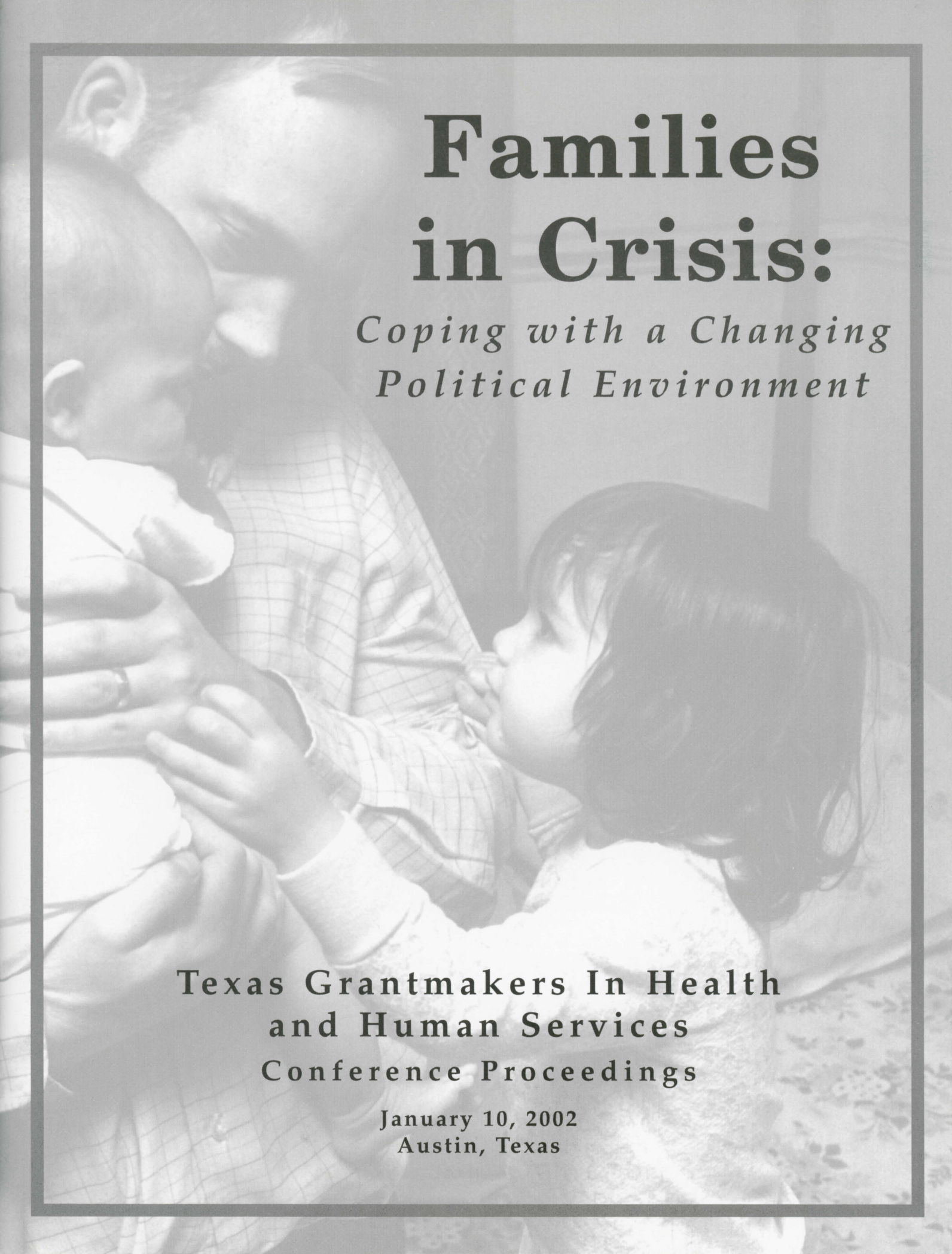

Families in Crisis:

Coping with a Changing Political Environment

Texas Grantmakers In Health and Human Services

Conference Proceedings

January 10, 2002
Austin, Texas

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A Conference Hosted by the Texas Grantmakers In Health and Human Services

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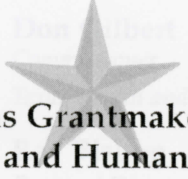

Texas Grantmakers In
Health and Human Services

Hogg Foundation for Mental Health

Introduction

In the spring of 2002, two of the most significant public family welfare programs in Texas—the Children's Health Insurance Program (CHIP) and the Personal Responsibility and Work Opportunity Act of 1996 (PRWOA)—face potentially dramatic changes that could have a tremendous impact on needy families across the state.

