education Programs Performance Assessment Report, School Year 2004–2005*, a joint report from JPC and the Texas Education Agency (TEA) submitted in May 2006, provides that in the 2004–05 school year, 34 percent of students were mandatory expulsions, 59 percent were discretionary expulsions, and 7 percent were in JJAEPs for other reasons.

The Texas Education Code, Chapter 37.007 defines mandatory expulsion by stating that a student shall be expelled from school if the student, on school property or while attending a school-sponsored or school-related activity on or off of school property engages in any of the following offenses, as defined by the Penal Code:

- uses, exhibits, or possesses a firearm, illegal knife, club or weapon
- engages in conduct that contains the elements of the offense of:
  - aggravated assault, sexual assault, or aggravated sexual assault;
  - arson, murder, capital murder, or criminal attempt to commit murder or capital murder;
  - indecency with a child
  - aggravated kidnapping
  - aggravated robbery
  - manslaughter or criminally negligent homicide
  - retaliation
- sells, gives, or delivers to another person, or possesses, or uses, or is under the influence of marihuana, a controlled substance, a dangerous drug, or an alcoholic

FIGURE 1
STATUTORY REQUIREMENTS OF JJAEPS

- The statutorily established academic mission of the JJAEP is to enable students to perform at grade level pursuant to Texas Education Code §37.011(h);
- JJAEPs are required to operate seven hours per day for 180 days per year pursuant to Texas Education Code §37.011(f);
- JJAEPs must focus on English/language arts, mathematics, sciences, social studies and self-discipline but are not required to provide a course necessary to fulfill a student's high school graduation requirements pursuant to Education Code §37.011(d);
- JJAEPs must adopt a student code of conduct pursuant to Texas Education Code §37.011(c)
- The juvenile board must develop a written JJAEP operating policy and submit it to JPC for review and comment pursuant to Education Code §37.011(g);
- JJAEPs must adhere to the minimum standards set by JPC and found in Title 37, Texas Administrative Code Chapter 348 pursuant to Texas Education Code §37.011(h) and Texas Human Resources Code §141.042(6). JJAEPs are required by these standards to have one certified teacher per program and an overall instructional staff-to-student ratio of no more than 1 to 24. Instructional staff must have a Bachelor's degree from a four-year accredited university. Additionally, the operational staff-to-student ratio is required to be no more than 1 to 12; and
- The juvenile board or the board's designee shall regularly review a JJAEP student's academic progress. For high school students, the review shall include the student's progress towards meeting high school graduation requirements and shall establish a specific graduation plan per Texas Education Code §37.011(d).

Sources: Juvenile Probation Commission; Texas Education Agency.

beverage, or commits a serious act or offense while under the influence of alcohol. This conduct requires mandatory expulsion if the conduct is punishable as a felony.

The code also outlines discretionary expulsion criteria, which include:

- sells, gives, or delivers to another person, or possesses, uses, or is under the influence of marihuana, a controlled substance, dangerous drugs, or alcohol, when punishable as a misdemeanor
- possession of a volatile chemical (inhalant)
- assault of a school district employee or volunteer
- deadly conduct
- mandatory expulsion offenses that are committed within 300 feet of school property
- aggravated robbery, aggravated assault, sexual assault, aggravated sexual assault, murder, capital murder, attempted murder or attempted capital murder that occurs off campus against another student
- terroristic threat
- felony criminal mischief, or
- serious or persistent misbehavior while in a Disciplinary Alternative Education Program

The General Appropriations Act (2006–07 biennium), Rider 12, page V–35, mandates that JJAEPs be held accountable by JPC and TEA. The agencies are to prepare a joint report regarding the performance of JJAEPs to be submitted to the Governor and the Legislative Budget Board in May of the first year of the biennium.

JJAEP FUNDING AND COSTS

The majority of funding for JJAEPs is from local tax revenues that flow through school districts and county commissioners' courts. State funding for JJAEPs is provided through JPC to local juvenile boards. A total of $17.1 million in Foundation School Funds (General Revenue Account No. 193) was appropriated in the General Appropriations Act for JJAEPs for the 2006–07 biennium. These funds are transferred via interagency contract from TEA to JPC.

The General Appropriations Act (2006–07 Biennium), Rider 9, page V–34, mandates that JPC distribute funds to counties required by statute to provide JJAEPs at the rate of $59 per student attendance day for mandatory expulsions. Counties with populations between 72,000 and 125,000 have the option of operating voluntary or mandatory JJAEPs. If a county provides a mandatory JJAEP, it becomes eligible for the same $59 per student attendance day as the more populous counties. If a less populous county operates a voluntary JJAEP, it is not subject to JPC approval, nor held to the same standards as mandatory counties. It is also not eligible for funding at $59 per student attendance day. The rider provides that JPC set aside $0.5 million in each year of the biennium for grant funding for mandated and non-mandated counties, should those counties choose to apply for additional funds. Counties between 72,000 and 125,000 that elect to operate a voluntary JJAEP are eligible to apply for this grant funding only. Counties with a population less than 72,000 may operate a JJAEP, but are only eligible for state grant funding.

The General Appropriations Act (2006–07 Biennium), Rider 9, page V–34, further states that JPC may expend any remaining funds for summer school programs in mandated counties for any student assigned to a JJAEP. Summer school expenditures may not exceed $3.0 million per year. The allocated funds for JJAEPs are not intended as an entitlement, and are limited to the amounts transferred from the Foundation School Fund No. 193. The $59 per student attendance day amount may vary depending on the amount of mandatory students attending JJAEPs. JPC may reduce, suspend, or withhold JJAEP funding from counties that do not comply with standards, accountability measures, or Texas Education Code Chapter 37.

JPC reports that the appropriation provided for JJAEP reimbursement is less than the actual average cost per mandatory student attendance day. The *Juvenile Justice Alternative Education Programs Performance Assessment Report, School Year 2004–2005* dated May 2006, states that the range for the 2004–2005 school year was $69 to $254 per student attendance day. The average was $126 and the median was $107 per mandatory student attendance day for the 2004–05 school year.

JPC requested as an exceptional item in its 2008–2009 Legislative Appropriations Request that the cost per mandatory student attendance day in JJAEPs be increased from $59 to $90. The agency's justification for the exceptional item request is that JJAEP students have a multitude of social service needs. The agency reports that "JJAEPs provide a variety of services including individual, group and family

counseling, substance abuse counseling, life skills classes, mental health evaluations and cognitive skills training."

Based on TEA data, the cost per student attendance day for public school education averages $35. This cost includes special programming and operating expenses based on a 180-day school year. The additional cost of JJAEPs may be related to its smaller scale and the additional services provided.

JJAEP PROGRAMS AND SERVICES

JJAEPs vary in size according to the population of their county. JJAEPs cannot refuse to accept a student who received a mandatory expulsion, even if the program is functioning at capacity. Most JJAEPs manage this problem by reducing student lengths-of-stay in the program, or by limiting the amount of non-mandatory students they accept.

There are mandatory JJAEPs in the following 27 Texas counties:

Bell	Denton	Jefferson	Tarrant
Bexar	El Paso	Johnson	Taylor
Brazoria	Fort Bend	Lubbock	Travis
Brazos	Galveston	McLennan	Webb
Cameron	Harris	Montgomery	Wichita
Collin	Hays	Nueces	Williamson
Dallas	Hidalgo	Smith	

Counties with a population less than 125,000 may elect to develop a JJAEP. Currently, state funds support seven counties with voluntary JJAEPs. This group was awarded $0.3 million in grants for voluntary JJAEPs in the 2005–06 school year.

Atascosa	Hardin	Hopkins	Karnes/Wilson
Hale	Hill	Houston	

The Texas Education Code, Chapter 37.011, specifies that a JJAEP must focus on English, language arts, mathematics, science, social studies, and self-discipline. Most JJAEPs provide additional services, which vary among school districts. JPC staff requested that all JJAEP administrators categorize their programs as one of the following models:

- Military component: includes drill instructors, military uniforms, physical training, military-style discipline, drill, or regiment
- Therapeutic model: places a heavy emphasis on counseling and behavior management
- Traditional school model: patterned after a regular, independent school district setting

JPC reports that in the 2004–05 school year, three JJAEPs incorporated the therapeutic model (11 percent); eight the military model (31 percent); and 15 the traditional school model (58 percent). **Figure 2** shows the services provided in JJAEPs in the 2004–05 school year.

JJAEP DEMOGRAPHICS

Subsequent references to school years in this text will only refer to the second year of the school term.

Hispanics constituted more than one-half of JJAEP placements since the program's inception. Hispanic students accounted for 54.2 percent of all students in JJAEPs during the 1999 school year. The proportion gradually increased to 56.2 percent during 2002. Since 2002, Hispanic students have accounted for 59 percent of all students in JJAEPs. Data shows the Hispanic student population in JJAEPs has increased every year.

The proportion of white students increased between 1999 (24.9 percent) and 2001 (28.2 percent). Between 2001 and 2004, the proportion of white students decreased from 27.3 percent to 23.6 percent. The proportion of white students slightly increased to 23.7 percent in 2005. The 2000 Census indicated that white juveniles ages 12 to 18 accounted for 46 percent of all juveniles in that age category. Compared with white juveniles in the general population ages 12 to 18, the white student population in JJAEPs is relatively small.

The proportion of black students declined between 1999 and 2001. While 19.3 percent of the student population in 1999 was black, the proportion decreased to 15.4 percent in 2001. Since 2001, the proportion of black students has stabilized around 15 percent.

Students from other racial/ethnic groups made up less than 2 percent of the total student population between 1999 and 2005. **Figure 3** shows this data.

The majority of mandatory JJAEP students are males. The proportion of male students decreased from 85.6 percent in 1999 to 78.5 percent in 2005. The proportion of female students gradually increased from 14.4 percent in 1999 to 21.5 percent in 2005.

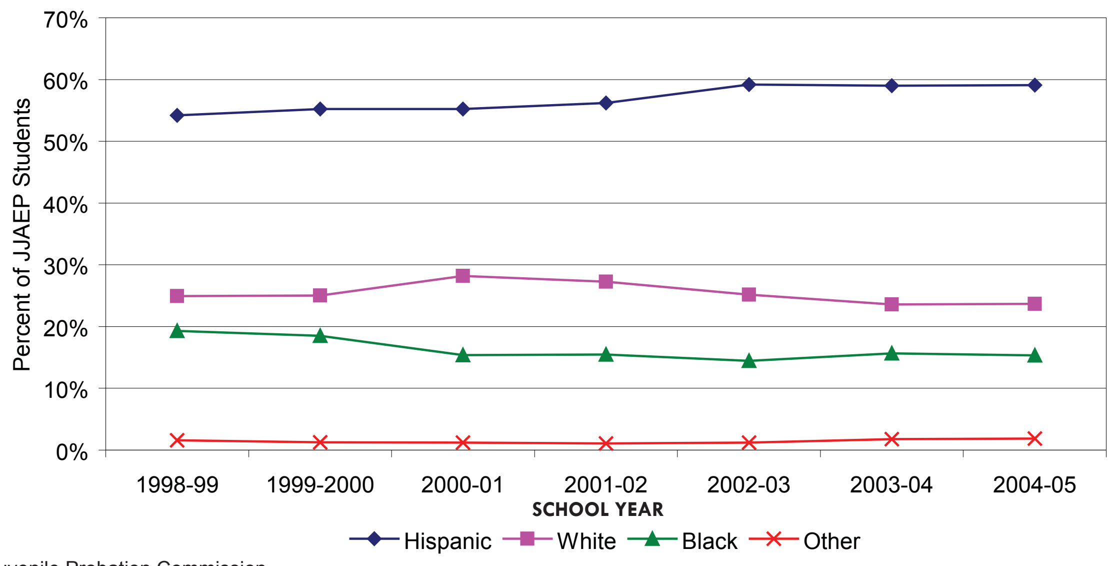
Eight of every ten mandatory JJAEP students are between age 13 and 17. This age group accounted for 89.5 percent of all mandatory JJAEP students in 1999, while the proportion

FIGURE 2
SERVICES AND APPROACHES PROVIDED BY JJAEPS, SCHOOL YEAR 2004–2005

SERVICES AND PROGRAMMING OFFERED	MILITARY COMPONENT	THERAPEUTIC MODEL	TRADITIONAL SCHOOL MODEL	TOTAL	PERCENTAGE
Life skills training	8	3	14	25	96%
Drug/alcohol prevention/intervention	8	3	14	25	96
Individual counseling	8	3	12	23	88
Substance abuse counseling	8	3	12	23	88
Community service	7	3	11	21	81
Group counseling	6	3	10	19	73
Anger management programs	6	3	10	19	73
Tutoring or mentoring	4	3	9	16	62
Family counseling	6	1	8	15	58
Mental health evaluation	6	3	5	14	54
Physical training or exercise program	8	0	5	13	50
Vocational training/job preparation	5	1	6	12	46
Immediate punishment for infractions	6	0	5	11	42
Parenting programs for student's parents	3	1	6	10	38
Drill instructors as staff	8	0	2	10	38
Military drill and ceremonies	7	0	1	8	31
Experiential training	2	2	3	7	27
Military-style uniforms for staff	6	0	1	7	27
Military-style uniforms for students	7	0	0	7	27
Other	2	0	4	6	23
Service learning	1	2	1	4	15%

Sources: Juvenile Probation Commission; Texas Education Agency.

FIGURE 3
JJAEP MANDATORY PLACEMENT BY RACE/ETHNICITY, SCHOOL YEARS 1998–99 TO 2004–05



Source: Juvenile Probation Commission.

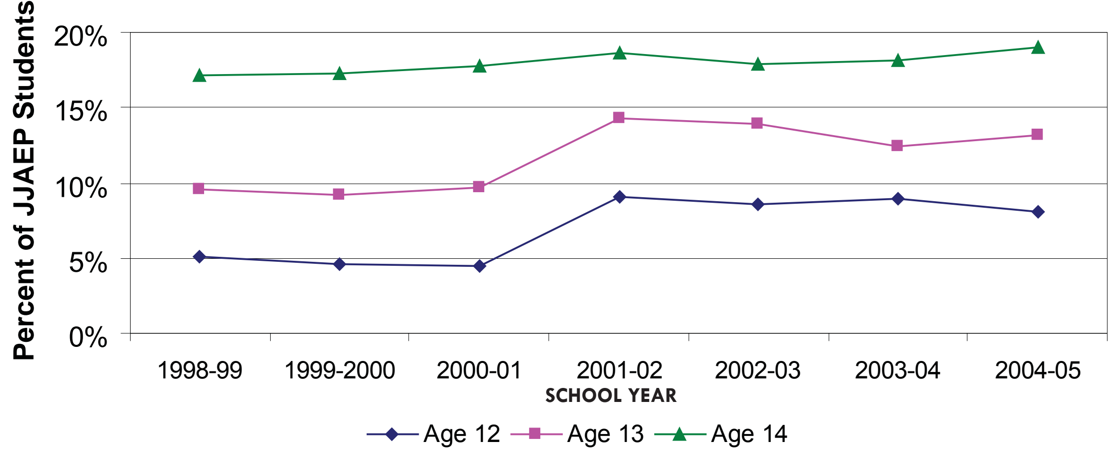
decreased to 87.3 percent in 2004. In the most recent school year for which age-related data is available (2005), the group accounted for 88.2 percent of all mandatory JJAEP students. **Figure 4** and **Figure 5** show this data.

The 16-year-old mandatory JJAEP students accounted for the single largest age group between 1999 and 2001. The proportion increased every school year during this period, ranging from 21.9 percent to 25.2 percent. Since 2001, the 15-year-old mandatory JJAEP students have accounted for the single largest age group, with the proportion ranging from 23.7 percent to 24.9 percent. In general, the 15 and 16-year-old students have accounted for over 40 percent of the mandatory JJAEP student population since 1999.

Offenses which require mandatory expulsion are stated in the Texas Education Code, §37.007. A distinction is made between firearms, illegal knives, clubs, and prohibited weapons. A prohibited weapon is defined in Penal Code §46.05 as one of the following:

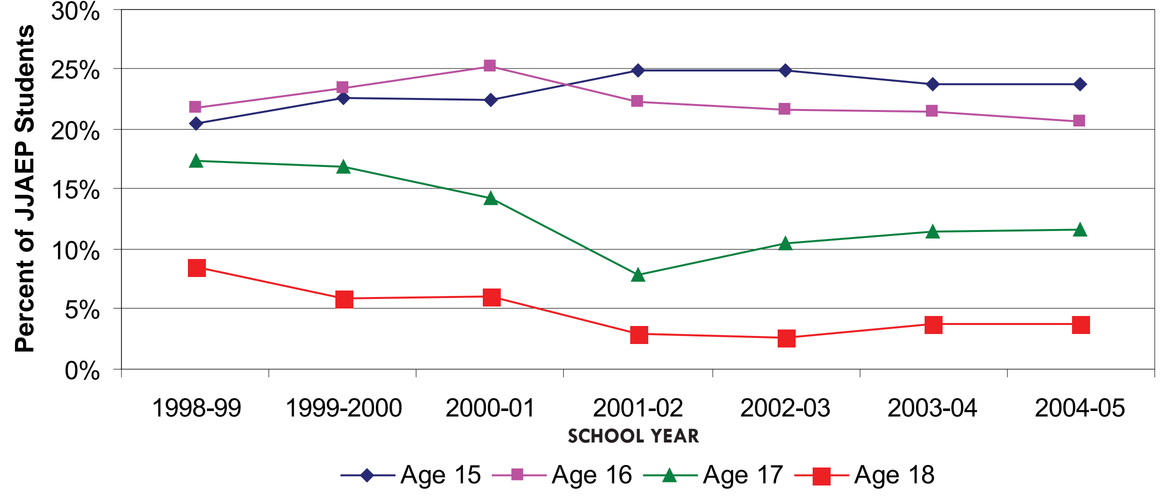
- an explosive weapon
- a machine gun
- a short-barrel firearm
- a firearm silencer
- a switchblade knife
- knuckles
- armor-piercing ammunition
- a chemical dispensing device
- a zip gun

FIGURE 4
MANDATORY PLACEMENT OF JJAEP STUDENTS AGE 12 TO 14, SCHOOL YEARS 1998–99 TO 2004–05



Source: Juvenile Probation Commission.

FIGURE 5
MANDATORY PLACEMENT OF JJAEP STUDENTS AGE 15 TO 18, SCHOOL YEARS 1998–99 TO 2004–05



Source: Juvenile Probation Commission.

The five most frequent offenses resulting in mandatory expulsion and placement in a JJAEP from 1995 to 2005 were felony drug possession, possession of a prohibited weapon, aggravated assault, possession of an illegal knife, and possession of a firearm. These five offenses comprise more than eight of every 10 offenses that have led to the mandatory placement of juveniles in JJAEPs. While the proportion of these five offenses decreased from 91.8 percent in 1999, they still constitute 88.8 percent of all offenses in 2005. **Figure 6** shows this data.

An important trend in these offenses is the proportion of felony drug offenses increased from 35.8 percent in 1999 to 48.3 percent in 2005. Currently, almost 50 percent of JJAEP mandatory placements are the result of felony drug offenses.

The proportion of juveniles placed in JJAEPs for possession of firearm or illegal knife offenses declined since 1999. Possession of firearms accounted for 11.4 percent of all offenses in 1999 but decreased to 3.4 percent in 2005. The proportion of placements due to the possession of prohibited weapons gradually increased since 1999 from 15.6 percent to 18 percent in 2005.

POPULATION TRENDS AND PROJECTIONS

Projections of mandatory JJAEP student populations were made using three datasets: Texas State Data Center population projections, public school enrollment compiled by TEA, and mandatory JJAEP student population data provided by JPC.

1. *Texas State Data Center Projections.* The Texas State Data Center population projections of juveniles in Texas ages 12 to 18 from 2000 to 2011 are based on the 0.5 migration scenario. The 0.5 migration scenario assumes one-half the net migration rates that existed in the 1990s. It further assumes a slower but steady growth of the population than what occurred during the 1990–2000 period. The population of the 12 to 18-year group is projected to increase until 2008, and to decline each year through 2011. The projected decline in the juvenile population from 2009 to 2011 is mainly caused by a decrease in the white and black juvenile population for this age group and a relatively slow growth of the Hispanic juvenile population.
2. *Public School Enrollment Data.* The data for public school enrollment in Texas for grades 7 to 12 from 1999 to 2006 was provided by TEA. The enrollment for grades 7 to 12 in Texas public schools increased every year since 1999. The current rate of growth is projected to continue.
3. *Mandatory JJAEP Placements.* Data for the mandatory JJAEP student population from 1999 to 2006 was obtained from JPC. The historical data shows the mandatory JJAEP student population has increased every year since 1999.

FIGURE 6
OFFENSES LEADING TO MANDATORY JJAEP PLACEMENT, SCHOOL YEARS 1998–99 TO 2004–05

SOURCE: Juvenile Probation Commission.

Legislative Budget Board staff computed the proportions of the general population of ages 12 to 18 years that were in grades 7 to 12 from the 2000 school year to the 2006 school year. The same method was used to obtain proportions for JJAEP placements from the public school enrollment.

The proportion obtained for public school enrollment was multiplied by the State Data Center projection for 2007 to derive the public school enrollment for the 2007 school year. The process continued for each year through the 2011 school year to derive the projected amount for public school enrollment.

The projection of JJAEP placements used a similar method. For this projection, the proportions for JJAEP placements were multiplied by the projected public school population.

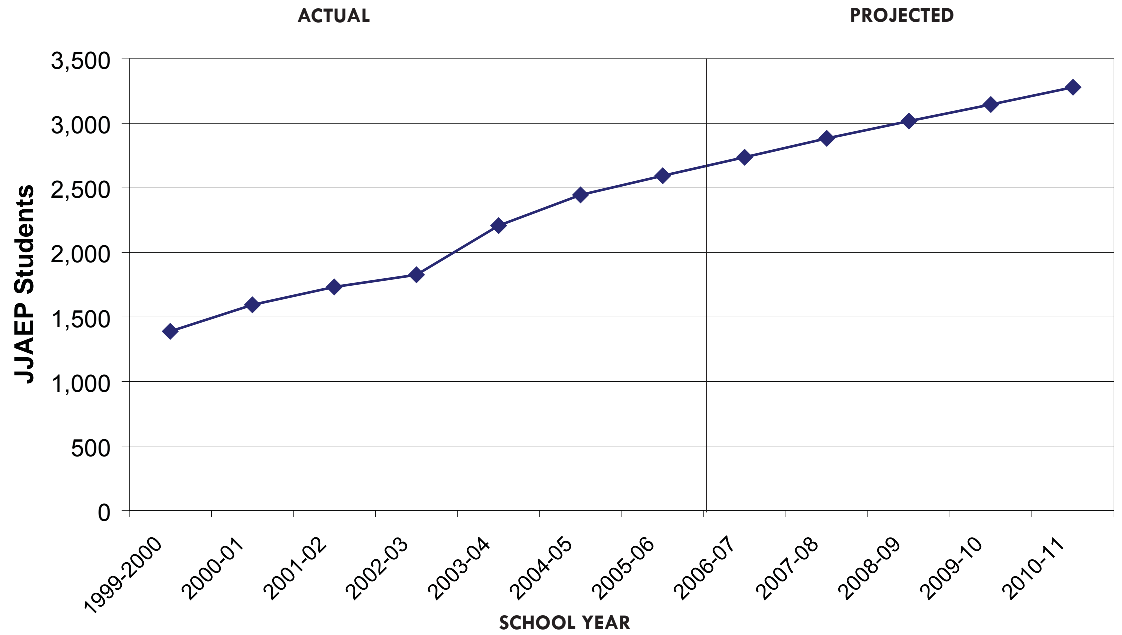
Historical and projected JJAEP mandatory student populations are shown in **Figure 7** and **Figure 8**. The mandatory JJAEP student population grew every year since 1999, when 1,207 juveniles were placed in JJAEPs. The amount more than doubled by 2005 to 2,445 and the preliminary estimate indicates that the amount for 2006 will be 2,593. The greatest increase of 21 percent occurred during the 2004 school year. The most current data from 2006 indicates that the mandatory JJAEP student population

FIGURE 7
ACTUAL AND PROJECTED MANDATORY JJAEP STUDENTS, SCHOOL YEARS 1998–99 TO 2010–11

SCHOOL YEAR	JJAEP PLACEMENTS	CHANGE
1998–99	1,207	---
1999–2000	1,388	15.0%
2000–01	1,593	14.8
2001–02	1,732	8.7
2002–03	1,826	5.4
2003–04	2,209	21.0
2004–05	2,445	10.7
2005–06	2,593	6.1
2006–07	***2,737***	***5.6***
2007–08	***2,884***	***5.4***
2008–09	***3,016***	***4.6***
2009–10	***3,145***	***4.3***
2010–11	***3,280***	***4.3***
Annual Average Growth (2006–07 to 2010–11)		*4.8%*

SOURCES: Legislative Budget Board; Texas State Data Center; Juvenile Probation Commission; Texas Education Agency.

FIGURE 8
ACTUAL AND PROJECTED MANDATORY JJAEP STUDENT POPULATION, SCHOOL YEARS 1998–99 TO 2004–05



SOURCES: Legislative Budget Board; Texas State Data Center; Juvenile Probation Commission; Texas Education Agency.

increased by 6.1 percent. Overall, the mandatory JJAEP student population increased by an average of 11.7 percent since 1999.

The mandatory JJAEP student population is expected to increase from 2,593 in 2006 to 3,280 in 2011. During the projection period, the population of the mandatory JJAEP students is expected to increase each school year from 2006 to 2011 at an annual rate of 4.8 percent.

Mandatory student attendance days determine funding allocations provided by JPC to counties mandated to operate JJAEPs. **Figure 9** shows total mandatory student attendance days for all JJAEPs from 1999 through the 2006 school year. The total school attendance days for all JJAEP mandatory students have increased every year since 1999, with most of the increases being after 2003.

Students completed 67,878 mandatory student attendance days in 1999 compared with 81,607 in 2001. This is an increase of 20.2 percent for the two-year duration. The next two-year duration from 2001 to 2003 indicated a slower increase of 9.1 percent in mandatory student attendance days. Students completed 89,022 mandatory student attendance days during 2003, as shown in **Figure 10**.

The greatest increase in mandatory student attendance days occurred between 2003 and 2005. Students completed 128,057 mandatory student attendance days during the 2006 school year. This is an increase of 43.8 percent for the three-year duration. JJAEP mandatory student attendance days increased from 67,878 in 1999 to 128,057 in 2006, a difference of 88.7 percent.

Mandatory student attendance days are projected to increase to 131,153 in 2007, and gradually increase to 140,478 by 2011. During the projection period, mandatory student attendance days will increase at an annual rate of 1.9 percent.

Most mandatory student attendance days can be attributed to five counties: Harris, Dallas, Bexar, Tarrant, and Hidalgo. **Figure 11** shows historically the amount of mandatory student attendance days throughout these five counties.

In 1999, the five counties with the highest proportion of mandatory school attendance days accounted for 56.6 percent. The proportion increased to 60.8 percent in 2006.

Harris County recorded an increase of 233.6 percent in mandatory student attendance days between 1999 and 2006. Mandatory student attendance days in Harris County increased by 178 percent between 2003 and 2006. This increase is significantly higher than other counties.

Dallas County recorded an increase of 130 percent in mandatory student attendance days between 1999 and 2006. Mandatory student attendance days in Dallas County

FIGURE 9
JJAEP TOTAL MANDATORY STUDENT ATTENDANCE DAYS, SCHOOL YEARS 1998-99 TO 2010–11

SOURCE: Legislative Budget Board; Juvenile Probation Commission.

FIGURE 10
ACTUAL AND PROJECTED JJAEP MANDATORY STUDENT ATTENDANCE DAYS, SCHOOL YEARS 1998–99 TO 2010–11

SCHOOL YEAR	JJAEP ATTENDANCE DAYS	CHANGE
1998–99	67,878	---
1999–2000	73,830	8.8%
2000–01	81,607	10.5%
2001–02	83,036	1.8%
2002–03	89,022	7.2%
2003–04	108,138	21.5%
2004–05	124,562	15.2%
2005–06	128,057	2.8%
2006–07	***131,153***	***2.4%***
2007–08	***134,209***	***2.3%***
2008–09	***136,416***	***1.6%***
2009–10	***138,370***	***1.4%***
2010–11	***140,478***	***1.5%***
Annual Average Growth (2006–07 to 2010–11)		*1.9%*

SOURCES: Legislative Budget Board; Texas State Data Center; Juvenile Probation Commission; Texas Education Agency.

increased by 74.9 percent between 2003 and 2006, but decreased by 1.0 percent between 2005 and 2006.

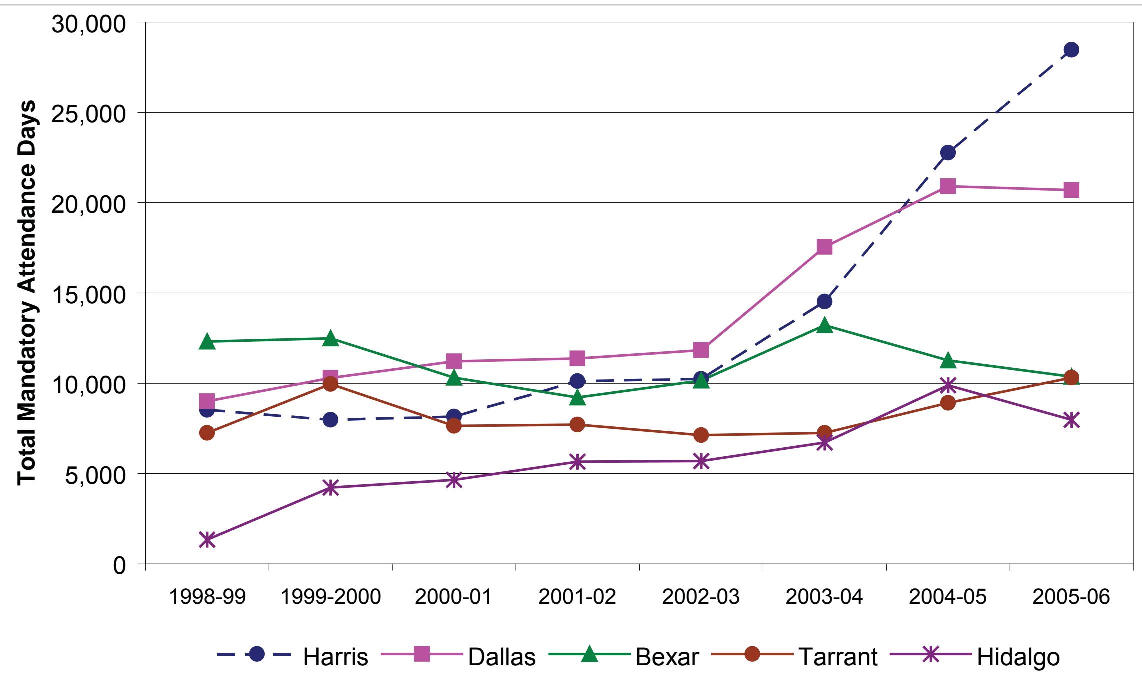
Bexar County recorded a decrease of 15.7 percent in mandatory student attendance days between 1999 and 2006. Bexar County recorded a 2.1 percent increase in mandatory student attendance days between 2003 and 2006, but had a decrease of 7.9 percent between 2005 and 2006.

Tarrant County's mandatory student attendance days increased by 42.3 percent between 1999 and 2006. The mandatory student attendance days in Tarrant County decreased between 2002 and 2004, but have increased over the last two school years.

Hidalgo County recorded the largest increase, 496.4 percent, in mandatory student attendance days between 1999 and 2006. Mandatory student attendance days in Hidalgo County increased by 40.1 percent between 2003 and 2006.

The information in this report indicates that JJAEPs provide a variety of programs, including educational services, to youth who commit criminal acts in a school setting. This population of students presents a challenge to educators. These programs provide an alternative setting for student learning when such behaviors prevent youth from attending school in a regular setting.

FIGURE 11
JJAEP MANDATORY STUDENT ATTENDANCE DAYS IN THE TOP FIVE COUNTIES, SCHOOL YEARS 1998–99 TO 2010–11



SOURCE: Juvenile Probation Commission.

OPTIONS TO IMPROVE STATE FINANCING OF WATER PROGRAMS

State funding for water-related programs comes from various sources. The Texas Commission on Environmental Quality's water programs are funded with General Revenue Funds and fee-supported General Revenue–Dedicated Funds. The Water Development Board also receives appropriations of General Revenue Funds for its programs and for debt service on water bonds, along with funding from non-General Revenue Funds accounts (Other Funds). The Soil and Water Conservation Board uses General Revenue Funds as its sole source for state-funded water-related programs. In 2006–07 approximately $198 million was spent on water-related programs, $103.6 million in General Revenue Funds.

Before the 2006–07 biennium, a much larger portion of the Texas Commission on Environmental Quality's funding came from General Revenue Funds. The Seventy-ninth Legislature, Regular Session, 2005, replaced approximately $40 million in General Revenue Funds with funding from General Revenue–Dedicated Water Resource Management Account No. 153. This change occured because there were enough funds to cover these appropriations in the account, and because the agency reported that such expenditures previously paid using General Revenue Funds could be eligible for funding from General Revenue–Dedicated Funds. However, the revenue in the account is not estimated to cover the 2006–07 level of appropriations during the 2008–09 biennium, with a revenue shortfall of $5.3 million in the General Revenue–Dedicated Funds, based on current revenue and expenditure trends.

There are multiple options for increasing revenues available for water-related programs, including: across-the-board increases on existing fees to the Water Resource Management Account No. 153 (in some cases, this would require statutory change; in other cases, the changes could be made through agency rulemaking); changes to fee structures to reduce inequities among fee payers; increasing fees to cover the cost of programs designated to be funded by specific fees; extending existing fees from which certain entities are exempted to a larger group of fee payers; and implementing one or more new fees proposed in past Legislatures, such as an annual fee per resident/connection fee, a reported use fee, the removal of the exemption of sales tax on water and wastewater services, and/or a bottled water fee.

By increasing existing water-related fees or creating new fees to cover a greater portion of the state's water-related expenditures, the state could reduce its reliance on General Revenue Funds for water programs and create a more comprehensive water funding system.

FACTS AND FINDINGS

- ♦ Texas relies on state funds to pay for much of its water-related program costs. During the 2006–07 biennium, $103.6 million in General Revenue Funds is expected to be spent on water-related programs, and $94.4 million in General Revenue–Dedicated Funds is expected to be spent on such programs.

CONCERNS

- ♦ A large portion of the state's water programs at the Texas Commission on Environmental Quality is paid using proceeds of fee revenues deposited to the credit of the Water Resource Management Account No. 153 (General Revenue–Dedicated Funds). However, available balances and projected revenues are not sufficient to cover the agency's expected water program expenditures in 2008–09.
- ♦ Inequity exists among fee payers subject to the Consolidated Water Quality fee assessed by the Texas Commission on Environmental Quality in that those entities discharging the greatest amounts of wastewater pay less by volume than many smaller entities.
- ♦ The Texas Commission on Environmental Quality's Public Health Service fee revenues do not cover the costs of the Public Drinking Water program, even though the fee is designated to pay for such program costs.
- ♦ According to a 2007 Texas Water Development Board report, the state's water-related infrastructure needs will exceed $30 billion between now and 2060, yet the state has not established a dedicated funding source to meet any portion of this demand.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Water Code, Section 26.0291(e), to remove the cap on the Consolidated

Water Quality Fee assessed by the Texas Commission on Environmental Quality, so that the fee is assessed equitably on all fee payers.

- ♦ **Recommendation 2:** Include a rider to the 2008–09 General Appropriations Bill to increase the Public Health Service Fee through rulemaking to ensure that revenues from the fee cover costs of monitoring safe drinking water throughout the state through the Safe Drinking Water Program.

DISCUSSION

Much of the funding for the state's water programs currently is derived from state sources, including General Revenue Funds and General Revenue-Dedicated Funds. **Figure 1** shows the 2006–07 General Revenue Funds and General Revenue–Dedicated Funds expended and budgeted amounts for each agency's water programs.

FEES DEPOSITED TO THE WATER RESOURCE MANAGEMENT ACCOUNT

The revenue stream for the Water Resources Management Account No. 153 consists of 28 different fees generating from $38.3 million in revenues in 2006 to a projected $41.2 million in 2009. Two fees accounted for most of the revenue deposited in this account in fiscal year 2006. The Consolidated Water Quality (CWQ) fee brought in approximately $18.7 million in revenues, while the Application of Certificate of Convenience and Necessity fee, brought in only $6,000. In addition, there are and several other fees that brought in no revenues during fiscal years 2005 or 2006 for various reasons.

The expended/budgeted amount from the Water Resource Management Account No. 153 total approximately $51 million, including benefits, each year during the 2006–07 biennium, and a similar level would be expected to be appropriated for the 2008–09 biennium to maintain existing levels of activity in Texas Commission on Environmental Quality (TCEQ) water programs. Given that expenditures out of the Water Resource Management Account No. 153 are projected to exceed revenues by about $14 million per year, balances in the account will need to be used to continue this level of appropriations in the 2008–09 biennium. Since the agency only projects a balance of $22 million in the account on August 31, 2007, additional funding will be necessary to support TCEQ programs.

Revenues to the Water Resource Management Account No. 153 derive from 28 separate fees assessed on water utilities, water rights holders, industrial water users, and so forth. Of these fees, only the fees in **Figure 2** were considered as potential sources of additional revenue.

FIGURE 1
STATE FUNDING FOR WATER PROGRAMS, AS OF AUGUST 2007

AGENCY	ACCOUNT	2006	2007	2006–07 BIENNIAL TOTAL
Commission on Environmental Quality				
	General Revenue*	$5,526,417	$5,504,119	$11,030,536
	GR–Dedicated Account 153	45,117,611	47,048,310	92,165,921
	GR–Dedicated Account 158	1,043,988	1,179,326	2,223,314
Water Development Board				
	General Revenue	20,210,993	17,101,464	37,312,457
Debt Service Payments for Non-Self-Supporting G.O. Water bonds				
	General Revenue	17,100,180	19,112,986	36,213,166
Soil and Water Conservation Board				
	General Revenue	9,606,033	9,458,814	19,064,847
	Total General Revenue	52,443,623	51,177,383	103,621,006
	Total GR–Dedicated	46,161,599	48,227,636	94,389,235
	TOTAL	**$98,605,222**	**$99,405,019**	**$198,010,241**

*A small portion of Texas Commission on Environmental Quality 's General Revenue appropriations are for non-water programs. For the purposes of this report, that amount is not assumed to be significant.
SOURCES: Commission on Enviornmental Quality; Water Development Board; Soil and Water Conservation Board.