In just two years, Texas' CHIP program enrolled more than half a million children in an insurance program for families who earn too much money to qualify for Medicaid, yet are unable or cannot afford to buy private insurance through their employer. Recent concerns have arisen as to whether state allocations can keep pace with demand, or whether restrictions are needed to better manage the program's growth.

At the same, the U.S. Congress has begun the process of reauthorizing the PROWA, the most sweeping overhaul of social welfare programs since the New Deal. Since the reforms' enactment there have been a number of successes, failures, and potent effects on low-income families for which Congress will have to account in the coming months.

In order to inform Texas grantmakers about the challenges and opportunities confronting both programs—as well as to inform their philanthropic efforts across the state—the Texas Grantmakers In Health and Human Services (TGIHHS) held a conference entitled *Families in Crisis: Coping with a Changing Political Environment* in Austin on January 10, 2002. The conference brought together some of the leading experts on CHIP and Welfare Reform to explain some of the difficult decisions and challenges facing Texas families.

This document is a proceedings of that conference and is being distributed by the Hogg Foundation for Mental Health to further broaden the reach and understanding of the conference.

Bear in mind that this is a transcript of the presentations—not specially prepared text—and should be read as such.

About TGIHHS

TGIHHS is comprised of grantmakers seeking to improve the health of, and delivery of human services to, the people of Texas. TGIHHS is a model for ways in which philanthropic and governmental groups can work together on health-related issues. More than 40 Texas foundations participate in the TGIHHS.

Each year, TGIHHS hosts several workshops that provide a forum for grantmakers to meet with local and state representatives to learn more about emerging health issues. The workshops feature guest speakers who discuss health issues, their likely impact, and the specific ways in which foundations can provide funding solutions.

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*** Editor's Note:** *Readers are reminded that this is a* **transcript** *of speakers' presentations. In some instances, the transcripts have been minimally edited for clarity.*

Dr. Julie Graves Moy of the Texas Department of Health was also a presenter at this conference, but her presentation was unavilable for publication

Peggy B. Smith, Ph.D.

Professor, Baylor College of Medicine

The opening presentation was given by Dr. Peggy Smith, a professor in the Department of Obstetrics and Gynecology, Psychology, and Pediatrics at Baylor College of Medicine in Houston. As director of the county-wide Baylor's Teen Health Clinic, she is responsible for the direction, the evaluation, and funding of six reproductive health programs for indigent teens. She is an expert in teen reproductive health and is widely published with three books and literally dozens of articles on this topic. Dr. Smith earned her bachelor's, master's and doctoral degrees from The University of Texas at Austin. She is also an advisor to the Hogg Foundation's National Advisory Council.

I am really pleased to be here today. It is a real treat to talk about something that I am passionate about. I caught myself earlier saying that I had been doing this for over 30 years. I know its hard to believe that I am that old, but it is true and I have come to love and appreciate the issues that we are all committed to. I'd like to share with you an overview that outlines the state of women's and children's health and some ways that we can improve upon those issues that are very important to our state. Given the slate of talented speakers here today, I had several challenges. My first challenge was to avoid being redundant. My second challenge was to provide you information that would push the envelope in terms of looking at health from a social point of view. My third challenge was to think about sociological issues that have driven the medical community and perhaps need to be brought into the sunlight.

Over years that I have worked in adolescent pregnancy at the medical school, providing top-notch care as it relates to perinatal outcomes. We were always somewhat astonished that the six-week checkup would bring a less than optimal return for the baby and mother. That has really driven me to look at the issue of health care from a sociological point of view.

So today I have a very interesting challenge: evaluating medical care from a sociological point of view and looking at what the literature tells us, so as to set the stage for health care reform for women and children.

Let me quickly acknowledge a book that has been really seminal for me in learning about the link between medical care and social care, and that is *Health and Social Organization*, which is a great source of reference for how social practices affect the welfare of women and children. I also really want to acknowledge Dr. Al Tarlov, whose institute at Rice University has done a great job of marrying critical data with social practice.