FIGURE 2
EXISTING FEES CONSIDERED AS POTENTIAL SOURCES OF ADDITIONAL REVENUE

FEE	PROJECTED REVENUE FISCAL YEAR 2006
1. Consolidated Water Quality Fee	$18,696,000
2. Water Utility Regulatory Fee	$5,165,000
3. Public Health Service Fee	$4,011,000
4. Water Utility Bond Issue Application Fee	$1,632,000
5. General Permit: Application	$1,420,000
6. General Permit: Storm water	$1,923,000
7. General Permit: Wastewater	$337,000

Source: Texas Commission on Environmental Quality.

Although any of the 28 fees could be increased to raise revenue for the Water Resource Management Account No. 153, many of these fees focus on a narrow group of fee payers or generate small to negligible amounts of revenue. This report only considers increasing the seven fees listed above because they are the best candidates for generating significant amounts of new revenues. Of these fees, six of the seven bring in over $1 million per year each, while the seventh, the General Permit-Wastewater, applies to a wide base of fee payers throughout the state.

CONSOLIDATED WATER QUALITY FEE

The Consolidated Water Quality (CWQ) Fee is assessed annually for each permit authorizing the treatment and/or discharge of wastewater issued under Chapter 26, Texas Water Code. Each permit is evaluated based on pollutant potential and permitted limits for flow volume, pollutants, toxicity, storm-water authorization, and major/minor facility status. Many utilities have several CWQ permits; one for each facility that discharges wastewater. Irrigators are not subject to the CWQ fee.

The TCEQ sets the CWQ Fee rates; however, the agency is restricted in the Texas Water Code, Section 26.0291(e) in assessing the annual fee to a limit of $75,000 per permit. If the TCEQ were to increase the rate on all fee-payers paying less than the $75,000 limit, additional revenue would be gained. This increase would mean that smaller water utilities and industrial users would be paying a greater portion of the costs than they are now paying. However, if the limit were removed and the current fee rate were applied to all fee-payers without a per-permit ceiling, the TCEQ estimates that an additional $7.9 million could be gained in annual revenue to the Water Resource Management Account No. 153.

The estimated effect resulting from removing the $75,000 limit while keeping the rate the same is shown in **Figure 3** for the top five fee payers. Each of these fee payers has several permits for which their fees reach the limit.

FIGURE 3
EFFECT OF REMOVING FEE LIMIT ON THE TOP FIVE FEE PAYERS, FISCAL YEAR 2006 RATES

ENTITY	CURRENT FEE	FEE IF $75,000 LIMIT REMOVED
City of Houston	$1,962,280	$2,393,955
City of Dallas	$286,485	$1,130,880
San Antonio Water System	$264,060	$1,012,150
Trinity River Authority	$207,040	$785,455
Gulf Coast Waste Disposal	$292,790	$772,900

Source: Texas Commission on Environmental Quality.

To generate that same amount of revenue ($7.9 million per year) without increasing or eliminating the limit would require the fee rate to be increased by 50 percent. However, this increase would only affect smaller fee payers (i.e., those with fewer customers or those whose activities presumably contribute proportionately less to water pollution in Texas). Those entities with permits already at the $75,000 limit would pay nothing additional. The Texas Legislature should consider removing the limit on the CWQ fee so that the TCEQ could assess the fee at the same rate on the CWQ fee to all fee payers, thereby achieving a more equitable assessment of fees based on impact to water quality (see Recommendation 1).

The Legislature could also clarify its intent to the TCEQ through a rider directing the agency to apply the same rate to all fee-payers. If the Legislature seeks to generate an amount of revenue less than $7.9 million per year, or the amount that would be generated based on current rates and no ceiling, language could be included in the rider directing the agency to lower the fee to a level that would generate the desired revenue stream.

PUBLIC HEALTH SERVICE FEE

The TCEQ sets the Public Health Service Fee rates and assesses it on all public drinking water systems based on the

number of retail connections served by the system. Proceeds of the fee are used by the TCEQ to assess the quality of water provided by water systems through the Public Drinking Water Program. Operators with less than 25 connections pay $75 per year, operators with 25 to 99 connections pay $150 per year, and those systems with 100 or more connections pay based on an exponential equation where the number of connections is raised to the 0.7 power. The resulting factor is then multiplied by $7.40. This formula provides that larger utilities pay less per connection than smaller utilities because costs associated with water quality assessments generally achieve economies of scale as the number of connections in a system increase.

According to the TCEQ, revenues from the Public Health Service Fee brought in $3.9 million in revenue in fiscal year 2006; however, this does not cover the full cost of administering the Safe Drinking Water Program of $5.1 million, and an estimated $581,000 per year in benefits cost. Therefore, the TCEQ should increase by rule the Public Health Service Fee by approximately 45 percent, or an amount sufficient to cover costs incurred in assessing the quality of water provided by water systems (Recommendation 2). A rider could also be included directing the agency to set fee rates to cover water quality assessment program costs. The following rider is suggested:

> **Public Health Service Fee.** The Texas Commission on Environmental Quality shall assess the Public Health Service Fee established in Texas Health and Safety Code, Section 341.041 at a level sufficient to cover expenditures related to the Public Drinking Water program (estimated to be $5,100,000 in each fiscal year of the biennium) as well as "other direct and indirect costs" related to the program during the 2008–09 biennium (estimated to be $581,000 in each fiscal year of the biennium).

Figure 4 shows the potential effect of increasing the Public Health Service to generate $1.8 million in additional revenues (for a total of $5.7 million in annual revenues) would have on the 10 largest fee payers if the exponential equation were changed so that the number of connections would be raised to 0.74 power, as compared to the 0.70 power currently used.

WATER UTILITY REGULATORY FEE

The Water Utility Regulatory Fee is collected by public utilities, water supply service corporations, and water districts. It is established in Texas Water Code, 5.701(n), and it is assessed against each retail customer at a rate of 0.5 percent of the charge for retail water or sewer service by public utilities as defined in Texas Water Code, Section 13.002 and water supply and service corporations (nonprofit corporations) and at a rate of 1 percent of the charge for retail water or sewer service by water districts, as defined in Texas Water Code, Section 49.001. The fee currently brings in $5.7 million per year, and it is assessed on approximately 1.9 million connections. Municipally- and county-owned water and wastewater systems, which represent 77 percent

FIGURE 4
PUBLIC HEALTH SERVICE (PHS) FEE INCREASE: IMPACT ON 10 LARGEST FEE PAYERS

The following is the projected impact on the 10 largest fee payers if the PHS were increased to a level to raise $5.7 million in total annual revenues, or $1.8 million above current levels.

TOP 10 PHS FEE PAYORS	CONNECTIONS	FEE REVENUE CURRENT 0.70	FEE REVENUE PROPOSED 0.74	DIFFERENCE	PERCENTAGE CHANGE
City Of Houston Public Works Dept	1,067,839	$122,796	$213,957	$91,160	74.2%
Dallas Water Utility	439,634	$65,977	$110,948	$44,970	68.2%
San Antonio Water System	417,814	$63,668	$106,846	$43,178	67.8%
City Of Fort Worth	267,211	$46,562	$76,755	$30,193	64.8%
City Of Austin Water & Wastewater	188,441	$36,463	$59,274	$22,810	62.6%
El Paso Water Utilities Public Service	173,000	$34,345	$55,640	$21,295	62.0%
City Of Corpus Christi	104,727	$24,170	$38,377	$14,208	58.8%
City Of Plano	101,136	$23,587	$37,399	$13,813	58.6%
City Of Arlington	99,298	$23,286	$36,895	$13,609	58.4%
City Of Garland	87,824	$21,368	$33,690	$12,322	57.7%

Source: Texas Commission on Environmental Quality.

of the 8.3 million connections in the state, are exempt from the fee.

The Legislature could modify the existing statute to apply the 1 percent rate to all current fee payers. This would generate an additional $4.4 million per year. Another option would be to apply the fee to systems currently exempt from the fee (mainly municipal systems). If the 0.5 percent rate were extended to include municipal systems, an additional $15.5 million in annual revenues could be collected, while extending the 1 percent fee to municipal systems would generate $31.1 million.

The Water Utility Regulatory Fee could be applied to all systems that are currently exempt, including municipal systems, at a rate of 0.5 percent of the charge for retail water or sewer service, resulting in a net gain to the Water Resource Management Account No. 153 of an estimated $15.5 million per year. This could allow for the use of such fee proceeds for water quality programs at the TCEQ. Although statutory provisions in Texas Water Code, Section 5.701 (p) and (q) provide for a broad use of the proceeds of the Water Utility Regulatory Fee, the name of the fee could be changed to the "Water Utility Fee," to indicate that the fee's purpose surpasses the scope of regulatory activities.

WATER UTILITY BOND ISSUE APPLICATION FEE

Water utilities and districts (but not municipalities) submitting applications to sell water- and wastewater-related bonds pay a fee to the TCEQ in the amount of $500 per bond application plus the cost of public notice. If the bonds are approved, the utility or district pays the TCEQ 0.25 percent of the amount of bond proceeds to be issued. The fee brought in $1.8 million in revenues in fiscal year 2005.

Because this fee is specifically related to the technical review of bond issuances, it is not recommended that the fee be increased or that proceeds of the fee be used for general water-related purposes.

GENERAL PERMITS

An entity discharging waste into or adjacent to waters in this state has the option of obtaining a General Permit from the TCEQ, rather than paying the Consolidated Water Quality Fee. There are three types of General Permits: General Permit Applications, General Permits—Stormwater, and General Permits—Wastewater. Collectively, General Permits brought in about $4.6 million in revenues in fiscal year 2006.

General Permits offer simplified procedures and result in fee payments ranging from $100 to $800 per year, plus the application fee of $100 due as the permits are issued or renewed on a five-year basis. A General Permit allows an entity to conduct an activity similar to other entities, without having to file an application providing detail on every aspect of the entity's operation, as long as the entity's activities do not cross a particular threshold set by the TCEQ, based on the entity's potential to pollute. An example would be a concentrated animal feeding operation (CAFO). A CAFO could apply for a General Permit, essentially agreeing that the applicant will abide by general rules and regulations specific to CAFOs of a certain size without needing to file a more complicated CWQ application. Another common General Permit is issued for stormwater from construction runoff.

Because General Permit fees are set in rule, the TCEQ could be directed to increase fee levels to generate a desired revenue increase. However, there would have to be a large increase in fees to generate significant additional revenues. For instance, if both the General Permit for Stormwater and the General Permit for Wastewater annual fees were doubled, only about $3.2 million in additional revenue would be generated. This option (Option 1) is not recommended because of the potential financial burden on the fee payers.

WATER USE FEES

Currently in Texas, holders of surface water rights pay the Water Use Permit (WUP) Application Fee only when that right is first obtained and/or transferred to another owner. The WUP includes filing and recording fees ranging from $100 to $2,000, depending on the amount of water rights being granted, as well as a per acre fee depending on the use—$0.50 per acre-foot for irrigation or storage in a reservoir (except storage for recreational use) and $1 per acre-foot for other uses. The TCEQ reports collections of $151,947 in WUP revenues in fiscal year 2006. Since the WUP is a one-time fee, and the current revenue stream is not significant, the WUP is not recommended as a candidate for fee increases.

Some water rights holders also pay an annual Water Use Fee (or WUF) based on the number of acre-feet of water rights permitted (not the actual amount used) in a given year for consumptive use, non-consumptive use, or hydropower use. Entities paying the CWQ fee and holding a municipal or industrial water right are exempt from the WUF fee under Texas Water Code 26.0291, if the use under the water right

is directly associated with the entity paying the CWQ fee. Agricultural use and hydroelectric facilities with less than two-megawatt capacity are exempt from this fee. That leaves only 207 fee payers currently paying the WUF. A total of $416,483 was collected in WUF revenues in fiscal year 2006 from these fee payers. Proceeds of the WUF are statutorily eligible to be spent for water quality purposes, which includes most water-related spending at the TCEQ.

The fee schedule for those paying the WUF is based on whether the use of water is considered consumptive, (e.g., for domestic and municipal, industrial, agricultural, or mining purposes) or non-consumptive (e.g., hydroelectric power, navigation, non-consumptive recreation). WUF payers pay based on the number of acre-feet of water rights held. For example, for a consumptive use, fee payers pay $0.22 per acre-foot up to 20,000 acre-feet and $0.08 per acre foot thereafter.

There are several options for generating additional revenues from the WUF. One option would be to increase the rates charged per acre-foot of water rights. However, since there are only 207 fee payers paying the WUF, this option would place a relatively large burden on a limited group of fee payers to generate significant revenues. Therefore, increasing the WUF fees is not recommended as a means to increase water-related fee revenues.

A second option is to extend the WUF to all holders of water rights, removing the exemption for those municipal and industrial users already paying the CWQ fee. The TCEQ reports that removing this exemption, which would require a statutory change to Texas Water Code, Section 5.701(h), would generate $2.1 million per year. The TCEQ reports that removing exemptions for irrigators from the fee would result in increased revenues of $856,000 per year, which would effectively triple the amount currently being collected.

In the past, several proposals have been conceived to increase the number of entities paying for the use of water through a WUF-type fee. Legislation considered by the Seventy-seventh Legislature, Regular Session, 2001, would have set an annual water rights fee to be imposed at a rate of: $0.50 per acre-foot for industrial uses; $0.10 per acre-foot for irrigation uses; one-hundredth of a cent per kilowatt produced for hydropower uses; and $0.50 per acre-foot for all other consumptive uses, excepting municipal uses and uses by holders within the jurisdiction of a watermaster. At the time, the Comptroller estimated that the proposal would produce $6.7 million in annual revenues.

The reason those within the jurisdiction of a watermaster were to be exempted from the annual water rights fee proposed under the bill was that those users already were paying fees based on water rights through Water Use Permit Fees deposited to the credit of the General Revenue–Dedicated Watermaster Administration Account No. 158. Municipal uses were likewise to be exempted based on the rationale that they are already paying significant fees for their water use through the CWQ fee.

Legislation in the Seventy-fifth Legislature, Regular Session, 1997, proposed another form of an annual water rights fee of $0.50 per acre-foot for industrial users and $0.10 per acre-foot for agricultural users, with all other users being exempt. That fee would generate an estimated $2 million per year.

An annual water use fee that would not exempt municipal uses, agricultural uses, and those located in watermaster areas could generate a significant amount of revenue. Based on TCEQ estimates of the number of water rights permitted, there are 58.7 million acre-feet of water permitted in the state. If an annual fee of $1 per acre-foot were imposed for all uses, an estimated $58.3 million in new revenues could be generated. **Figure 5** shows an estimate of the number acre-feet of water rights permitted by billing category for permitted rights currently paying the WUF and for all accounts.

FIGURE 5
ESTIMATED ACRE-FEET OF WATER RIGHTS PERMITTED BY BILLING CATEGORY, AS OF JULY 2006

BILLING CATEGORY	BILLED ACCOUNTS ACRE-FEET (MILLIONS)	ALL ACCOUNTS* ACRE-FEET (MILLIONS)
Consumptive	1.6	17.8
Non-Consumptive	0.5	8.0
Hydroelectric**	19.5	26.7
Irrigation	N/A	6.1
TOTAL	**21.6**	**58.7**

*Acre-feet numbers assume all municipal/domestic, industrial, mining, and recharge uses are consumptive unless a specific amount is reported. In cases with a single acre-feet listing reported for several use types, the total acre-feet is divided equally among the types listed.
**Many hydroelectric acre-feet amounts are listed only in the permit document; these amounts are not included in this table. Consequently, the true amount of hydroelectric acre-feet is higher than the amount in this table.
Source: Texas Commission on Environmental Quality.

If certain uses were exempted, if lower fees per acre-foot were applied to certain uses, or a lower overall rate were imposed, a lower revenue estimate would result based on the composition of fee rates imposed. Assuming the fee rate of $1 per year per acre-foot, the amounts in **Figure 5** indicate that exempting agricultural uses would result in the fee generating only $51.1 million, or $6.1 million less, in revenues. However, if all uses were assessed a fee at a rate lower than $1, and if a different rate were applied to different users, such as $0.50 per acre-foot for consumptive uses and $0.10 for all others, a reduced source of revenue of $14 million could be achieved.

If a specific use were targeted, another revenue scenario is possible. The TCEQ reports that industrial consumptive water rights total 9.9 million acre-feet; therefore, if only industrial users were to pay the fee, $9.9 million per year would be generated. Likewise, the TCEQ reports that if only agricultural users were assessed the fee, $6.1 million per year could be generated.

It is recommended that some level of annual water rights fee be implemented to generate additional revenues (Option 2). However, there could be some difficulty in administering a water use fee, especially if agricultural uses were included. According to the TCEQ, the agency possesses limited contact information for many water-rights holders because the only time the agency has contact with entities that are exempt from the WUF fee is when a permit is obtained or transferred. In some cases, water rights were obtained over 100 years ago, and the water right has never been transferred.

POTENTIAL NEW WATER-RELATED FEES

In addition to modifying or increasing existing fees, new fees could be created to generate water-related revenue. Several options are discussed below.

PER RESIDENT/CONNECTION FEE

Currently, there is no water-related fee assessed in Texas based on population or the number of water/sewer connections. Legislation in the Seventy-seventh Legislature, Regular Session, 2001, proposed a $1 per-resident annual water fee to be assessed by counties. A per-resident water fee would raise about $20.9 million in revenues, based on the state population per the 2000 U.S. Census. A per-resident fee might not be practical to implement, however, because it would require counties to develop a mechanism for passing on their costs in making fee payments to the state.

The Seventy-fifth Legislature in 1997 considered an annual water resource management fee of no more than $1 per month for each retail connection of a public water system. At that time, there were an estimated 5.7 million such connections, yielding an estimated $68 million annually in revenues. As of October 2006, the TCEQ estimates that there are 8.3 million connections, which could generate $99.6 million in annual revenues if the $1 per month per connection fee were instituted. Accordingly, a $0.10 per month per connection fee would generate $9.6 million annually.

A per connection water fee could be added to each retail water customer's bill, with the water utility retaining a small portion of the fee to cover administrative costs. Because a per connection water fee would affect practically all retail users of water, generate a steady and increasing revenue stream, and be reasonably simple to implement as compared to a population-based fee, it is recommended that a per connection fee be created (Option 3). The extent to which the Legislature would choose to generate revenue would dictate the monthly rate.

BOTTLED WATER FEE

Several proposals have been raised to generate revenues for water programs through bottled water sales. Legislation considered by the Seventy-seventh Legislature in 2001 proposed a $0.05 surcharge on the sale of each container of bottled water for retail sale. At the time, the legislation, if enacted, was expected to generate $52.1 million per year in fiscal year 2002, rising to $65.2 million by 2006, based on 2001 data for volumetric sales of water converted to a number of containers. The Seventy-fifth Legislature in 1997 considered a fee on the receipts of the bottled water supplier based on a graduated scale from $250 to $15,000, with the largest fee based on receipts of more than $10 million. In 1997, it was estimated that the fee would generate $870,000 per fiscal year.

In testimony to the Senate Committee on Natural Resources in August 2006, Water Development Board staff proposed removing the exemption from the state sales tax for bottled water. The agency estimated that this action would generate $57.1 million in fiscal year 2007, rising to $76.8 million by 2011. In addition, it would generate approximately $16.3 million in additional revenues for local governments imposing a sales tax throughout the state.

The amount of funds from either a $0.05 per bottle surcharge on bottled water, or the removal of the sales tax exemption for bottled would generate a significant and similar annual revenue stream and distribute the burden of the increase over a wide population. Both proposals would require statutory change so there is little preference for one version of the fee over the other. Nonetheless, a bottled-water surcharge would likely add more administrative costs to implement because no such per item surcharge currently exists. Removal of the sales tax exemption would likely result in minimal collections costs, since most entities selling bottled water already collect and remit sales taxes to the Comptroller. Therefore, removal of the sales tax exemption would appear to have a slight advantage over the bottled water surcharge (Option 4).

REPORTED USE FEE

An option for generating revenue for water programs would be to assess a fee on the amount of water used by consumers in Texas. Senate Bill 3 of the Seventy-ninth Legislature, Regular Session, 2005, proposed a water conservation and development fee equal to $0.13 for each 1,000 gallons of water used by ultimate consumers each month, with the first 5,000 gallons of consumption exempted from the fee. An exemption on the first 5,000 gallons per month is a standard consideration for the basic needs of the average household. Assessing a fee on amounts in addition to that amount could have the benefit of actually encouraging the conservation of water for things like lawn-watering, car-washing, and so forth. The Comptroller projected that this fee, which would have been collected by retail public utilities, was expected to generate between $119.6 million in 2006 and $140.5 million by 2010.

Depending on the amount of revenue that is sought to be generated, a monthly fee per 1,000 gallons of water over 5,000 gallons could be implemented to generate a significant amount of revenue (Option 5). Based on the Comptroller's estimates for Senate Bill 3, a fee of $.01 for each 1,000 gallons beyond the first 5,000 would be expected to generate between $9.2 million and $10.8 million per year, for example.

EXTENSION OF SALES AND USE TAX TO DOMESTIC SEWAGE SERVICE AND POTABLE WATER

Texas Tax Code, Section 151.315, specifically exempts water from the state sales tax. Texas Tax Code, Section 151.0048 (3)(D) exempts domestic sewage service from the state sales tax. Removing one or both of these exemptions would result in a significant revenue increase that could be earmarked for water programs.

Based on data collected by the TCEQ on revenue generated by water systems statewide, simply removing the sales tax exemption for all water service customers would result in a revenue gain of $164.7 million per year. If an exemption from the tax were maintained on the first 5,000 gallons per month for all water customers, but the exemption were removed on gallons above 5,000 per month, the TCEQ estimates $122.6 million in additional revenue would be generated. Regarding wastewater service, the TCEQ estimates that eliminating the sales tax exemption on all wastewater customers would generate $117.8 million per year, while exempting only that portion of wastewater service above 5,000 gallons per month would generate $78.7 million in additional revenue.

The Legislature might consider removing some portion of either or both the water and wastewater sales tax exemptions (Options 6 and 7). Because removing these exemptions could provide significantly more new revenues than would be sought by the Legislature, a rate lower than the standard 6.25 percent rate could be applied for water and/or wastewater sales. For instance, charging a sales tax of only 1 percent on water usage above 5,000 gallons per month would be expected to generate $19.6 million in new revenues per year, while a 1 percent charge on wastewater above 5,000 gallons per month would yield $12.6 million in additional revenues per year.

GROUNDWATER FEES

Several ideas regarding groundwater fees have been proposed in the past, such as during the Seventy-seventh Legislature, Regular Session, 2001, when a fee on the export of groundwater was considered. However, the revenues associated with this proposal were not expected to be significant. Another consideration for assessing fees on groundwater involves assessing fees on groundwater conservation districts, based on the number of acre-feet of groundwater withdrawn.

This report does not recommend any specific fees related to groundwater. However, many of the fees recommended above would capture groundwater use. The CWQ fee, for instance, is paid on discharges of wastewater, so the point of origin of the water does not matter. Other fees, such as the Water Regulatory Fee, the Per Connection Fee, Reported Use Fee, and the sales tax exemptions would affect all customers of retail water systems, regardless of the source of water in the system. Likewise, the Bottled Water Fee would indirectly be assessed mainly on groundwater, since

groundwater is the source for the vast majority of bottled water.

SUMMARY OF ADDITIONAL REVENUE OPTIONS

The extent to which the Legislature determines dedicated fee revenues should cover state water expenditures and the level of assistance the Legislature determines appropriate in meeting the state's long-term water demands could determine the amount of funds targeted to be raised. **Figure 6** summarizes the menu of options, along with the estimated maximum potential revenue these proposals could generate per year.

FISCAL IMPACT

Removing the $75,000 cap from the CWQ fee (Recommendation 1) would result in estimated additional annual revenues of $7.9 million, or $15.8 million for the 2008–09 biennium, to the General Revenue–Dedicated Water Resource Management Account No. 153. A lower level of revenue could be realized if the TCEQ was directed to reduce fee rates on all fee payers. This recommendation requires a statutory change in Chapter 26 of the Texas Water Code and the addition of a rider in the TCEQ's bill pattern directing the agency to apply the same CWQ fee rates to all fee payers and directing the agency to assess fees to collect a

FIGURE 6
OPTIONS FOR GENERATING WATER-RELATED FEE REVENUES

OPTION	FEE	STATUTORY REFERENCE	RATE PROPOSED	PROJECTED ANNUAL REVENUES (MILLIONS)	RECOMMENDATION/ COMMENTS
1	Water Utility Regulatory Fee	Water Code, 5.701(n)	1% to all current fee payers	$4.4	Statutory change required. Name could be changed to the "Water Utility Fee" to indicate broader use of fee.
			0.5% to municipal systems	$15.5	
			1% to municipal systems	$31.1	
2	Annual Water Rights/ Water Use Fee	Water Code, 26.0135(h)	Extension of current fee to municipal and industrial CWQ fee payers	$2.1	Requires statutory change. Including agricultural uses in the assessment of the fee could result in significant additional administrative costs.
			Extension of current fee to agricultural users	$0.865	
			$1/acre-foot fee on all uses	$58.3	
			$1/acre-foot fee on all uses except agricultural users	$51.1	
			$.50/acre-foot fee on consumptive uses; $.10 per acre/ft fee on all others	$14.0	
			$1/acre-foot fee on industrial consumptive rights only	$9.9	
3	Per Connection Fee	N/A (new fee)	$1/month for each retail connection	$99.6	Would require legislation creating the fee.
			$.10/month for retail connection	$10.0	
4	Bottled Water Fee	N/A (new fee)	$.05 surcharge per bottle of water	$65.2	Would require legislation creating the surcharge. Collections could impose administrative costs, since no similar surcharge currently exists.
		Tax Code, 151.315	Removal of Sales Tax Exemption	$57.1	Requires statutory change in Tax Code. Collection costs not expected to be significant.
5	Reported Use Fee	N/A (new fee)	$0.13 per 1,000 gallons over fist 5,000/month	$119.6	Would require legislation creating the fee. Could promote water conservation.
			$0.01 per 1,000 gallons over first 5,000 per month	$9.2	

(continued on next page)

FIGURE 6 (CONTINUED)
OPTIONS FOR GENERATING WATER-RELATED FEE REVENUES

OPTION	FEE	STATUTORY REFERENCE	RATE PROPOSED	PROJECTED ANNUAL REVENUES (MILLIONS)	RECOMMENDATION/ COMMENTS
6	Sales Tax on Water Service	Tax Code, 151.315	Removal of 6.25% Sales Tax Exemption	$164.7	Requires statutory change. Could also provide revenues for local governments.
			Removal of 6.25% Sales Tax Exemption for Usage over 5,000 gallons/month	$122.7	
			Apply 1% Sales Tax on Water Service over 5,000 gallons/month	$19.6	
7	Sales Tax on Wastewater Service	Tax Code 151.0048(3)(D)	Removal of 6.25% Sales Tax Exemption	$117.8	Requires statutory change. Could also provide revenues for local governments.
			Removal of 6.25% Sales Tax Exemption for Usage over 5,000 gallons/month	$78.7	
			Apply 1% Sales Tax on Wastewater Service over 5,000 gallons/month	$12.6	

Note: The amounts above are the maximum amounts the fees could generate, and that this report is not recommending that these fees be set to collect these maximum amounts. Nor is it recommended that all eight options, or even a majority of the options, be implemented.
Source: Legislative Budget Board.

targeted amount, to be determined by the Legislature (see **Figure** 7).

Recommendation 2 would increase the balance of the General Revenue–Dedicated Water Resources Management Account by approximately $3.6 million for the 2008–09 biennium. The recommendation would be implemented by adding a rider to the 2008–09 General Appropriations Bill directing the agency to assess the Public Health Service fee at a level sufficient to cover costs related to the Public Drinking Water Program (see **Figure 8**).

The fiscal impact for the additional revenue options summarized in **Figure 6** would depend on which fee(s) the Legislature might choose to create/increase, whether the Legislature would choose to fund all water programs through water-related funding sources, and the extent to which the Legislature would choose to fund water-related infrastructure funding needs. A combination of new fees and/or fee increases could result in new revenues ranging into the hundreds of millions of dollars per biennium.

The impact on method of financing associated with these options would depend on which fees were increased, whether sales tax exemptions were eliminated, and the account to which the Legislature would direct new fee proceeds. It is assumed that revenues associated with existing fees would be deposited the General Revenue–Dedicated Water Resource Management Account. Revenues associated with the removal

FIGURE 7
FISCAL IMPACT OF REMOVING THE $75,000 LIMIT ON THE CONSOLIDATED WATER QUALITY FEE

FISCAL YEAR	PROBABLE REVENUE GAIN/(LOSS) TO GENERAL REVENUE–DEDICATED FUNDS	CHANGE TO FTES COMPARED TO 2006–07 BIENNIUM
2008	$7,900,000	0
2009	$7,900,000	0
2010	$7,900,000	0
2011	$7,900,000	0
2012	$7,900,000	0

Source: Legislative Budget Board.

FIGURE 8
FISCAL IMPACT OF INCREASING THE PUBLIC HEALTH SERVICE FEE TO COVER COSTS RELATED TO THE PUBLIC DRINKING WATER PROGRAM AT THE TCEQ

FISCAL YEAR	PROBABLE REVENUE GAIN/(LOSS) TO GENERAL REVENUE–DEDICATED FUNDS	CHANGE TO FTES COMPARED TO 2006–07 BIENNIUM
2008	$1,781,000	0
2009	$1,781,000	0
2010	$1,781,000	0
2011	$1,781,000	0
2012	$1,781,000	0

Source: Legislative Budget Board.

of tax exemptions would be expected to be deposited to the credit of the General Revenue Fund. The proceeds of new fees could accrue to the Water Resource Management Account; however, depending on the use of the additional funds, proceeds of new fees could also be deposited to the credit of the Water Infrastructure Fund (Other Funds) created in Texas Water Code, Chapter 15, Subchapter Q, which currently has no source of revenue.

The introduced 2008–09 General Appropriations Bill does not address Recommendations 1 and 2.

POTENTIAL FUNDING SOURCES FOR COASTAL EROSION CONTROL IN TEXAS

Coastal erosion in Texas has been accelerated by human activities such as navigational dredging practices, ship wakes, and subsidence related to oil and gas development. The Seventy-sixth Legislature, 1999, enacted the Coastal Erosion Planning and Response Act, a coordinated effort of state, federal, and local entities to address this issue. However, the current funding source for the Coastal Erosion Planning and Response Act program, and the administration of the federally funded Coastal Management Program and Coastal Impact Assistance Program, will expire at the end of the 2006–07 biennium. For the Coastal Erosion Planning and Response Act program, the Coastal Management Program, and the Coastal Impact Assistance Program to continue at current funding levels, the state must identify a new revenue source. This source should come partially from coastal residents, coastal industries, and the general public because these parties cause erosion and/or benefit the most from erosion control projects.

FACTS AND FINDINGS

- ♦ Sixty-four percent of the Texas Gulf shoreline is affected by long-term erosion; this erosion is due in part to human activities such as waves generated by boats, the dredging and jettying of ship channels, and oil and gas related subsidence.
- ♦ A review of various federal programs determined that although there are Federal Funds available for erosion control, due to congressional budget cuts, federal requirements, and competing spending demands, these programs cannot be relied upon to address the state's coastal erosion control needs.

CONCERN

- ♦ The current funding for the Coastal Erosion Planning and Response Act program and the administration of the federal Coastal Management Program and Coastal Impact Assistance Program, will expire at the end of the 2006–07 biennium. Without this funding source, only an estimated $1 million in interest earnings in General Revenue–Dedicated Funds (i.e., Coastal Protection Account) will be available for funding these programs in the 2008–09 biennium.

RECOMMENDATIONS

- ♦ **Recommendation 1:** The Coastal Land Advisory Board should give priority to funding Coastal Impact Assistance Program applications for small beach re-nourishment projects to address erosion control funding needs.
- ♦ **Recommendation 2:** Amend Natural Resources Code, Chapter 40, Subchapter D to include a new funding source for the Coastal Erosion Planning and Response Act program, and for the administration of the Coastal Management Program and Coastal Impact Assistance Program that comes partially from coastal industry, coastal residents, and the general public, including a dockage fee, a windstorm insurance pool surcharge and redirecting one-third of the Outer Continental Shelf Settlement Funds to the Coastal Protection Account, respectively.
- ♦ **Recommendation 3:** Include a contingency appropriation rider in the 2008–09 General Appropriations Bill that appropriates $20.2 million to the General Land Office for the Coastal Erosion Planning and Response Act program and the administration of the Coastal Management Program and the Coastal Impact Assistance Program, contingent on the passage of legislation modifying the interest cap and authorizing new revenue.

DISCUSSION

The Texas coast, composed of 367 miles of coastline and more than 3,300 miles of bay shores, suffers from some of the highest rates of erosion in the country. On average, Texas loses 235 acres of Gulf shoreline each year, the equivalent of more than 181 football fields of beach. This enormous loss of shoreline is due to two kinds of erosion. The first, periodic erosion is caused by storms and hurricanes whose winds can drive currents and significant volumes of sand down the coast. The second, long-term erosion, which affects 64 percent of the Gulf shoreline, is caused by the rate of relative sea level rise and the lack of new sediment coming into the coastal system. Human activities such as waves from vessels, the dredging and jettying of ship channels, the use of shoreline protection structures, oil and gas related subsidence,

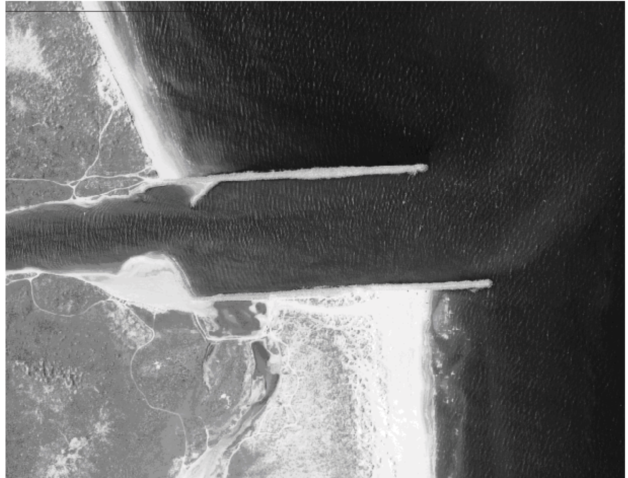
and the diversion of freshwater flows accelerate this natural process.

A primary cause of long-term erosion are waves, or wakes, created by marine vessels, which can erode unprotected shorelines or exacerbate erosion in areas already affected by natural processes. According to the Louisiana Department of Natural Resources, vessel wakes can cause navigational channels to widen at a rate of 3.2 to 8.4 feet per year. An increase in the number of ships that create large wakes could prove detrimental to certain parts of the coast. Additionally, the dredging done to create and maintain ship channels, and jetties built to keep them open can interrupt the natural flow of sand along the beach, causing an accumulation of sand on one side of a channel and beach erosion on the other. For example, the beach on the north side of the Mansfield Channel jetties in Willacy County erodes up to 13 feet per year. **Figure 1** shows this phenomenon.

Another cause for coastal erosion is subsidence, which can occur naturally as soils settle, as well as when groundwater, oil, and natural gas are removed. When subsidence occurs, the ground settles and fills up the void previously occupied by these substances. When coastal areas subside, wetlands, which can serve as a natural buffer against storm surge by reducing wave energy, are often flooded. Subsidence and erosion can also damage roads, homes, and other infrastructure.

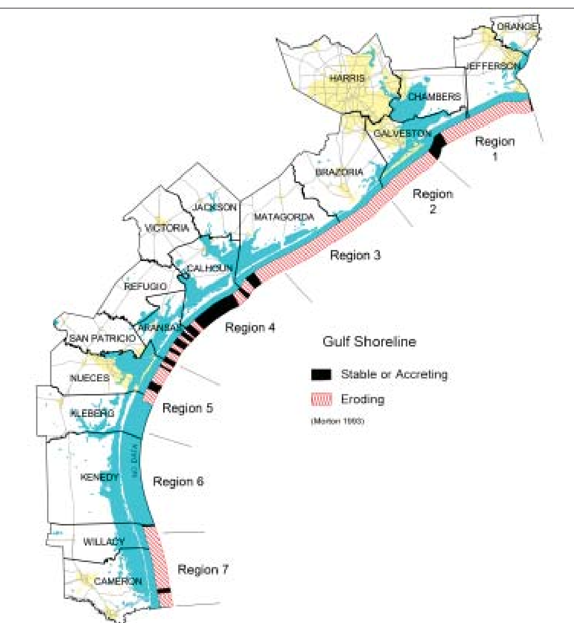
Figure 2 shows all of the critical eroding areas along the Texas coast.

FIGURE 1
MANSFIELD CHANNEL JETTIES, WILLACY COUNTY



SOURCE: General Land Office and Veterans' Land Board.

FIGURE 2
CRITICAL ERODING AREAS OF THE TEXAS GULF COAST



SOURCE: General Land Office and Veterans' Land Board.

COASTAL PLANNING AND RESPONSE ACT

To address these erosion concerns and provide funding for erosion control projects, the Seventy-sixth Legislature, Regular Session, 1999, enacted the Texas Coastal Erosion Planning and Response Act (CEPRA). CEPRA is a coordinated effort of state, federal, and local entities to control coastal erosion. The General Land Office (GLO) administers the program; since 1999 there have been four, two-year cycles of CEPRA funding.

CEPRA funds several types of erosion control projects, including beach nourishment, which involves using large amounts of sand to widen beaches in areas along the coast where affordable sand sources are available. An example of a beach nourishment project is the CEPRA Cycle 2 McGee Beach project. GLO partnered with the City of Corpus Christi to dredge and pump in sandy materials from outside the area to restore this public beach which eroded at a rate of three to four feet per year. The cost of the project was $960,000.

Beach nourishment alone does not solve most long-term erosion problems. For this reason, CEPRA also funds shoreline protection projects including the construction of the following structures:

- Brakewaters, structures protecting a shore area, harbor, anchorage, or basin from waves; can be constructed of

hard materials such as stone or concrete, or in areas where wave action is less intense, sand-filled geo-textile tubes can be used;

- Bulkheads, partitions adjacent to the shore, often made of reinforced concrete or steel to prevent against wave damage;
- Groins, shore-protection structures, usually perpendicular to the shoreline, built to trap littoral drift or retard erosion of the shore;
- Jetties, structures extending into the water to restrain currents; and
- Revetments, wave protection structures placed on existing sloping embankments.