My task is to link health behaviors and social policy as it relates not only to legislation, but to reform. I also want to give you some recommendations as members of the philanthropic community where you can marry these ideas and provide funding for programs that can bring about both social change and good health.

I have a tendency, as some of you know, when asked to turn on the light switch, to explain how electricity is made, so I am going to try to have some self-control in describing some of the phenomena.

The first thought that I want to share with you today is the following: why I would like to change the paradigm and look at health care reform from a sociological point of view. The health and well being of our general population, and women and children especially, specifically in the state of Texas, is not due to random circumstances but can be controlled and we can act to change it. It is not a roll of the dice. It is either a passive or active event that affects the health and well-being of our women and children.

I have always worked in a public health care environment—Ben Taub Hospital, LBJ Hospital, even Jefferson Davis Hospital—and so I feel a little bit of a heretic proposing that the health problems and disease that we see in our medical institutions are powerfully tied to social and physical environmental issues. It is a very different perspective from what we look at in the patient-doctor relationship.

Let me give you some theoretical examples of what I am saying. Some of these examples are out of the domain of reproductive health. That is because I think they make the point very clearly. We are all familiar with the settling of our country and the European migrations. There are bodies of knowledge which tell us that the contact with the European population, through the introduction of disease (and through the introduction of other variables) reduced the Indian population to 1/20th of its size. Infection alone was not solely responsible for the decimation this indigenous group in our country. But equal credit belongs to the impact of warfare and the social and cultural destruction that our European ancestors brought. Population concentrations in the reservations, the subsequent soil depletion, and the forced sanitation—again, factors that are not completely health-related—affect the health and well-being. in effect numerous, interrelated factors played a role in health.

Now, I am going to ask you to think about what determines health. What are the factors that make us healthy and what are the factors that make us sick? And I am going to ask you to think not only from a medical point of view, but from a health point of view, and as we look at socio-ecological variables, as we call

them. Hopefully, Patrick and DeAnn and some of the other people in the room will fill in and show you what those mean in terms of policy.

I am going to share with you five factors. Four of them are very health-related, yet they may not be the most powerful. The one that comes to mind immediately is the issue of genes and biology. I remember as if it were yesterday (although it was about 1953) I saw the article in Newsweek. It was a double-helical matrix that Watson and Crick invented, and I promise you that if I knew then what I know now I would have invested in Amgen many, many years before.

What we have discovered within many of our lifetimes was unequivocal evidence that genes and gene mutation cause disease. And so from our point of view we could look at about 4,000 genes. We can also look at some major issues that we see in public health, whether it be sickle cell in the clinics that we run for the indigent African-American population, cystic fibrosis in other populations, and if you want to carry it to the life cycle, Huntington's disease. What we have found is that genes do make a difference. The question I would like to put on the table is how much difference do they make? Now, we know it is a complicated question. We know that public health issues, such as diabetes, can show manifestations as we have in Texas (specifically in Houston) where the estimates are that as many as 25 percent of our Hispanic population may be prone to diabetes because of some of the environmental factors in which they work. I work at a high school called Austin High where 87 percent of the population is Hispanic, and we are picking up obesity precursors of this disease in this adolescent population on a high school campus.

The good news is that the incidence of illness caused by genetic abnormalities and mutations is less than about 1 to 5 percent of all diseases that affect us. So while genes are getting a lot of play in the press today, from a public health point of view, they are not the major driver for the issues that we look at in terms of policy and health care reform.

The second issue, in terms of the determinants of health for children and women, specifically, is the factor of health behaviors. I think in general a lot of individuals have learned that the health behaviors of women will affect the outcome of their infants and also their long-term health outcomes. Now, we know that these behaviors are interactive and some are more powerful than others. If you look at the research over the last 40 years you can see issues such as diet, tobacco use, alcohol and illicit drug use are interacting and causing issues related to cardiovascular disease and lung disease. The correlation is stronger in some entities than others, but nevertheless, we are giving a lot of attention to that. As a point of importance, about 20 percent of the disease burden that we see in the United States is attributed to these lifestyle practices.