The cost of these structures vary widely and are site-and project-specific. These types of projects occur in populated areas along the Texas coast and are generally for protecting public parks and infrastructure. The Cycle 1 Port Lavaca Bay Front Peninsula Project is an example of a hard structure project where the City of Port Lavaca Port Commission partnered with CEPRA to construct a bulkhead protecting 1,025 feet of a heavily used city park shoreline. The area was losing three to five feet of shoreline annually due to commercial vessel wakes and strong southeast winds. The total cost of the project was $572,000.

The CEPRA program also funds dune and marsh/wetland restoration projects and coastal erosion control studies. An example of a marsh restoration project is the CEPRA Cycle 2 Jumbile Cove (Galveston Island) Project-Phase II. GLO partnered with the Texas Parks and Wildlife Department and the U.S. Fish and Wildlife Service to build marsh mounds of dredged sediment and then plant smooth cord grass on the mounds. This project created over 78 acres of habitat for a cost of $569,000.

Funding for CEPRA projects is a mix of state and local funds. Project partners must provide at least a 25 percent match for beach nourishment and natural dune restoration projects, and a 40 percent match for shoreline protection, marsh restoration, and other projects or studies. One large-scale beach nourishment project, however, can be conducted each biennium by using up to one-third of the biennial funding without a match requirement. Potential project partners include any local government, state or federal agency, institution of higher education, or other public or private entity submitting a proposal to finance, study, design, install, or maintain an erosion response project. Projects are selected on criteria defined in the original CEPRA legislation such as severity of erosion; public access and safety issues; project benefits; feasibility; and cost effectiveness. Projects also receive a second round of reviews that consider legislative directives such as: location of the project; the level of federal and private funds that can be leveraged; and economies of scale. Based on the scores of these reviews, the agency determines a priority list of projects. In Cycle 4, the agency received 81 applications for projects requesting a total of $111.8 million and funded 17 projects totaling $7.3 million. Most proposed projects ranged in cost from $0.1 million to $2.3 million. **Figure 3** shows all four CEPRA funding cycles.

For the 2000–01 and 2002–03 biennia, the state revenue source for CEPRA projects was a $12.6 million biennial appropriation in General Revenue and a $2.4 million biennial appropriation in General Revenue–Dedicated Coastal Protection Account No. 027 (Coastal Protection Account) funds. For the 2004–05 biennium, the Seventy-eighth Legislature, 2003, appropriated $7.3 million in Coastal

FIGURE 3
COASTAL EROSION PLANNING AND RESPONSE ACT FUNDING CYCLES

				AMOUNTS APPROPRIATED	
BIENNIUM	FUNDING CYCLE	APPLICATIONS RECEIVED	PROJECTS FUNDED	GENERAL REVENUE FUNDS	GENERAL REVENUE–DEDICATED COASTAL PROTECTION ACCOUNT NO. 027
2000–01	Cycle 1	63	42	$12,600,000	$2,400,000
2002–03	Cycle 2	64	53	$12,600,000	$2,400,000
2004–05	Cycle 3	77	20	$0	$7,320,000
2006–07	Cycle 4	81	17	$0	$14,600,000*

*Fifty percent of these funds were transferred for the administration of the Coastal Management Program and the Coastal Impact Assistance Program.
SOURCE: General Land Office and Veterans' Land Board.

Protection Account funds and did not appropriate any General Revenue for the 2004–05 biennium based on a proposal from the GLO substituting its General Revenue by Coastal Protection Account funds as a means to comply with required budget reductions. However, this proposal did not comply with statute. According to statute, the Coastal Protection Account funds used for coastal erosion projects should not exceed the annual amount of interest income earned within the Coastal Protection Account, estimated to be $1.1 million for the 2004–05 biennium. The Coastal Protection Account's main revenue source was a two-cent-per-barrel fee on crude oil loaded or unloaded in Texas ports. This revenue source was created to fund oil spill prevention and response efforts, not as a primary funding source for coastal erosion projects.

To address this funding issue, the House Committee on Land and Resource Management of the Seventy-eighth Legislature, Regular Session, 2003, was charged with evaluating possible strategies for alternative funding sources for coastal erosion control. The committee identified several options and legislation was introduced recommending new surcharges that targeted industries affected by coastal erosion such as the petrochemical, hotel-motel, commercial shipping, and real estate industries.

Although none of the introduced legislation passed, the Seventy-ninth Legislature, 2005, did enact Senate Bill 1863, which removed the statutory cap on the use of the Coastal Protection Account to fund coastal erosion control for the 2006–07 biennium. This legislation also decreased the Coastal Protection Account fee from 2 cents per barrel of oil to 1-1/3 cent per barrel of oil, the ceiling on the fund from $25.0 million to $20.0 million (i.e., the balance in the account at which point collection of the Coastal Protection fee stops) and the floor on the fund from $14.0 million to $10.0 million (i.e., the balance in the account at which point collection of the Coastal Protection fee resumes). These modifications generated additional revenue by increasing the number of months the Coastal Protection fee is collected. A rider in the 2006–07 General Appropriations Act appropriated $14.6 million out of the Coastal Protection Account to the GLO, contingent on the Comptroller certifying this additional revenue. The legislation also expanded the use of the fee to fund the administration of the federally funded CMP and CIAP, which had also been funded out of the Coastal Protection Account. Approximately $7.3 million of the total $14.6 million went to fund the administration of coastal programs for the 2006–07 biennium. However, all of these modifications to statute and the rider are only stopgaps and will expire at the end of fiscal year 2007. For CEPRA, the CMP, and CIAP to continue alternative funding must be identified.

ALTERNATIVE FUNDING OPTIONS

There has been interest in to what extent Texas could rely on Federal Funds as opposed to new state revenue to address coastal erosion issues. A review of various federal programs including the U.S. Army Corp of Engineers Continuing Authorities Program (CAP) and specifically authorized projects process, and CMP, determined these programs cannot be relied upon to address Texas' coastal erosion issues. Although there are Federal Funds available for erosion control projects, congressional budget cuts to the CAP, federal requirements associated with the specifically authorized projects process, and the CMP's competing spending demands diminish the reliability of these federal programs.

Another suggested funding option for addressing Texas' coastal erosion control needs is the federal CIAP program. This program offsets impacts caused by offshore oil and gas drilling and is expected to bring in $240 million to Texas over the next four years for projects. There are several issues with relying on CIAP as a revenue source. First, 35 percent of annual CIAP funding, about $21 million, will go directly to the state's 18 coastal counties. This distribution will leave only 65 percent, about $39 million, to fund state projects, which the Coastal Land Advisory Board (CLAB) must approve. Second, like CMP, CIAP can fund a variety of projects in addition to erosion control making competition great for these funds. These projects include: air quality studies, removal of derelict structures, and the plugging of orphaned oil wells. Finally, certain structural and large beach nourishment projects could require an Environmental Impact Statement (EIS) or Environmental Assessment (EA), which could take up to three years to complete when grantees only have a maximum of three years to spend CIAP funds. The EIS/EA requirement would not, however, pertain to small re-nourishment projects. Therefore to address a portion of the funding needs, Recommendation 1 proposes that the CLAB give priority to funding CIAP applications for small beach re-nourishment projects. Although these CIAP funds could help meet some of Texas' erosion control requirements, they will not address all of the requirements, therefore, the state must consider other funding options, including new fees.

POTENTIAL NEW FUNDING SOURCES

To fund CEPRA and the administration of CMP and CIAP equitably, revenue should come from a variety of sources. These sources include parties responsible for causing erosion and those that benefit from erosion-control projects.

Numerous studies show that the dredging and ship wakes associated with large commercial and recreational marine vessels have accelerated erosion along the Texas coast. Additionally, the drilling by the petrochemical industry has also exacerbated the problem by causing subsidence in certain coastal areas.

Several parties benefit from erosion control, including coastal residents, who benefit directly from CEPRA, CIAP, and CMP projects such as shoreline protection structures that protect city parks, neighborhood roads, and private and public infrastructure. Coastal industries also benefit from CEPRA projects. For example, CEPRA funded several projects that have maintained and help protect the Gulf Intracoastal Waterway, on which most of the state's petrochemical facilities are located, from erosion. There are also many CEPRA, CMP, and CIAP projects that are beneficial to the general public. Texans, no matter where they live, benefit from erosion control and other coastal resource projects, including enjoying newly re-nourished popular tourist beaches and benefiting from restored wetlands that serve as buffers against hurricane winds.

For all of these reasons, Recommendation 2 provides for a portion of the funding for CEPRA and for the administration of CMP and CIAP come from coastal industry, coastal residents, and the general public.

To provide the coastal industry portion of the necessary funds, Recommendation 2 would authorize a dockage fee. A $150 dockage fee on commercial shipping and commercial passenger vessels docked at Texas port facilities could generate $7.6 million per biennium based on estimates from the U.S. Army Corp of Engineers. Noncommercial and government vessels as well as vessels with a draft (distance between the highest waterline and the bottom of a ship) of less than 18 feet would be exempt. Ports would retain 1 percent of the dockage fee to cover their administrative expenses.

Alternative options to the dockage fee are a cruise line passenger-fee and a surcharge on liquefied natural gas (LNG) processing. A $5 surcharge per passenger on commercial passenger vessels such as cruise liners and casino ships traveling from Texas ports could generate $6.8 million per biennium based on data from the ports of Galveston, Houston, and Corpus Christi. Noncommercial and government vessels, or vessels with an overnight-accommodation capacity of less than 12 would be exempt. This fee would represent a small increase on the average ticket price. A $.000001 fee on each cubic foot of LNG processed at Texas LNG terminals could generate $5.5 million per fiscal year based on estimates from the Federal Regulatory Energy Commission. Currently, there is only one terminal planned to be operational during the 2008–09 biennium on the Texas coast, but there is a plan for six future terminals. LNG terminals convert natural gas that has been liquefied for shipping purposes back to gas and then transport the gas via pipelines and trucks. There are two reasons why a fee on LNG processing is an appropriate funding source for coastal erosion control: (1) the increased ship traffic associated with these facilities could create further erosion problems; and (2) these terminals are located on the Gulf Intracoastal Waterway that CEPRA funds have maintained and protected from erosion.

Recommendation 2 would authorize a fee for the windstorm insurance pool be issued to provide the coastal residents' share of the needed funds. A $20 surcharge on insurance policies issued by the Texas Windstorm Insurance Association (TWIA) could generate between $7.0 and $7.6 million per biennium based on estimates from TWIA that there will be up to 175,000 to 190,000 policy holders by fiscal year 2008. TWIA, which is neither a state agency nor a for-profit company, provides windstorm insurance to residents of coastal communities whose private insurance policies do not cover wind and hail damage. This surcharge will affect those recently impacted by Hurricanes Rita and Katrina; however, it represents approximately a 2.5 percent increase per policy, which is on average $800 a year. The windstorm insurance pool surcharge should only provide a portion of the needed funding because local residents' tax revenue already goes to provide the project match for some CEPRA projects.

To provide the General Revenue portion of the needed funds, Recommendation 2 would provide for legislation that allocates a portion of the Outer Continental Shelf Settlement revenue currently deposited to the General Revenue Fund to the Coastal Protection Account instead. These funds are part of a settlement with the federal government over damage from offshore oil and gas drilling. Two-thirds of the revenue, a portion of oil and gas royalty funds from production on federal leases, is deposited into the Permanent School Fund and one-third is deposited into the non-dedicated portion of

the General Revenue Fund. The 2006–07 Biennial Revenue Estimate for the General Revenue Fund portion is $8.4 million.

To provide the necessary funds for CEPRA and the administration of CMP and CIAP for the 2008–09 biennium Recommendation 3 would include the following rider in the 2008–09 General Appropriation Bill:

Contingency Appropriation for General Revenue–Dedicated Coastal Protection Account No. 027.

a) Contingent upon enactment of legislation by the Eightieth Legislature, Regular Session, 2007, modifying the limitation on the use of the funds in and increasing revenues to the General Revenue–Dedicated Coastal Protection Account No. 027; and

b) Also contingent on the Comptroller of Public Accounts certifying that revenue in the General Revenue–Dedicated Coastal Protection Account No. 027 exceeds the amounts contained in the Comptroller of Public Accounts' Biennial Revenue Estimate by at least $20,200,000 for the 2008–09 biennium, the General Land Office and Veterans' Land Board is hereby appropriated out of the General Revenue–Dedicated Coastal Protection Account No. 027 $15,000,000 for the 2008–09 biennium for coastal erosion control grants in Strategy B.1.2, Coastal Erosion Control Grants and $5,200,000 for the 2008–09 biennium for the administration of coastal resource programs in Strategy B.1.1, Coastal Management and Strategy B.1.2, Coastal Erosion Control Grants.

In addition, contingent on the enactment of this legislation, the number of full-time-equivalent (FTE) positions authorized for the General Land Office and Veterans' Land Board for the 2008–09 biennium is increased by 38 FTEs for the purpose of implementing projects and activities funded by the appropriations made in this section.

The $20.2 million estimate, $15 million for CEPRA grants and $5.2 million for the administration of coastal resource programs, provides the agency with the same level of funding they had in the 2002–03 biennium before they substituted their General Revenue Funds for General Revenue–Dedicated Coastal Protection Account funds.

FISCAL IMPACT OF THE RECOMMENDATIONS

The implementation of Recommendation 2 to seek new funding sources would result in an estimated $23.0 to $23.6 million gain in General Revenue–Dedicated Funds (Coastal Protection Account) for the 2008–09 biennium. This gain is subject to the dockage fee generating $7.6 million per biennium, the windstorm insurance pool fee generating between $7.0 and $7.6 million per biennium, and the re-directed Outer Continental Shelf Settlement funds being $8.4 million per biennium. The introduced 2008–09 General Appropriations Bill does not address any of the recommendations.

STREAMLINE THE FUNDING STRUCTURE FOR STATE AND LOCAL PARKS

Texas has 108 state parks, natural areas and historic sites, totaling about 596,000 acres. In fiscal year 2005, these sites attracted more than 9 million visitors, and the state will spend more than $113 million during the 2006–07 biennium to operate state parks. The state also provides 50 percent matching grants to local governments to help them acquire and develop parks, grants for local recreation and conservation programs that target underserved populations, and limited funding for indoor recreation facilities.

While the Texas Parks and Wildlife Department charges entrance and use fees for facilities, parks do not generate sufficient revenue to pay for operations, maintenance, repairs, and debt service on bonds issued to fund past repairs. As a result, General Revenue and General Revenue–Dedicated Funds are used to augment state and local park budgets. The Texas Legislature appropriates revenue from several different funding sources for this purpose including Sporting Goods Sales Tax; Boat and Boat Motor Sales and Use Tax; Unclaimed Refunds of Motorboat Fuel Tax; 15 percent of Boat Registration and Titling fees; and a small amount of "pure" General Revenue Funds.

Since 1993, a portion of the tax revenue generated from the sale of sporting goods has been statutorily dedicated to fund state park operations, capital, and local park grants. The Sporting Goods Sales Tax is the primary source of General Revenue Funds for parks, with a current statutory allocation of $32 million per year. However, the Sporting Goods Sales Tax generates more than $100 million in revenue per year. This amount presents an opportunity to simplify the funding structure for parks, maximize the use of the Sporting Goods Sales Tax and better match its use to its intended purpose.

CONCERNS

- State parks are not self-supporting and have historically received tax support. The cap on the current Sporting Goods Sales Tax allocation requires the use of other General Revenue-related sources such as the Boat and Boat Motor Sales and Use Tax to provide on-going funding for park operations.
- Two-thirds of Sporting Goods Sales Tax revenue is generated from sales of bicycles and related supplies, hunting and firearms equipment, exercise equipment, and fishing tackle. According to the April 2000 Sunset Advisory Commission Staff Report on the Texas Parks and Wildlife Department, while some components of the Sporting Goods Sales Tax are not directly related to park use, no other significant tax or user fee provides a greater connection to park use.
- Statutory allocations have exceeded appropriations out of the General Revenue–Dedicated Texas Parks and Wildlife Conservation and Capital Account and the General Revenue–Dedicated Texas Recreation and Local Parks Account. In addition, appropriations out of the General Revenue–Dedicated State Parks Account have not always taken advantage of increased state park revenue. As a result, unexpended balances in these three accounts have grown over time.
- There are sufficient balances available in the General Revenue–Dedicated Texas Recreation and Local Parks Account to fund local park grants at the $15.5 million annual level currently allowed by statute through fiscal year 2011.
- The Texas Parks and Wildlife Department identified more than $345 million in repair and facility needs at parks statewide. However, there is insufficient unissued bond authority available to meet these needs.
- For the 2008–09 biennium, the Texas Parks and Wildlife Department requested an increase of $85.4 million per year to provide "adequate funding" for state parks and support functions. While the agency has transferred operations and/or ownership of 12 state parks and historic sites to other public and private entities since fiscal year 1999, the extent of the current need suggests the agency should identify and initiate actions to transfer parks and historic sites that are not in alignment with the agency's mission and state conservation and recreation needs.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Tax Code, Section 151.801 to remove the existing statutory Sporting Goods Sales Tax cap of $32 million per year and authorize the Texas Legislature to set the cap each biennium in the General Appropriations Act.

- **Recommendation 2:** Maximize the use of Sporting Goods Sales Tax revenue by replacing the allocation of Boat and Boat Motor Sales and Use Tax in the Texas Parks and Wildlife Department's method-of-finance table with Sporting Goods Sales Tax revenue.
- **Recommendation 3:** Appropriate, for the 2008–09 biennium, the unexpended balances in the three General Revenue–Dedicated accounts (State Parks Account, Texas Recreation and Parks Account, and Parks and Wildlife Conservation and Capital Account) that receive revenue from the Sporting Goods Sales Tax.
- **Recommendation 4:** Amend Texas Parks and Wildlife Code, Section 24.003 to temporarily suspend the Sporting Goods Sales Tax allocation to the General Revenue-Dedicated Texas Recreation and Local Parks Account for the acquisition and development of local parks until fiscal year 2012.
- **Recommendation 5:** Appropriate, for the 2008–09 biennium, Sporting Goods Sales Tax revenue for park capital repair and debt service needs.
- **Recommendation 6:** The Texas and Parks Wildlife Department should identify park and historic sites that may be transferred to local governments, private or non-profit entities or other state agencies and initiate appropriate action to transfer sites.

DISCUSSION

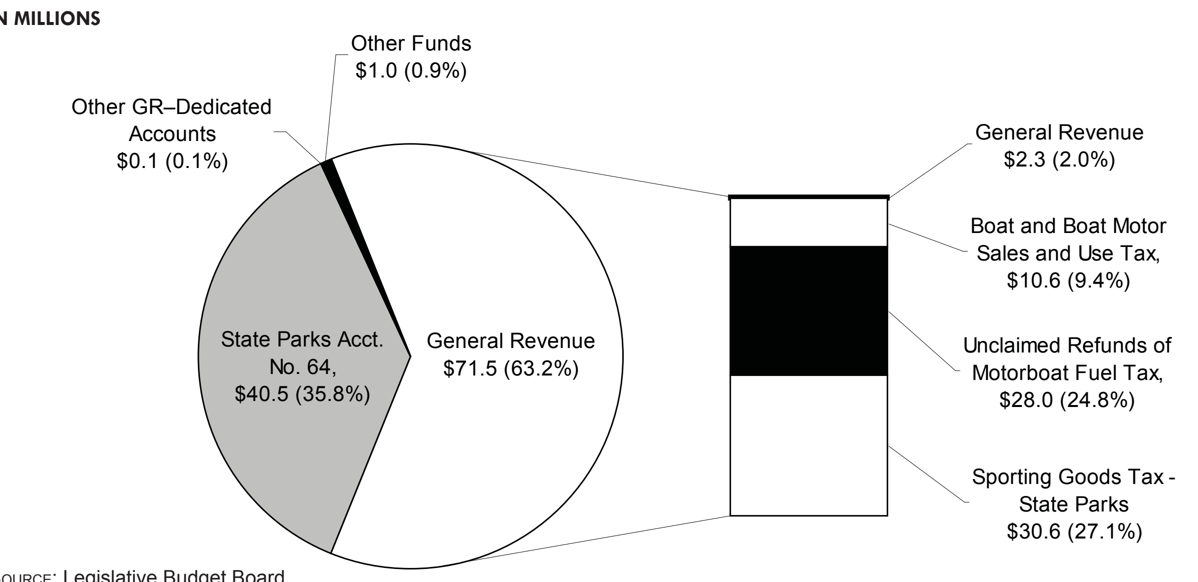
The Texas Parks and Wildlife Department (TPWD) manages and operates a total of 108 state parks, natural areas and historic sites, totaling about 596,000 acres. In fiscal year 2005, more than 9 million people visited these sites, and the state will spend more than $113 million during the 2006–07 biennium to operate state parks. State parks have historically been non self–supporting, thus requiring the appropriation of General Revenue Funds. **Figure 1** shows the methods of finance for state parks.

State parks are funded by an allocation of the Sporting Goods Sales Tax, the Boat and Boat Motor Sales and Use Tax, and a statutory allocation that TPWD receives from the Unclaimed Refunds of Motorboat Fuel Tax. Legislation enacted in 2003 provides another source of General Revenue–Dedicated Funds for state parks. TPWD is required to transfer 15 percent of all annual boat registration and title fees deposited into the Game, Fish and Water Safety Account, and transfer it to the State Parks Account. Between the existing allocations of funds from the Sporting Goods Sales Tax, Boat and Boat Motor Sales and Use Tax, and Unclaimed Refunds of Motorboat Fuel Tax, approximately 63 percent of state park operations are funded with General Revenue Funds.

Figure 2 shows the percentage change in the operating budget for state parks over the last four biennia.

FIGURE 1
STATE PARK FUNDING, BY METHOD OF FINANCE
2006–07 BIENNIUM

IN MILLIONS



Source: Legislative Budget Board.

FIGURE 2
COMBINED STATE PARK OPERATIONS STRATEGIES, 1998 TO 2007 BIENNIA

BIENNIUM	BIENNIAL TOTAL	PERCENTAGE CHANGE
1998–99	$68,422,737	-
2000–01	$85,651,203	25.2%
2002–03	$100,556,206	17.4%
2004–05	$103,172,726	2.6%
2006–07	$113,139,314	9.7%
Spending increase – 1998–99 to 2006–07		65.4%

SOURCE: Legislative Budget Board; Texas Parks and Wildlife Department.

SPORTING GOODS SALES TAX ALLOCATION

Since 1993, a portion of the sales tax revenue generated by sporting goods has been statutorily allocated to fund state park operations, capital, and local park grants. Prior to 1993, state and local parks were each allocated a one penny per pack tax on cigarettes, which probably set the precedent for providing equal allocations to state and local parks. The Sporting Goods Sales Tax allocation was introduced because the cigarette tax proved to be a declining revenue source that bore no relationship to the mission of providing state park services.

The Texas Tax Code Section 151.801 limits the Sporting Goods Sales Tax credited to the Texas Parks and Wildlife Department to $32 million per year. Unlike taxes on specific items, the Comptroller of Public Accounts (CPA) estimates revenue from this tax based on a statutory definition of sporting goods. As shown in **Figure 3**, according to the CPA, two-thirds of Sporting Goods Sales Tax revenue is generated from sales of bicycles and related supplies, hunting and firearms equipment, exercise equipment, and fishing tackle.

The CPA derives estimates for this tax using a national survey of the sporting goods market. **Figure 4** shows Sporting Goods Sales Tax collections for fiscal years 1993 to estimated 2009, and appropriations for state and local parks out of this revenue source for fiscal years 1993 to 2007.

According to the April 2000 Sunset Advisory Commission Staff Report on TPWD, while some components of the Sporting Goods Sales Tax are not directly related to park use, no other significant tax or user fee provides a greater connection to park use. Approximately $20.5 million of an estimated $104.8 million in Sporting Goods Sales Tax revenue was appropriated for state and local parks in fiscal year 2006. The remaining revenue from the Sporting Goods Sales Tax was deposited to the state's General Revenue Fund.

FIGURE 3
ESTIMATED STATE SALES TAX REVENUE FROM THE SALE OF SPORTING GOODS FISCAL YEAR 2006

CATEGORY OF SPORTING GOOD	REVENUE (IN THOUSANDS)	PERCENTAGE OF TOTAL	CUMULATIVE PERCENTAGE
Bicycles and Supplies	$20,596.3	19.6%	19.6%
Hunting and Firearms Equipment	19,851.7	18.9	38.5
Exercise Equipment	18,573.5	17.7	56.2
Fishing Tackle	12,342.9	11.8	68.0
Golf Equipment	9,663.5	9.2	77.2
Camping	4,488.1	4.3	81.5
Snow Skiing Equipment	3,004.6	2.9	84.4
Hunting-Outdoor Apparel	1,798.9	1.7	86.1
Billiards/Indoor Games	1,833.0	1.7	87.8
Baseball/Softball	1,652.5	1.6	89.4
Skin Diving and Scuba Gear	1,521.8	1.5	90.9
Archery	1,483.2	1.4	92.3
Wheel Sports and Pogo Sticks	1,472.6	1.4	93.7
Tennis Equipment	1,336.4	1.3	95.0
Other	5,212.1	5.0	100.0
TOTAL	**$104,831.1**	**100.0%**	

SOURCE: Comptroller of Public Accounts.

FIGURE 4
STATE SALES TAX COLLECTIONS AND PARK APPROPRIATIONS FROM THE SALE OF SPORTING GOODS
FISCAL YEARS 1993 TO 2009

FISCAL YEAR	COLLECTIONS	APPROPRIATIONS FOR STATE AND LOCAL PARKS
1993	$58,251,000	$26,012,000
1994	$61,113,000	$27,000,000
1995	$64,166,000	$27,000,000
1996	$67,297,000	$32,000,000
1997	$70,520,000	$32,000,000
1998	$73,179,000	$32,000,000
1999	$76,075,000	$32,000,000
2000	$80,008,000	$32,000,000
2001	$84,230,000	$32,000,000
2002	$87,119,000	$32,000,000
2003	$90,905,000	$32,000,000
2004	$93,821,000	$23,654,226
2005	$97,125,000	$23,654,226
2006	$104,831,100	$20,545,580
2007*	$108,396,000	$20,508,448
2008*	$112,512,000	to be determined
2009*	$116,652,000	to be determined

*Estimated.
Source: Comptroller of Public Accounts.

While the types of sporting goods items listed in **Figure 2** may not always be used in state and local parks, surveys have shown a relationship between the purchase of sports equipment and state park visitation.

Recommendation 1 would amend the Texas Tax Code, Section 151.801 to remove the existing statutory Sporting Goods Sales Tax cap of $32 million per year and authorize the Texas Legislature to set the cap each biennium in the General Appropriations Act. Because the funding needs of the state park system and local park grants will fluctuate over time, a cap set in statute limits the flexibility of the Legislature to respond to changing needs. For example, market conditions have allowed the state to issue debt for infrastructure maintenance and repairs, including repairs at state parks, at low interest rates. However, as market conditions change, the state may find that using cash to pay for infrastructure repairs may be a better use of state funds. Creating a cap that "floats" with appropriations would also allow the Legislature to spend one-time revenue sources such as unexpended balances in General Revenue–Dedicated Fund accounts that support parks. Finally, a floating cap would continue to allow the Legislature to spend Sporting Goods Sales Tax not needed to fund state and local parks on other budget priorities.

BOAT AND BOAT MOTOR SALES AND USE TAX

In addition to the Sporting Goods Sales Tax allocation and "pure" General Revenue, there are two other sources of General Revenue Funds that are appropriated for state park operations—the Unclaimed Refunds of Motorboat Fuel Tax, which is statutorily allocated to the agency, and a portion of the Boat and Motorboat Sales and Use Tax. The latter is not a statutory allocation, but rather an allocation that is made through the General Appropriations Act in the agency's method-of-finance table.

As shown in **Figure 5**, the Texas Legislature has appropriated funds collected from the Boat and Boat Motor Sales and Use Tax for state park operations since the 2000–01 biennium.

FIGURE 5
BOAT AND BOAT MOTOR SALES AND USE TAX
FISCAL YEARS 2000 TO 2007

FISCAL YEAR	BOAT AND BOAT MOTOR SALES AND USE TAX ALLOCATION FOR STATE PARKS
2000	$5,600,000
2001	$5,600,000
2002	$5,000,000
2003	$5,600,000
2004	$5,300,000
2005	$5,300,000
2006	$5,300,000
2007	$5,300,000

Source: Legislative Budget Board.

Recommendation 2 would maximize the use of Sporting Goods Sales Tax revenue by replacing the allocation of Boat and Boat Motor Sales and Use Tax in the Texas Parks and Wildlife Department's method-of-finance table with Sporting Goods Sales Tax. This would allow the Boat and Boat Motor Sales and Use Tax to be retained in the state's General Revenue Fund and used for other budget priorities. Since this is not a statutory allocation, no change in statute is required to implement this recommendation.

UNEXPENDED BALANCES IN GENERAL REVENUE–DEDICATED ACCOUNTS

Under current Texas law, revenue from the Sporting Goods Sales Tax is distributed among three General Revenue–Dedicated Fund accounts. Proceeds from the Sporting Goods Sales Tax up to $27 million are divided equally between the State Parks Account and the Texas Recreation and Local Parks Account. Beginning in fiscal year 1996, the state split proceeds above $27 million, up to the statutory cap of $32 million, as follows: 40 percent to State Parks Account, 40 percent to the Texas Recreation and Local Parks Account, and 20 percent to the Texas Parks and Wildlife Conservation and Capital Account.

State Parks Account: Along with several other revenue sources, the Sporting Goods Sales Tax is deposited into the State Parks Account. The Parks and Wildlife Code Section 11.035 allocates $15.5 million annually to this account. The allocation formula is as follows:

- $1,125,000 per month of the first $27 million in Sporting Goods Sales Tax revenue: 12 x $1,125,000 = $13.5 million.
- 40 percent of the amount over $27 million and up to $32 million:
  $5 million x 40 percent = $2 million
- For a total of $13.5 million + $2 million = $15.5 million.

Funds in the account are not designated for a specific purpose by statute, although the Legislature has appropriated the funds in the account for state parks. Use of these funds includes acquisition, planning, development, administration, operation, maintenance, and improvements of state parks and historic sites.

In addition to the Sporting Goods Sales Tax allocation, the State Parks Account receives revenue from a variety of sources:

- state park fees and the Texas State Park Pass;
- 15 percent of boat registration and titling fees deposited to the Game, Fish and Water Safety Account are transferred to the State Parks Account;
- park concessions;
- grants and donations that are restricted to uses identified by the donor;
- land sale proceeds which by law may only be used to acquire or improve land dedicated to the same purpose as the land sold;
- the sale of timber or iron ore from state park lands; and
- income from leases and royalties for oil and gas on state park lands.

Texas Recreation and Local Parks Account: The allocation of Sporting Goods Sales Tax revenue to the Texas Recreation and Parks Account (Texas Parks and Wildlife Code Section 24.003) is done in the same manner and allotted the same amount, $15.5 million, as the State Parks Account.

TPWD can use money in the Texas Recreation and Local Parks Account to provide the local match for federal grants; state matching grants of 50 percent for the acquisition and development of local parks; and grants for local recreation, conservation, or educational programs targeted towards underserved populations. By law, when revenues (i.e., the Sporting Goods Sales Tax allocation) to the account exceed $14 million per year, 15 percent of these receipts must be spent on matching grants of 50 percent for the acquisition and development of indoor recreation facilities.

Parks and Wildlife Conservation and Capital Account: The Parks and Wildlife Conservation and Capital Account receives the remainder of the $32 million annual Sporting Goods Sales Tax allocation after distributions to the State Parks Account and the Texas Recreation and Local Parks Account are made (Texas Parks and Wildlife Code Section 11.043). The allocation is calculated as follows:

- State Parks Account allocation of $15.5 million + Texas Recreation and Local Parks Account allocation of $15.5 million = $31 million.
- The remainder: $32 million - $31 million = $1 million.

Funds in the Parks and Wildlife Conservation and Capital Account can only be used to acquire and develop parks, fisheries and wildlife projects, including repair/renovation, improvements, equipment and debt service for these properties.

The other sources of revenue that are deposited into this account besides the Sporting Goods Sales Tax include motor vehicle registration fees and interest on state deposits and treasury investments. This revenue is restricted to specific uses.

Balances in these three accounts have increased since fiscal year 2001 due to (1) entrance and use fee increases implemented in March 2003 and (2) statewide budget reductions of 7 percent in fiscal year 2003 and 12.5 percent in the 2004–05 biennium, which resulted in the Texas Legislature appropriating:

a) $14.7 million less than the $31 million Sporting Goods Sales Tax allocation for local park grants in the 2004–05 biennium and $20.5 million less in the 2006–07 biennium; and

b) none of the $2 million Sporting Goods Sales Tax allocation for capital projects in the 2004–05 and 2006–07 biennia.

Because statutory allocations to the Texas Recreation and Parks Account and the Parks and Wildlife Conservation and Capital Account have exceeded appropriations from these accounts, and because appropriations out of the State Parks Account have not taken advantage of increased state park fee revenue, unexpended balances in these accounts have grown over time, especially the Texas Recreation and Parks Account and the Parks and Wildlife Conservation and Capital Account. The ending balances for the accounts from fiscal year 2001 to fiscal year 2007 are shown in **Figure 6**.

Recommendation 3 proposes that the Texas Legislature consider appropriating the unexpended balances in the three General Revenue–Dedicated accounts that receive Sporting Goods Sales Tax (i.e., State Parks Account, Texas Recreation and Parks Account, and Parks and Wildlife Conservation and Capital Account). This would reduce the need to appropriate new Sporting Goods Sales Tax revenue in the 2008–09 biennium.

Since the 2004–05 biennium, the Legislature has appropriated less than the statutory allocation of the Sporting Goods Sales Tax to local parks. Despite reductions in appropriations, the Sporting Goods Sales Tax allocation for local parks continues to be a revenue stream to the Texas Recreation and Local Parks Account. Since fiscal year 2004, balances in this account have grown significantly and are used by the Comptroller to certify the General Appropriations Bill.

Recommendation 4 would amend the Texas Parks and Wildlife Code, Section 24.003 to temporarily suspend the Sporting Goods Sales Tax allocation to the General Revenue–Dedicated Texas Recreation and Local Parks Account for the acquisition and development of local parks until fiscal year 2012. The current estimated ending balance for fiscal year 2007 of $72 million is sufficient to fund local park grants at the $15.5 million annual level currently allowed by statute through fiscal year 2011.

PARK REPAIR AND FACILITY NEEDS

TPWD has identified more than $345 million in repair and facility needs at parks statewide. Of this amount, $66 million of repairs is considered critical and relates to health and safety or regulatory compliance (e.g., water/waste water systems). Both revenue and general obligation bonds have been issued in the past to fund repairs. While bond financing is available for a portion of current needs, Sporting Goods Sales Tax revenue could also be used to finance capital repairs which would reduce the need for long-term debt in future years.

Since 1967, $189.8 million in bonds have been authorized to fund the long-term capital needs at TPWD facilities. Major bond programs and their legal authorizations include:

- $75 million in park development bonds, Section 49-e, Article III, Texas Constitution. Also known as the "Connally Bonds," these bonds were originally authorized by the voters in 1967.
- $60 million in revenue bonds, General Appropriations Act, Seventy-fifth Legislature, 1997; House Bill 3189, Seventy–fifth Legislature, 1999.

FIGURE 6
ENDING BALANCES IN ACCOUNTS NO. 64, NO. 467, AND NO. 5004, FISCAL YEARS 2001 TO 2007

	ESTIMATED ENDING BALANCE			
ACCOUNT	FISCAL YEAR 2001	FISCAL YEAR 2003	FISCAL YEAR 2005	FISCAL YEAR 2007
State Parks Account No. 64	$1,535,083	$1,569,716	$3,019,598	$9,829,826
Texas Recreation and Local Parks Account No. 467	$4,042,707	$36,841,583	$46,734,233	$72,017,035
Parks and Wildlife Conservation and Capital Account No. 5004	$139,433	$2,010,342	$2,443,983	$5,801,290

SOURCES: Comptroller of Public Accounts; Texas Parks and Wildlife Department.

- $54.8 million in general obligation bonds, Section 49-h, Article III, Texas Constitution; House Bill 3064, Seventy-seventh Legislature; General Appropriations Act, Seventy-seventh Legislature, 2001; and General Appropriations Act, Seventy-ninth Legislature, 2005. Also known as "Proposition 8" bonds, the Texas Legislature must authorize the expenditure of these bonds before they are issued.

The Seventy-fifth Legislature, Regular Session, 1997, appropriated $60 million in revenue bonds to address a backlog of critical repairs. As of November 2006, TPWD expended all of these bond proceeds, mostly for water and wastewater renovations and general facility repairs.

The Seventy-sixth Legislature, Regular Session, 1999, allocated $16.3 million of the remaining $75 million of park development bonds for conservation education projects, including construction of nine World Birding Centers in South Texas. As of November 2006, TPWD expended all of these funds.

For fiscal year 2003, the Texas Legislature appropriated $36.8 million in Proposition 8 bonds to address a backlog of critical repairs, fund scheduled repairs, and provide for development and renovations at a handful of specific park sites. To date, TPWD has expended or encumbered $31.7 million of the $36.8 million appropriation. This was the first appropriation of the $101.5 million in Proposition 8 bond proceeds that have been requested by the agency.

To avoid new debt service costs, the Seventy-eighth Legislature, Regular Session, 2003, did not appropriate any additional Proposition 8 bonds for the 2004–05 biennium. Non-self-supporting general obligation bonds like the Proposition 8 bonds depend on the General Revenue Fund for debt service, and represent debt that the state is pledged to pay with the first receipts of General Revenue Funds deposited into the state treasury. The Seventy-ninth Legislature, Regular Session, 2005, appropriated $18.1 million in additional Proposition 8 bonds for the 2006–07 biennium to fund scheduled repairs. **Figure 7** shows the project and timeframe allocations for Proposition 8 bond proceeds that have been approved by the Legislature or requested by the agency.

Proposition 8 bond proceeds have been spent on projects not only at state parks, but also wildlife and fisheries facilities. The agency estimates that approximately 83 percent of revenue bond proceeds and 72 percent of Proposition 8 bond proceeds were expended on capital projects at state parks since fiscal year 1998. As required by the Texas Constitution, all park development bond proceeds have been spent on state park projects.