The third factor that I would like to ask you to consider as you look at health care policy and philanthropic intent, is the relationship between medical care and public health. Now, those of you who know me can embrace the fact that I am into low-tech medical care. Low-tech medical care saves more lives than all the CAT scans that I see in the medical center. The first important fact to share with you is that medical care and public health basically have caused a precipitous rise in our life expectancy over the last 40 years. Many people do not realize that our gains in life expectancy are impacted very strongly by two low-tech things: sanitation and family planning. And so as I look at policy and formation of legislative initiatives for our population in Texas and for women and children specifically, I find that the low-tech issues, whether they be sanitation along the border or family planning for the migrating Hispanic populations and the poor in our city, bring about more positive health outcomes than high-tech diagnosis and medical treatment. And again, I sound like a heretic to the medical establishment, but this is what the literature is telling us.

The fourth issue is a little bit more ethereal. It is the big picture in terms of health outcomes and determinants of health. It is what we talk about in terms of plants and humans and natural environments. I really did not pay very much attention to this until last year during the presidential campaign. Houston, as I recall, was identified as the most polluted city in the country, and unfortunately we probably could support that belief because asthma is a major issue in our city. So the interaction of how we treat our environment and what it does to our children is significant. The stress that occurs in the water, and the air, and the soil is played out in respiratory diseases in our young children, specifically our African-American population in Houston. So this is a major determinant in health care.

But the one determinant that I think is the most complicated to understand, and probably the most powerful, is the issue that has been identified by sociologists and anthropologists: the social and societal factors that drive health care and the positive or negative outcomes. Basically, if you want to look at this in a somewhat simplistic format, it has described how we live together and how it affects our health. You know, someone way back said, "Can't we just get along?" And getting along will affect our physical and our personal health. There are some sociologists and a lot of the health policy folks that I have been talking to that believe that this is the most powerful factor in the determining of health care for children and women in Texas.

Now, as I warned you, I am going to tell you how electricity is made, but I think it is important to see that this is not a belief from just the last 40 years. There are, if you will, anthropological, historical models, that I will list very quickly, that support the fact that how we relate to each other as human beings will affect how healthy we are and the ultimate survival of

our civilization as we know it.

If you want, go back to the Ice Age. Just recently they discovered the remains of the prehistoric man who crossed over the hill in Switzerland and died in the mountains of Italy. The major issue of his life was surviving the low temperatures and dealing with inadequate food supplies in the Ice Age. As a migratory hunter, his native threat was the temperature and starving to death, so people of his time had to cooperate, had to get along to ensure their survival.

Look to the Copper Age, which was a much more technical, advanced society. They made tools, but to do so they had to have high social organizations, and they had to be organized in a positive way, because if they did not, there were health hazards associated with the concentrations of populations, including a variety of pestilences and plagues.

Then you can look at the Bronze Age, where the source of relationships as trading routes were developed, sparked an even higher level of social organization. But again, with that concentration of individuals, if they did not get along, if they did not work together, if they did not develop some good social systems—unclean water, pestilence, plagues, and epidemics followed. So what I am proposing to you is not only the clear relationship between what people do and how healthy they are, but a paradigm through which something that in our philanthropic community and in our legislative policies should be evaluated.

Now, I am going to talk very quickly about the Twentieth Century. We have opened all sorts of transoceanic travel, we have brought all sorts of pathogens to unexposed populations. As we have seen in the HIV/AIDS epidemic (and, if you believe in Randy Schultz's book, *And the Band Played On*, there was one flight attendant on Air Canada who basically made a big difference in the contagion of HIV/AIDS in this country) most of our threats currently are not from natural phenomena; except those that are facilitated, such as anthrax. So the piece that I would like you to consider is that we are now at a point where we are looking at the replacement of infectious diseases (those diseases that kill in developing countries) to chronic diseases that are affected by how we live, what we do, and our behaviors.

So if you look at our health profiles in terms of what kills Americans—tuberculosis, (which is a major killer) pneumonias, sepsis—they have been replaced by fancier diseases. We may be living longer, but we are also switching the terms of what our health profiles look like.

So just a very quick summary in terms of what I have said. The good or the bad news is that we have triumphed, because of public health, over many infectious diseases that are related to very simple—what I call low-tech—practices. We sanitize our water. It is very rare we have a cholera outbreak in the state of Texas yet just 200 miles away, it is a major issue in Mexico. Simple low-tech. We hopefully are eating better. We put fortification in our milk. Our children are bigger than ever before, and sometimes too big. We are doing mass inoculations and we have antibiotics that are readily available and keep us very, very well.

The other side of the coin is that in our rising affluence, we are perhaps seeing a new relationship to chronic diseases. And as you look at income, higher consumption of red meat, tobacco usage, consumption of alcohol, and sedentary lifestyle due to the development of machines, what kills us is related to what we do and how we live. As I was listening to NPR the other night, I think Texas has the dubious honor of having the most obese women in the United States. So is that a function of a high living standard? No, but it may be a function of being sedentary. So the types of challenges that we have, not only relate to what we do, but who we are, and how we manage our affluence.

So I have a second good news/bad news. Our health behaviors, at this point in time, are declining as a major explanation of chronic diseases. But the bad news—and this is where I think sociologists can really educate us—is that some of the social behaviors and some of the social factors that we see in our community are influencing the health outcome of our nation or our state. I am going to develop this for a little bit and hopefully convince you that social policy is just as important as medical policy.

So we can talk about social factors. What are those issues? And some of these are words that are difficult to immediately conceptualize, but you will understand when I share with you the information. We talk about social inequalities in our country and we talk not about access to medical care, but we talk about education, income, assets, or job class, and there has been some movement in the recent past to address these. As I was listening to TV yesterday and the Bush Administration's bragging about their Education Reform Act, I wondered if they're reading the same books I am, because higher education does have some correlations with better health care. Also, some of the programmatic theoretical models, such as the resiliency model by Bernard and the assets model by Benson and Scales, support the factor that if you want to have healthier people you give them assets and social support.

So what I am trying to do in the next couple of minutes is to make a case. That case for you in terms of policy and philanthropy, is to link population health and the health of women and children in Texas with social factors. I am going to share with you basically about five points. I am not going to spend a long time describing them, but I think that intuitively you will agree that there are some empirical bases for them. The first one is that disease prevalence and death rates vary non-randomly in our state, in our cities, and in our neighborhoods, and that the higher the social position is, the better the level of health.

Now, I know St. Luke's Episcopal Health Charities through St. Luke's Hospital has done an incredible piece of research that has been made available to all of us, and that is to look at neighborhoods, to see how healthy they are, and to see which neighborhoods should receive some intervention. And in addition to this, is their statistical analysis, which is available on the web at www.SLEHC.org. It will not only link to areas of greatest need, but link also in the same areas where the resources exist, and in sociological language. So we not only know from the data that there is a non-random variance, but we also can tell where the areas are and what social pathways are available to address these.

The second piece is very intuitive. It is that health and social gradience is continuous and that as social status increases, so, in general, does health. This also relates to social position and health—the same sort of relationship. And then if you want to look at the reverse, social inequality, it has some responsibility for health. So if there is social inequality, the health status has been marginalized. And the one that we see on TV every day (whether it be Afghanistan or Mexico) is that as you look at the slope of income inequality, the steeper it gets across populations, the shorter is the nation's life expectancy. I think that is a very important piece to think about when we look at developing countries, and specifically when we look at those populations who are going across forced borders. It is not only the Pakistan/Afghanistan border; it is the Texas/Mexico border, or the Texas and the invisible border of El Salvador. All those factors come into play as we look at social and health outcomes.

So I am going to ask you to stretch a little bit more as we try to develop philanthropic and legislative policy and think about another aspect of social inequality and how it relates to issues that also affect health. What I'd like to say to you is that the easy one to look at is voter apathy. I mean, in the Houston elections, a turnout of 20 percent is a miracle. But the relationship becomes more overwhelming when you look at social inequality as it relates to family structure, its relationship to delinquency, its relationship to drug abuse, its relationship to violence, and—taking this one step further-—how those affect major health issues in our community.

So what I've tried to do is to ask you to consider an out-of-the-box analysis. That is, if you want to improve the health outcomes of women and children in our state, we need to emphasize events that are non-medical and that surround them. These non-medical events can be everything from the inability to get a good education to the issue of dealing with drug abuse and violence. These behaviors will significantly affect the health of our kids.