Recommendation 5 would appropriate Sporting Goods Sales Tax revenue for park capital repair and debt service needs. Of

FIGURE 7
PROPOSITION 8 BOND PROCEEDS ALLOCATION, FISCAL YEAR 2002 THROUGH THE 2008–09 BIENNIUM ($ MILLIONS)

	APPROVED			AGENCY REQUEST	
CATEGORY	2002–03	2004–05	2006–07	2008–09	TOTAL
Scheduled Repairs	$32.5	$0.0	$18.08	$18.4	$69.0
Park-related	23.4	0.0	12.8	15.7	51.9
Wildlife/Fisheries Related	9.1	0.0	5.2	2.8	17.1
Park Specific Funding					
San Jacinto	0.9	0.0	0.0	11.4	12.3
Battleship TEXAS	0.1	0.0	0.0	12.4	12.5
Admiral Nimitz*	0.4	0.0	0.0	0.0*	1.1*
Sheldon Lake	2.6	0.0	0.0	0.0	2.6
Levi-Jordan	0.3	0.0	0.0	3.8	4.1
Total	**$36.8**	**$0.0**	**$18.08**	**$46.0**	**$101.5**

*The Admiral Nimitz Historic Site was transferred to the Texas Historical Commission in fiscal year 2006. The Texas Historical Commission has not requested the amount that could have been allocated for the site for the 2008–09 biennium—$0.7 million. As a result this amount is available for other purposes. The Texas Historical Commission does have a related $1.2 million in General Revenue Funds exceptional item request for the site, now called the National Museum of the Pacific War. Requested funding would provide for renovations, exhibits, facilities maintenance, and capital repairs.
Sources: Legislative Budget Board; Texas Parks and Wildlife Department.

the $850 million in Proposition 8 bonds originally authorized, approximately $280.5 million in unissued authority remains. TPWD is one of 14 agencies authorized to spend Proposition 8 bond proceeds. Consequently, an alternative funding source may be required to fund state park repair projects. Increasing the appropriation of Sporting Goods Sales Tax revenue to the Parks and Wildlife Conservation and Capital Account, which may be used to fund capital repairs, renovations and debt service, would provide alternative funding.

Debt service requirements for parks-related bond projects totaled $16.3 million in General Revenue Funds for the 2006–07 biennium. Of this amount, $8.8 million is for debt service on prior issuances of revenue bonds and is appropriated to TPWD. An additional $7.5 million in General Revenue Funds is appropriated to the Texas Public Finance Authority for debt service on general obligation bonds for state park projects. Existing debt service requirements are estimated to be $18.4 million in General Revenue Funds in the 2008–09 biennium. Using Sporting Goods Sales Tax revenue for debt service would allow "pure" General Revenue Funds to be appropriated for other priorities.

TRANSFERRING STATE PARK OWNERSHIP AND OPERATIONS

The current state park inventory includes 108 state parks, natural areas, and historic sites. Since fiscal year 2001, the agency has transferred operations and/or ownership of 12 state parks, natural areas, and historic sites as shown in **Figure 8**.

Transferring state parks, natural areas, and historic sites can reduce overall operating costs when the transferred site costs more to operate than it generates in revenue. For example, in fiscal year 2006 the agency transferred five sites to other state agencies, a non-profit organization and a local government. Site transfers provided the agency with a total cost savings for the 2006–07 biennium of $765,657 as shown in **Figure 9**. These are funds that are available to pay operating expenses at other sites in future biennia.

In its 2005 Land and Water Resources Conservation and Recreation Plan, the TPWD designated 17 state parks that were eligible for transfer. Four of the state parks have been transferred since then, leaving 13 for future consideration. The agency indicated in its 2005 Land and Water Conservation Plan that it will consider transferring these sites if the opportunity arises.

The TPWD used the following criteria to identify these 17 potential transfer sites:

- site functions more as a local park and has been developed for local use (e.g., baseball fields, swimming pools; golf courses);
- site serves a single community (e.g., completely surrounded by a single community);
- site is small with little opportunity for expansion;

FIGURE 8
PARK, NATURAL AREA, AND HISTORIC SITE TRANSFERS, MARCH 2001 TO DECEMBER 2006

DATE OF TRANSFER	TEXAS PARKS AND WILDLIFE DEPARTMENT PROPERTY	TRANSFER ENTITY
March-01	Lubbock Lake Landmark	Texas Tech University
January-02	Jim Hogg State Historic Site	City of Rusk
May-02	Lake Rita Blanca	City of Dalhart
August-02	Port Lavaca Fishing Pier	City of Port Lavaca
August-02	Old Fort Parker	Limestone County
February-03	Boca Chica State Park	Lease to U.S. Fish and Wildlife Service
February-04	Kerrville Schreiner State Park	City of Kerrville
November-05	Admiral Nimitz Historic Site	Texas Historical Commission
December-05	Matagorda Island	Wildlife Division – Texas Parks and Wildlife Department
January-06	Bright Leaf Natural Area	Austin Community Foundation
February-06	Copano Bay Fishing Pier	Texas Department of Transportation
August-06	Lake Houston State Park	City of Houston

SOURCES: Legislative Budget Board; Texas Parks and Wildlife Department.

FIGURE 9
COST SAVINGS RESULTING FROM FACILITY TRANSFERS, FISCAL YEARS 2006–07

FACILITY	TRANSFER DATE	RECIPIENT	ESTIMATED EXPENDED FISCAL YEAR 2006	REVENUE FISCAL YEAR 2006	ESTIMATED PROFIT/ (LOSS) FISCAL YEAR 2006	ESTIMATED NET (COST)/SAVINGS FISCAL YEAR 2006	ESTIMATED NET (COST)/ SAVINGS FISCAL YEAR 2007
Nimitz Historic Site	Nov-05	Texas Historical Commission	$739,399	$415,548	($323,851)	No savings	No savings
Matagorda Island	Dec-05	Texas Parks and Wildlife Deparment	$106,545	Not Available	Not Available	$194,184	$300,729
Bright Leaf State Natural Area	Jan-06	Austin Community Foundation	$29,015	Not Available	Not Available	$29,617	$58,632
Copano Bay Fishing Pier	Feb-06	Texas Department of Transportation	$0	$0	$26,488	($26,488)	($26,488)
Lake Houston State Park	Aug-06	City of Houston	$89,414	$74,681	($14,733)	$110,369	$125,102
TOTAL						**$307,682**	**$457,975**

Note: (Cost)/savings in 2006–07 are compared to 2005 figures. Prorated (cost)/savings shown in fiscal year 2006 based on reduced number of months in operation if applicable; fiscal year 2007 reflects a full 12 months of (cost)/savings.
Sources: Legislative Budget Board; Texas Parks and Wildlife Department.

- site is underutilized;
- future development of site is not funded; and
- site is adjacent to land owned by another recreation or conservation organization that could better manage the site.

The 2005 Land and Water Conservation Plan noted that TPWD leases many sites from other governmental entities. When these lease agreements expire or if an opportunity to terminate the lease arises, the agency may return management responsibility of the site. The agency evaluates state parks on lakes to determine whether the entire lake should be managed by it or another entity to avoid redundancy and duplication of effort.

Figure 10 shows the 13 state parks eligible for transfer according to agency. Those assigned a ranking of "1" could be transferred by not renewing a lease. Those with a ranking of "2" include parks that are owned by the TPWD, but could be transferred to local government for operation and maintenance. The agency has the authority to award grants to entities that are willing to assume this responsibility. In the past, the agency has in some instances included deed restrictions in its title transfers and ensure that a property continues to be a public park and that natural and cultural resources are protected. If all 13 state parks were transferred, the state would save approximately $745,000 per year in net operating expenses, the sum of total expenditures minus revenues.

In December 2006, the agency identified 21 historic sites eligible for transfer to the Texas Historical Commission. **Figure 11** shows a listing of the 21 sites. The agency used two criteria to identify these sites— 1-none of the identified sites operate outdoor recreation facilities, and 2-none require park police protection.

Recommendation 6 directs TPWD to develop a list of park and historic sites that may be transferred to local governments, private or non-profit entities or other state agencies and initiate appropriate action to transfer sites. While the agency has transferred operations and/or ownership of parks in the past, the extent of the current need suggests the agency should identify and initiate actions to transfer parks and historic sites that are not in alignment with the agency's mission and state conservation and recreation needs. Criteria TPWD could consider in making this assessment include:

- the profit/loss of each park;
- proximity to urban areas;
- statewide significance of the site's heritage, cultural, and natural resources;

FIGURE 10
POTENTIAL STATE PARK SITES TO TRANSFER

RANK	TPWD PROPERTY	FISCAL YEAR 2006 BUDGETED	FISCAL YEAR 2006 FULL-TIME EQUIVALENTS	FISCAL YEAR 2005 REVENUE	FISCAL YEAR 2005 EXPENDITURES	SAVINGS/ (COST) IF TRANSFERRED	FISCAL YEAR 2005 VISITORS	POTENTIAL TRANSFER ENTITY	NEARBY CITY
1	Lake Casa Blanca	$541,038	13.90	$599,655	$476,350	($123,305)	219,764	Webb County	Laredo
1	Lake Whitney	367,473	9.00	354,518	329,518	(25,000)	135,112	Corps of Engineer	Whitney
1	Lake Texana	408,576	9.76	262,996	408,149	145,153	87,418	Lavaca/Navidad River Authority	Edna
1	Somerville - Birch Creek	360,165	8.74	274,012	306,187	32,175	205,656	Corps of Engineer	Somerville
1	Somerville - Nails Creek	166,664	3.37	123,688	273,058	149,370	58,003	Corps of Engineer	Ledbetter
1	Lake Colorado City	349,954	9.06	141,470	328,457	186,987	58,078	Texas Electric	Colorado City
1	Atlanta	211,276	5.47	70,515	180,331	109,816	37,089	Corps of Engineer	Atlanta
1	Lake Tawakoni	279,303	6.49	237,335	267,350	30,015	59,200	Sabine River Authority	Wills Point
1	Martin Creek Lake	300,780	7.38	220,115	275,912	55,797	75,832	Texas Utilities	Tatum
2	Lockhart	298,967	7.30	202,541	278,885	76,344	47,548	Local Management	Lockhart
2	McKinney Falls	423,368	10.17	513,376	382,839	(130,537)	93,595	Local Management	Austin
2	Big Spring	104,338	2.38	29,449	97,206	67,757	38,299	Local Management	Big Spring
2	Lake Arrowhead	318,556	7.40	112,806	283,432	170,626	68,811	Local Management	Wichita Falls
	Totals	**$4,130,457**	**100.00**	**$3,142,476**	**$3,887,674**	**$745,198**	**1,184,405**		

SOURCES: Legislative Budget Board; Texas Parks and Wildlife Department.

FIGURE 11
TEXAS PARKS AND WILDLIFE DEPARTMENT HISTORIC SITES TO TRANSFER

	HISTORIC SITE	FISCAL YEAR 2006 REVENUE	FISCAL YEAR 2006 BUDGETED	SAVINGS/(COST) IF TRANSFERRED	FISCAL YEAR 2006 FULL-TIME EQUIVALENTS	FISCAL YEAR 2005 VISITORS
1	Acton Cemetery	n/a	n/a	n/a	n/a	n/a
2	Caddoan Mounds	$10,933	$74,384	$63,451	2.5	6,192
3	Casa Navarro	6,518	67,943	61,425	1.8	2,351
4	Confederate Reunion Grounds	n/a		n/a		10,435
5	Eisenhower Birthplace	15,971	85,991	70,020	2.0	8,936
6	Fanin Battleground	0	33,552	33,552	1.0	10,973
7	Fanthorp Inn	3,200	65,287	62,087	1.8	1,877
8	Fort Lancaster	5,631	68,573	62,942	1.8	2,773
9	Fort Leaton	10,986	152,354	141,368	3.3	3,566
10	Fulton Mansion	131,728	215,800	84,072	5.7	16,209
11	Landmark Inn	135,950	184,603	48,653	5.0	8,348
12	Levi Jordan	n/a	n/a	n/a	n/a	n/a
13	Lipantitlan	n/a	n/a	n/a	n/a	n/a
14	Magoffin Home	10,498	125,952	115,454	3.9	5,074
15	Monument Hill/Kreishe Brewery	20,871	145,987	125,116	3.9	10,658
16	Post Isabel	n/a	n/a	n/a	n/a	n/a
17	Sabine Pass	0	40,189	40,189	1.0	35,423
18	Sam Bell Maxey House	1,140	89,709	88,569	1.9	3,985
19	Sebastopol House	2,316	108,209	105,893	2.5	2,836
20	Starr Family	6,102	106,398	100,296	2.4	3,710
21	Varner-Hogg Plantation	23,424	282,652	259,228	7.2	38,816
	Totals	**$385,268**	**$1,847,582**	**$1,462,314**	**47.6**	**172,162**

SOURCES: Legislative Budget Board; Texas Parks and Wildlife Department.

- visitation and occupancy rates;
- availability of similar recreational areas or facilities in close proximity; and
- the site's deferred maintenance needs.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementing all six recommendations would have a cost of $36.2 million in General Revenue–Dedicated Funds for the 2008–09 biennium, as a result of spending balances in the General Revenue–Dedicated State Parks Account, Texas Recreation and Local Parks Account and Parks and Wildlife Conservation and Capital Account. **Figure 12** shows the five-year fiscal impact of the recommendations. The introduced 2008–09 General Appropriations Bill includes $5,231,242 per year in Sporting Goods Sales Tax revenue for local park grants. The 2008–09 cost shown below for the General Revenue–Dedicated Texas Recreation and Local Parks Account reflects the incremental amount required to reach an annual funding level of $15.5 million. There could be additional costs depending on appropriation decisions made by the Eightieth Legislature regarding funding for state and local parks.

The introduced 2008–09 General Appropriations Bill does not address any of the six recommendations.

FIGURE 12
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2008 TO 2012

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED STATE PARKS ACCOUNT	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED TEXAS RECREATION AND LOCAL PARKS ACCOUNT	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE–DEDICATED PARKS AND WILDLIFE CONSERVATION AND CAPITAL ACCOUNT
2008	($9,829,826)	($10,268,758)	($5,801,290)
2009	$0	($10,268,758)	$0
2010	$0	($10,268,758)	$0
2011	$0	($10,268,758)	$0
2012	$0	($4,785,793)	$0

SOURCE: Legislative Budget Board.

IMPROVE MANAGEMENT OF THE STATE PARK SYSTEM

In August 2006, the State Parks Advisory Committee presented a report to the Texas Parks and Wildlife Commission recommending that all proceeds from the Sporting Goods Sales Tax, along with any related user fees and taxes, be appropriated to operate and repair the infrastructure of the state park system. In response to this report, and other concerns, the Texas Parks and Wildlife Department submitted a Legislative Appropriation Request to the Governor and the Legislative Budget Board that would increase operating and capital funding for the state park system by $183.6 million for the 2008–09 biennium, compared to the $168.7 million expended and budgeted for the 2006–07 biennium in All Funds. Overall, the agency has requested $352.3 million for state park funding.

Before increasing appropriations to this level, the agency could improve its analysis and evaluation practices, and thereby improve state park facilities and operations management, at its current level of funding. These steps would help the agency ensure the public safety of state park staff and visitors, provide better financial oversight, and enhance visitor services.

CONCERNS

- ♦ The Texas Parks and Wildlife Department lacks a standard definition for "health and safety repair needs" and does not indicate or flag such repair needs in its facility management information system. As a result, Austin headquarters' staff must do extensive work to sort out and prioritize health and safety risks.
- ♦ One-quarter of state park funding, or an estimated $15.2 million in fiscal year 2007, is attributable to direct and indirect administrative costs. In spite of this significant administrative cost percentage, the Texas Parks and Wildlife Department has not allocated sufficient support for important budget and law enforcement oversight functions.
- ♦ The quality of state park visitor services, facility maintenance, and staff performance are not evaluated in a comprehensive and integrated manner. As a result, the agency does not have consistent information about the quality of park operations.
- ♦ The Texas Parks and Wildlife Department does not require state park managers to provide a thorough analysis of their private park competitors' fees, services, and occupancy when they submit annual fee-adjustment proposals.
- ♦ Fee proposals, which are user fee recommendations from each state park manager, are submitted to the Texas Parks and Wildlife Department headquarters in a paper format. This format increases the time and cost involved in reviewing the proposals.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Include a rider in the 2008–09 General Appropriations Bill requiring state park employees to use a standard definition to identify or flag health and safety-related repair needs in its facility management information system.
- ♦ **Recommendation 2:** Include a rider in the 2008–09 General Appropriations Bill requiring the Texas Parks and Wildlife Department to redirect staff resources so that critical budget, law enforcement, and overall public safety management functions are performed.
- ♦ **Recommendation 3:** Include a rider in the 2008–09 General Appropriations Bill requiring the Texas Parks and Wildlife Department to develop and implement an annual state park performance review process that evaluates visitor satisfaction, safety, staff performance, occupancy rates, park and concession profitability, and the facility maintenance of each state park and historic site.
- ♦ **Recommendation 4:** Include a rider in the 2008–09 General Appropriations Bill requiring all state park managers to conduct a thorough competitive analysis that shows their competitors' fee levels, visitor capacity, services, and amenities.

DISCUSSION

The Texas Parks and Wildlife Department (TPWD) manages the natural and cultural resources of Texas and provides hunting, fishing, and outdoor recreational opportunities. Appropriations for the 2006–07 biennium total $500.7 million in All Funds. The TPWD is authorized to employ

2,901.8 full-time-equivalent positions to fulfill the agency's responsibilities. Agency programs are managed by six divisions:

- Coastal Fisheries
- Inland Fisheries
- Infrastructure
- Law Enforcement
- State Parks
- Wildlife

Agency administrative support is provided by four divisions:

- Administrative Resources
- Communications
- Human Resources
- Information Technology

STATE PARKS ADVISORY COMMITTEE REPORT

To better understand and address the challenges facing the state park system, The Texas Parks and Wildlife Commission appointed the State Parks Advisory Committee in April 2006 to make recommendations in four areas:

- Funding options to properly care for the existing state park system;
- Any existing units of the system that might be operated by more appropriate entities;
- The role of public-private partnerships in parks; and
- Options to secure the future needs for state and local parks identified in the TPW Land and Water Resources Conservation and Recreation Plan.

The committee issued a report in August 2006 containing a recommendation regarding the use of sporting goods sales tax revenue. Under current law, the agency may not use more than $32 million per year of sporting sales tax revenue to support state and local parks. The committee recommended removing this cap, which would result in all sporting goods sales tax revenue, which is estimated to be $112.5 million for fiscal year 2008, being allocated to state and local park support.

Although the TPWD's Legislative Appropriation Request to the Legislative Budget Board and the Governor does not assume full use of the sporting goods sales tax, the agency's request for 2008–09 biennial state park funding is twice the amount expended and budgeted for the 2006–07 biennium in All Funds. The total 2008–09 biennial request, which includes operating costs, capital repairs, new land acquisition, and bond proceeds, is $352.3 million.

Several steps could be taken, however, to improve the management of the state park system with the agency's current level of funding. They would allow the agency to better evaluate and respond to infrastructure and operational challenges, and enhance the physical condition of and visitor satisfaction with state parks.

STANDARDIZE STATE PARK INFRASTRUCTURE REPAIR PROCESS

The TPWD created the Infrastructure Division in 1997 to provide project management, professional planning, design, construction, and technical services. A key feature of the division's responsibilities is planning and implementing repairs to the state park system's aging infrastructure.

The repair planning and budgeting process begins when park managers and regional directors enter information about facility problems into the Facility Management Information System (FMIS) and ends in the division submitting a prioritized project list and related budget to the agency director and commission for approval. The repair list for the first year of the biennium is adopted in the summer before the fiscal year begins. During the second year, a repair list is adopted in November in preparation for each regular legislative session. The list typically contains new proposed projects and prior year repair needs that have not been addressed.