Now, what are some of the philanthropic issues that you may want to consider based on the empirical literature? One that I know we in Houston have done a lot of work on is looking at cognitive development and its affects on early childhood effects on health and social class. The literature is really clear about this. As children develop cognitively and have good stimulation, those factors are strong predictors of whether or not they finish high school and whether or not they are healthy adults. So early on, if there are positive experiences and good interaction, we know there will be good cognitive capacity. We know that they'll have better math skills, IQ will go up, there will be fewer behavioral problems, and there will be a higher rate of school completion.

There was some literature the other day that really struck me and committed me to the fact that working with children before they go to school is where the action is. It said that as you look at individual children who had behavioral disorders at four years of age in preschool they continued to have negative outcomes in terms of school performance. Early intervention has profound results.

The second is the issue of social capital. If you have strong social capital, if you have a strong infrastructure, if you strengthened the infrastructure of the Fifth Ward in Houston, for example, you will improve that community's health. I can give you stories on an incidental basis that this is happening. Social behaviors have a direct relationship to the outcome of the individual community.

Also, the issue that I think is very intuitive—but it is important that we continue to push the envelope even when we sometimes lose interest and enthusiasm—is that health and education are linked. We knew that all the time, but if you look at the statistics and you look at the groups of individuals who are still smoking, they are individuals in the lower class. I know when I started working at Baylor College of Medicine, unfortunately, there were a lot of physicians who smoked. At this point in time, very, very few of those physicians still smoke. But, if you go to individuals who have low educational attainment, in general, you are going to see that they are much slower to respond to the issues that are promoted in health education. And this includes other issues—seat belts, helmets, alcohol abuse. Health and education are linked.

We also know that if you want to have a healthy child, be sure that the parent is educated. What the literature is telling us is that lower-educated parents have children who are less healthy and have poorer well-being. A final piece that is very intuitive—but again from a policy point of view is as important as the early intervention—is that protective factors do exist and enhance positive and emotional development of children. These are just as important as physical development. Positive parenting, as well as negative parenting, makes a difference. These are areas that are not strongly embraced by the medical community; but, nevertheless, make a difference in terms of a child who succeeds and a child who fails.

So let me give you some policy applications and

tell you what has happened in Houston in terms of taking the literature to address the childhood issue and promoting messages to the community. One policy application is to look at legislation that will strengthen prenatal services that assure adequate nutrition. While this is an important goal of Healthy People 2010, it is still not at the level that is recommended by the federal government. Another is to look at secure relationships in the family. As we know, children who are loved and taken care of in a family setting, however we define that setting, are going to be better off than those who are not. So policies that allow family leave, that allow people to keep their jobs, that allow flex time, provide nurseries on site—all serve to actually strengthen families. Whatever it takes to make the family stronger. We need to ask ourselves what policies are in the best interest of our children? What policies will make our children healthier? Socio-economic inequities can be something as simple as not having certified day care for people who need it.

The piece that is dear to my heart (and is sometimes hard to link to policy) is to continue the funding of early childhood education. We know in some of the research that has been done in Houston, that it really does make a difference in terms of certain practices for pre-term children. So let me talk just very briefly about what's happening in Houston. I've been privileged to work with Dr. Holtzman and Dr. Ward and some other people in this room to bring about changes as it relates to children in deprived areas of Houston. I remember about eight years ago at Rice University at the student center, a group of philanthropic entities got together—some of those are in the room today—and decided that they were going to do something big for children. Since then the Greater Houston Collaborative for Children has identified the following: 1) messages that are clearly articulated in the body of the empirical research; 2) taking those messages and collaboratively agreeing that they are important for our community; and, 3) taking it upon themselves to translate those messages through evaluation of other work in the United States (such as I Am Your Child in California) to communicate messages to parents that seem so intuitive, but are hard to link social and physical behavior with the outcome of health.

So just very quickly, let me show you the ones that we have chosen. First, the social and emotional experiences of a child will affect its development and will lay the foundation for intellectual and emotional health. So we have really tried to educate people that this and parental involvement make a difference.

Second, that relationships make all the difference in the world, and that early development depends on healthy relationships. Those relationships translate not only to the family, but into settings for day cares.

Third, (and probably the most needed given the fact that the majority of women now work, and children are in the care of individuals other than nuclear extended family members) is that we need to have quality day care. Quality day care has an important developmental effect on the children who reside in those programs. There are a variety of issues here. We know that there is some support for the four to six-year-old, but there is very little support for the zero to three-year-old. If you believe in early brain development, that is where the action is.

Fourth, parents, however we define them, are active ingredients in their children's lives. The overriding policy implications (not only be from the philanthropic point of view, even from a legislative point of view) is how do we make the Family Medical Leave Act work for parents? How do we promote responsible parenting and how do we provide the support for parents who were parents probably too early and have too many children, but still, nevertheless, are the caretakers?

And finally, the one that got me in my career 30 years ago, is how do we get prenatal care and healthy nutrition to women and to babies? I have heard that that is the most important time of life, and the most dangerous trip we will ever make is the process of being born. Yet those messages sometimes are lost because they are so intuitive.

So those are the thoughts I wanted to share with you today. The final one is that if children are going to be healthy, their parents need to be healthy. So how do we make that happen? We need to focus on how we make Healthy Steps work and how we give parents the support they need. How do we educate them and make parenting a positive experience in a very complicated life? I want to thank you for your attention. I hope this stretches beyond walls and links social and medical care. Please do not report me to my boss. I am not a heretic. I am just trying to think outside the box. Thank you for your time.

DeAnn Friedholm

Executive Director, The Children's Defense Fund – Texas

DeAnn Friedholm is the executive director of the Children's Defense Fund of Texas. She is a graduate of The University of Texas at Austin and The University of Texas at Austin's Lyndon Baines Johnson School of Public Affairs. She has worked for Texas Governors Mark White and Ann Richards, as well as Lieutenant Governor Bob Bullock. In 1993, she was appointed Texas Medicaid Director, and in 1994 she was named Texas Commissioner of Health and Human Services. In 2001 she was appointed to her current position at the Children's Defense Fund of Texas. Friedholm is a long-time advocate for low-income families and has a special interest in getting health care for the uninsured and, as such, has received numerous awards recognizing her work on behalf of Texans.

Good morning. I think Peggy Smith has laid out an extremely fascinating and important framework for thinking about children's health and some of the public policy opportunities and challenges that we have in Texas. I am going to focus primarily on the attempts that we have made through the years to improve access to health care through insurance for children. First, I have to make one caveat, and that is to say that having insurance is not the be-all and end-all. It does not solve all of our health care issues and problems, particularly the sociological ones that Dr. Smith just highlighted for us. But we know from study after study after study, that having insurance is the key to accessing the medical system in this country. So without insurance the prospects of having the ability to get health care assistance—be it physicals, immunizations, or mental health assistance—is much, much less if you do not have insurance.

I am going to focus today on the federal and the state activities over the last three decades that have led us to where we are today and spend most of my time talking about what is going on in the state of Texas. I want to suggest two or three things that the philanthropic community might think about doing to help us make our case to policymakers.

The Children's Defense Fund has three offices in Texas. I am in charge of all of them, but I am here in Austin. We also have an office in Houston and in South Texas (the Rio Grande Valley) located in McAllen. As our parent organization in Washington, D.C. has done since 1973, we work on research and public education about children's issues and policy development. We also provide leadership and advocacy on many children's issues, particularly those of low-income disadvantaged, and disabled children.

In Texas, our focus has been exclusively on children's health care issues for the last couple of years. We particularly have been engaged at the community level, both in Houston and in the Rio Grande Valley, in trying to help families learn about and use the health care programs that are available from our state, particularly Medicaid and the Children's Health Insurance Program (CHIP).

Just to give some sense of this, I think it is really important to understand the barriers and the challenges we face; to quickly think back to how we have gotten to where we are in terms of the provision of health care for low-income kids. From 1965, when Medicaid was established, until about the mid-'80s, the only way you could get onto a health insurance program that was government sponsored (unless you had something at the local level) was for your mom to be on cash assistance. And in most states you had to have only a mom on cash assistance—you couldn't have two parents. The state set the level of eligibility, and states like Texas set an extremely low level of eligibility—around a quarter of the federal poverty level. Today that level is between 17 and 20 percent of poverty. So the only way that the government was going to provide health coverage for you as a child—unless you had some kind of special problem where there was a program set up specifically to help you (like kidney disease, etc., we call them the body parts programs)—you would have to be on welfare. Welfare was a difficult system to negotiate and carried an enormous stigma, for obvious reasons. It required you to own virtually nothing; you had to be extraordinarily poor. And that was it. That was what you could do, unless you were permanently disabled, and then you could get on Medicaid because you had a permanent disability.