Before a project list is submitted to the TPWD's executive director and the Texas Parks and Wildlife Commission, each project on the list must first be scoped and a cost estimate developed for the project. Information used to produce a project scope and estimated budget is developed through extensive communication with state parks mangers and regional directors. The FMIS database contains both minor and major repair needs. Minor repairs are done by the State Parks Division staff, while the Infrastructure Division conducts major repair projects.

According to the agency, the FMIS database does not isolate or identify health and safety repair needs. When a park manager enters a repair problem into the database, there is no way to flag items that put the public or park staff at risk. During the process of developing a major repair list for

management approval, Infrastructure Division must contact park managers to determine a facility problem's severity.

With no standard definition for health or safety facility problems, park managers and Infrastructure Division staff will have differing opinions about what constitutes a public safety risk. As a result, descriptions of facility problems in FMIS are inconsistent. At a minimum, this lack of common terms for identifying health and safety facility problems results in an inefficient process for arriving at an annual major repair plan.

Recommendation 1 would require state park employees to use a standard definition to flag health and safety facility problems in the FMIS. Agency management would check the facility database to identify new facility problems and then set priorities to address these problems on a regular basis. This standardization would ensure that the Infrastructure Division and park managers use a clear and consistent definition for the most critical facility problems risks and be able to act in a timely manner to resolve them.

REDIRECT STAFF RESOURCES FOR BUDGET AND LAW ENFORCEMENT OVERSIGHT

The Law Enforcement and Budget Management branches, which are units within the State Parks Division, play a central role in administering the state park system. The Law Enforcement branch section oversees the performance of 150 park peace officers and ensures that officers comply with state training and conduct standards. The Budget Management branch develops and monitors the budgets of 108 state parks and historic sites.

The agency does not provide adequate resources for these branches. Staffed with three employees, the Budget Management branch administers a complex reporting system that helps develop and monitor the budgets for all state parks and historic sites, as well as the divisions' eight regional offices and its Austin headquarters. Much of the park specific data is compiled manually. The result is that the branch's director does not have enough time to thoroughly review monthly expenditures, compare actual to budgeted expenditures, or spot important trends in expenditure categories on a real-time basis.

The Law Enforcement branch has not been provided the staff to maintain historical data on state park arrests and citations. Although a new process was established in December 2006 in which park police officers will submit patrol logs electronically, historical data on citations and arrests has not been compiled. Also, the agency is unable to provide reports on the number of accidents and injuries that have occurred in each state park.

These shortcomings could be addressed by implementing Recommendation 2. Recommendation 2 would reassign two employees to the Budget Management branch and one employee to the Law Enforcement branch. The Budget Management director would then be able to perform important financial oversight functions. The additional employee for the Law Enforcement branch would allow its director to access and analyze historical information on arrests and citations. Working with the safety staff of the Infrastructure Division, the Law Enforcement branch would be able to generate reports that combine law enforcement data with information on accidents, injuries, and property damage.

As indicated by **Figure 1**, the agency budgeted $15.2 million and 205 full-time equivalents (FTEs) for direct and indirect administration in fiscal year 2007. This amount represents 25 percent of the funding and 18 percent of the FTEs allocated for the state park system in fiscal year 2007. Given this ample level of administrative support, the agency should be able to redirect sufficient resources to ensure that critical

FIGURE 1
TEXAS STATE PARKS SYSTEM DIRECT AND INDIRECT ADMINISTRATIVE RESOURCES
FISCAL YEAR 2007 BUDGETED

	EXPENDITURES	FULL-TIME EQUIVALENTS
Direct Administration		
Austin Headquarters	$5,503,327	69.5
Regional Offices	$2,855,823	38.6
Total, Direct Administration	$8,359,150	108.1
Indirect Administration	$6,875,789	96.9
Total, Direct and Indirect Administration	$15,234,939	205.0
State Park Field Operations	$45,676,062	960.6
Grand Total, Administration and Operations	$60,911,001	1,165.6
Direct and Indirect Administration	$15,234,939	205.0
Percentage of Grand Total	**25%**	**18%**

Source: Legislative Budget Board.

budget, law enforcement, and overall public safety management functions are performed.

DEVELOP AND IMPLEMENT STATE PARK PERFORMANCE REVIEWS

Modern state parks are similar to, and often compete with, urban tourist destinations. In addition to many of the same recreation opportunities that cities now have, state parks provide accommodations such as outdoor dining pavilions, lodging facilities, and utility hookups for large recreational vehicles. Also, parks must ensure visitor comfort with water/wastewater and electricity service, and maintain public safety through law enforcement oversight. This broad range of services, plus newer ones such as wireless internet access, indicates that state parks are attempting to meet the expectations of potential visitors who can choose among many recreation options.

To stay competitive in the outdoor recreation market, this wide range of state park services must be offered in a way that satisfies visitors. For example, the state park system of Florida uses a system of service standards and performance reviews to help ensure visitor satisfaction. Florida state park operations are guided by a set of standards for infrastructure maintenance, public contact, and other features that play a role in visitor satisfaction. Using these standards as a benchmark, regional park managers conduct annual inspections of each park and rate their performance. Any weaknesses found during the inspection are addressed in a corrective action plan that park managers must follow. The success of Florida's performance based system has helped the state win the National Recreation and Parks Association Gold Medal Award in 1999 and 2005.

In contrast to Florida's approach, the TPWD does not conduct annual park reviews or inspections that systematically compare standards to actual performance in the significant areas that affect visitor satisfaction. The agency has made strides to improve the way state parks present themselves to the public. Its Communication Division does visitor surveys to gauge general satisfaction levels. As noted previously, the agency also conducts annual facility-repair assessments. Also, managers in some parks evaluate how their services and fees compare to nearby private parks.

Recommendation 3 would require the TPWD to develop and implement an annual state park performance review that integrates existing visitor surveys and facility condition data, with on-site reviews of safety, staff performance, occupancy rates, and park and concession profitability of each state park and historic site.

Creating a park performance review system could be accomplished with the agency's existing resources. Each park inspection costs the state of Florida approximately $300 per park. The TPWD could develop a set of operating standards by identifying the best practices followed by state park managers. Once standards are in place, the performance review process would integrate visitor survey results and facility maintenance information with inspection ratings performed by the State Park Division's regional directors. Following the example set by the Florida park system, these reviews would be used to develop a corrective action plan to address weaknesses as well as commendations for above average results.

ANALYZE COMPETITION BETWEEN STATE AND PRIVATE PARKS

In 1994, the TPWD established a new "market-oriented" approach to setting park fees. Under this approach, park managers each year recommend entrance, overnight stay, activity, facility use fees, and concession charges. These fees must fall within ranges set by the Texas Parks and Wildlife Commission. Park managers submit a written justification for their fee recommendations, which are reviewed by regional directors, the director of the State Parks Division, and finally the Department's Executive Director. Fee adjustments typically go into effect at the beginning of each calendar year.

Park managers are encouraged to conduct an assessment of the private parks in their vicinity before they recommend a fee adjustment. A thorough assessment involves identifying the kind of services nearby private parks offer, their occupancy capacity, service quality, seasonal use, marketing, and fee levels. This analysis not only lets the manager know whether a fee adjustment should be recommended, but also allows them to identify ways to more successfully compete with private parks.

This kind of thorough analysis is beneficial to both park managers and Austin headquarters staff. A detailed competitive analysis provides valuable information about how well state parks are competing in the recreation market. Also, the affect of increasing park fees on visitation can be better assessed by comparing current or proposed park fees to those charged by the competition. Even though the benefits of a thorough competitive analysis are clear, the State Parks Division encourages but does not require parks manager to

carry them out. Some managers conduct and submit the results of their analyses along with their fee recommendation, but many do not.

Recommendation 4 would require all state park managers to conduct a thorough competitive analysis that shows their competitors' fee levels, visitor capacity, quality of service, and types of amenities. The results of this analysis would accompany annual fee-adjustment proposals. Under this recommendation, the agency would also replace the inefficient practice of submitting fee adjustment proposals in a paper format with an electronic reporting system.

To implement Recommendations 1, 2, 3, and 4, the following rider language could be included in the 2008–09 General Appropriations Bill.

State Park Facilities and Operations Management.
Using the funds appropriated above to the various strategies that are specified in the following provisions, or to any relevant strategy, the Texas Parks and Wildlife Department shall:

a. Require state park employees to use a standard definition to identify or flag health and safety-related repair needs in its facility management information system; and require the Infrastructure Division to monitor and set priorities to address new health and safety-related facility problems on a weekly basis.

b. Redirect $107,161 and three full-time equivalent employees to Strategy B.1.3, Parks Support, from Strategy E.1.1, Central Administration, so that the Budget Management section can perform critical budget analyses, and so that public safety staff, such as the Law Enforcement Division, can produce reports on the number of accidents, injuries, as well as property damage and crime incidents in each state park.

c. From Strategies B.1.1, State Park Operations, and B.1.3, State Park Support, develop and implement an annual state park performance review process that evaluates visitor satisfaction, safety, staff performance, occupancy rates, park and concession profitability, and the facility maintenance of each state park and historic site.

d. From Strategies B.1.1, State Park Operations, and B.1.3, State Park Support, ensure that all park managers conduct a thorough competitive analysis that shows their competitors' fee levels (e.g., private campgrounds such as Kampgrounds of America), visitor capacity, services, and amenities. These analyses should accompany the manager's annual-fee proposals, and the entire package should be submitted electronically.

FISCAL IMPACT OF THE RECOMMENDATIONS

There would be no fiscal impact to the state from Recommendations 1, 2, 3, and 4. The introduced 2008–09 General Appropriations Bill includes a rider to implement Recommendations 1, 2, 3, and 4.

USE UNEMPLOYMENT INSURANCE FUNDS TO PAY RELATED BOND DEBT

As of October 2006, the Texas Unemployment Compensation Trust Fund, which is comprised of employer taxes, had a fund balance of approximately $2 billion. The statutory maximum fund balance was approximately $1.7 billion. The difference is a surplus of $323 million, which employers are entitled to in the form of credits. In fiscal year 2003, the Texas Unemployment Compensation Trust Fund became insolvent and $1.4 billion in bonds were issued by the Texas Public Finance Authority on behalf of the Texas Workforce Commission. The bonds are short-term bonds with low-interest rates. While prepaying the bonds under these conditions may yield minimal benefits to the state, employers would no longer be liable for the obligation tax they are currently paying. This prepayment of the bonds would also increase the Texas Workforce Commission's debt capacity for future use in the case of an economic downturn. Paying the bond debt would benefit employers by keeping unemployment taxes low, reducing an employer's cost of doing business in the state, and by helping to maintain the solvency of the Texas Unemployment Compensation Trust Fund. Employers in Texas could save $5.5 million in assessments for interest payments and debt service reduction if the Texas Workforce Commission used the Texas Unemployment Compensation Trust Fund to pay outstanding bond debt issued to pay unemployment benefits.

CONCERN

- The Texas Labor Code narrowly defines the use of the Texas Unemployment Compensation Trust Fund to be used to pay benefits to claimants. As a result, the state is prevented from using funds from the Texas Unemployment Compensation Trust Fund to pay bonds that have been issued to pay for benefits of eligible unemployed claimants although it is allowed by federal law. Employers are required to pay a separate obligation assessment to pay the outstanding debt—increasing an employer's financial liability.

RECOMMENDATION

- **Recommendation 1:** Amend the Texas Labor Code to allow the amount above the minimum balance in the Texas Unemployment Compensation Trust Fund to be used to pay the principal amount of bond obligations or other debt as allowed by federal law, in addition to its current use.

DISCUSSION

The federal and state governments jointly administer the Texas Unemployment Insurance Program, which provides temporary cash benefits to eligible workers who have become unemployed through no fault of their own. Benefits paid to eligible unemployed claimants come from the Texas Unemployment Compensation Trust Fund. The fund receives revenue from state payroll taxes levied on employers and is a federal trust outside of the state treasury. Section 204.061 of the Texas Labor Code provides that the fund must maintain a minimum balance of $400 million or 1 percent of the state's total taxable wages, whichever is greater. A fund maximum limit is also defined in statute as 2 percent of taxable wages, which was $1.7 billion in October 2006.

Based on the Texas Workforce Commission's (TWC) most recent projections, the statutory floor was $831.2 million in October 2006, and the actual balance was $1,985.2 million. **Figure 1** shows that the projected balance was above the minimum balance by $1,154.0 million and above the ceiling by $322.8 million. The balance has exceeded the ceiling since April 2006.

The fund minimum balance is calculated once each year as part of the unemployment insurance (UI) tax rate calculations to determine whether a deficit tax is necessary for the next tax year. Employers pay the deficit tax, which provides the revenue to maintain the fund's mandatory minimum balance. In addition to maintaining a minimum balance, the fund

FIGURE 1
UNEMPLOYMENT COMPENSATION TRUST FUND BALANCE
FISCAL YEAR 2007

	BALANCE ($ MILLIONS)
October 1, 2006 Balance:	$1,985.2
Trust Fund Minimum Balance:	$831.2
Trust Fund Maximum Balance:	$1,662.4
Balance is above the minimum balance by:	$1,154.0
Balance is above the maximum balance by:	$322.8

SOURCE: Texas Workforce Commission.

must also have enough money to pay its UI claimants. The last time the fund balance fell significantly below the minimum balance was December 2002. The insolvency of the fund prompted TWC to borrow money from the federal government at a 6 percent interest rate, and later issue bonds to make up for the shortfall and repay the federal government. Opting to issue bonds, instead of continuing to borrow from the federal government, saved Texas employers an estimated $300 million over the five-year prepayment period. This action kept employers' taxes from increasing by avoiding a deficit tax.

As provided in Section 203.102 of the Texas Labor Code, bond obligations are paid with funds from the Obligation Trust Fund comprised of receipts from a separate assessment on employers. Employers are assessed an unemployment obligation tax if "bond obligations are due and the amount necessary to pay in full those obligations…is not available in the Obligation Trust Fund or available otherwise." TWC sets the rate in an amount that ensures timely payment of the bond obligations.

In August 2003, TWC completed the sale of $1.4 billion in bonds, which are scheduled to be paid off in December 2009. The proceeds from the sale of the bonds were used for payment of benefits to eligible unemployed claimants, the repayment of principal and interest incurred on advances from the federal government and payment of the interest on the bonds. As shown in **Figure 2**, as of October 31, 2006, there was an outstanding debt balance of $652.2 million, $246.3 million in variable rate debt (series C and D bonds) and $405.9 million in fixed-rate debt (series A and B bonds).

FIGURE 2
TEXAS WORKFORCE COMMISSION
OUTSTANDING BOND DEBT BALANCE
AS OF OCTOBER 2006, FISCAL YEAR 2007

BOND	BALANCE ($ MILLIONS)	MATURITY DATE
Series A:	$256.2	Dec 2008
Series B:	$149.7	Jun 2007
Series C:	$46.3	Prepayment option
Series D:	$200.0	Prepayment option

SOURCE: Texas Public Finance Authority.

The obligation assessment for fiscal year 2007 will yield an estimated $325.3 million for the year, which is sufficient to retire the series B and C bonds as provided in the bond covenants. As a result, series B and C bonds will be completely repaid by the end of fiscal year 2007 and the outstanding debt at that time will be the series A and D bonds in the amount of $421.2 million as shown in **Figure 3**. TWC indicated that the remaining debt will be paid off with the revenue collected from the fiscal year 2008 obligation assessment.

FIGURE 3
TEXAS WORKFORCE COMMISSION
OUTSTANDING BOND DEBT PROJECTED BALANCE FOR SEPTEMBER 2007, FISCAL YEAR 2008

BOND	BALANCE ($ MILLIONS)	RATE
Series A:	$256.2	Fixed
Series B:	$0	Variable
Series C:	$0	
Series D:	$165.0	

SOURCE: Texas Public Finance Authority.

PAYING DEBT SERVICE WITH UI TRUST FUND

Federal and state law limits the use of the fund. The fund has always been used to pay benefits to UI claimants. In 2003, the U.S. Department of Labor issued a position letter that stated that the fund could be used to pay "the principal on a loan from any source that is used to pay UC [unemployment benefits]". This means that it would be permissible to use the fund to eliminate the bond obligations if the Texas Labor Code were amended to allow for this use. Recommendation 1 would amend the Texas Labor Code to allow the fund to be used to pay the principal on a loan from any source, including bond obligations, that is used to pay unemployment benefits. This would align the state statute governing the use of the fund with the federal statute.

As of December 2006, $41.7 million in prepayments over the amount that was projected to be prepaid in the original debt schedule have been applied toward the bond debt balance. The Texas Public Finance Authority (TPFA) estimates that this accelerated prepayment saved $4.4 million in interest fees. If the remaining projected variable debt balance of $165 million in September 2007 is prepaid with money in the fund on September 1, 2007, TPFA estimates that employers could realize $5.5 million in savings from avoiding interest costs.

It may be possible to use an escrow account to pay fixed-rate bonds, but federal guidance is pending on this approach. The fixed-rate bonds do not have a prepayment feature, which prohibits the state from paying the bonds before their

maturity date. TPFA indicates that an escrow account in the state treasury dedicated to pay the fixed-rate debt could be created to pay off the debt as scheduled. The amount required to pay the principal would be deposited into the escrow account. Using an escrow account would relieve employers from being required to pay the obligation assessment in fiscal year 2008, which would be used to pay bond obligations and bond administrative expenses as provided by Section 203.102 of the Texas Labor Code. This would result in a net debt service reduction of approximately $4.7 million if paid by September 2007. However, there is no specific direction from the U.S Department of Labor as to whether the fund could use an escrow account to repay bonds. As of November 2006, TWC staff believe that this approach would violate the statutory limitations on the use of the fund. TWC estimates that the fund balance will be $976.2 million above the required minimum balance on October 2007 and $109.9 million above the maximum balance. At this level, there would be sufficient funds to pay off the Series D bond.

While the state would not realize a gain of General Revenue Funds by prepaying the UI bonds, the recommendation to amend the Texas Labor Code to allow this additional use of the fund would provide TWC the option of reducing debt service in the future and reduce the obligation assessment on employers.

FISCAL IMPACT OF THE RECOMMENDATION

Recommendation 1 would not result in a fiscal impact to General Revenue Funds in the 2008–09 biennium.

Since the state uses Federal Funds to administer the Unemployment Insurance program, and because all benefit payments are made through the Texas Unemployment Compensation Trust Fund, no General Revenue Funds are used for any purposes relating to unemployment insurance. However, pending statutory change, Recommendation 1 would cost the Texas Unemployment Compensation Trust Fund $165 million to pay the Series D bond as depicted in **Figure 4**. Recommendation 1, if implemented, would also save Texas employers $5.5 million in assessments for interest payments in fiscal year 2008, and they could expect to pay a lower obligation assessment in fiscal year 2008 with the significant decrease in debt balance.

FIGURE 4
FISCAL IMPACT OF USING THE UNEMPLOYMENT COMPENSATION TRUST FUND'S SURPLUS TO PAY BOND DEBT

FISCAL YEAR	PROBABLE SAVINGS/(COST) TO UNEMPLOYMENT TRUST FUND ACCOUNT 938
2008	($165,000,000)
2009	$0
2010	$0
2011	$0
2012	$0

SOURCE: Legislative Budget Board.

The introduced 2008–09 General Appropriations Bill does not address Recommendation 1.