Starting in the mid-1980s, however, Congress started figuring out that health care for children was a vital issue for all the reasons that Dr. Smith just laid out for us. It is very important that children have access to the health care system. Unless they had some insurance coverage, the private market was not devised for low-income families, and, in particular, low-income children. So this prompted Congress to begin a series from 1984 until about 1990, to decouple children's ability to get Medicaid from the requirement of having to be on cash assistance. And so the law changed so that you could get medical care for a very poor child in a two-parent family who would not have to be on cash assistance. Then you could have a child up to 185 percent of poverty as a baby, along with its mom, being able to get coverage for prenatal care, which as Dr. Smith pointed out, everyone understands is essential to ensure a healthy birth.

And so for about five or six years Congress would say, "We are going to cover six-year-olds up to 100 percent of poverty," and then the states would have the option to follow that. Texas, believe it or not, took every option at the very first opportunity. We have

such a reputation for not doing for people, but with very strong ethics of leadership of former Lieutenant Governor William P. Hobby and others in the state, Texas did take advantage of the federal programs and we did see some significant increases in coverage for kids and for pregnant women. I cannot stress that enough. We took advantage of every one of those.

As I have already mentioned, Texas had one of the most conservative poverty programs—we were 49th in the country in what we would do for cash assistance—and therefore, obviously, when Medicaid for kids was tied to cash assistance, we had a very low rate of coverage. We did not do much with it. We did not cover many children. And we did the expansions that I have mentioned to the point that we had about 1.3 million children on Medicaid when I was Medicaid director starting in 1993. And to this day we still continue to cover 50 percent of all the births in the state of Texas through the Medicaid program.

I wish I could tell you that 50 percent of the birth moms in this state got early and adequate prenatal care. I cannot tell you that. I can tell you that Medicaid helped cover their birth expenses and to some extent offered the ability to have early and adequate care if we could get the mother into the system early enough in her pregnancy. But nonetheless, Medicaid is a major provider of health care services for children and for pregnancies in our state.

Then we saw—as welfare reform happened and families were moved out of welfare and into the working world—that many kids fell off of Medicaid even though they were still eligible for it. In Texas, depending on which ranking you read, we were either the worst or the next to the worst in the numbers of children who were going without health insurance. By the way, other health indicators were also horrible for us in terms of things like immunization rates, getting preventive services, and high rates of other easily preventable problems. We had the huge measles outbreak in 1989-90, which was ridiculous since it was totally preventable, but many children died and it cost the state literally millions of dollars in local taxes and services to take care of those kids who got the measles. So it is not a nice picture; not a pretty picture. When 25 percent (one in four children in the state) sought care, it was much later and after they were much sicker than they should have been because they were uninsured. Frequently they ended up in emergency rooms and other publicly funded systems, which cost us our local property taxes three to four times more than what it would have cost for the same service in a doctor's office. So we ended up using the emergency rooms as clinics, if you will, for low-income working families.

The key here—and something that I just have to emphasize over and over again to every group I speak with—is that these are children of working parents. Ninety percent of them have at least one parent with a full-time job. We are not talking about that old welfare connection that so many people believe to this day, that the perception of moms not doing anything but sitting around. Even though we split those two programs in the mid-1980s, today that stigma is still attached to Medicaid. There are still people who believe that if you are on Medicaid somehow your family is not working and they are not pulling their own weight.

In 1999 we took advantage of a new federal program called the Children's Health Insurance Program. It was created by Congress in 1997 through a bipartisan bill put together by Senators Orin Hatch from Utah and Ted Kennedy from Massachusetts. You could not get two more polarized people on the political spectrum, but they both agreed that this country had to do something to address the growing problem of so many children without access to our health care system. And our Texas Legislature in 1999 passed a very good CHIP program covering kids to double the poverty level—an enormous expansion over Medicaid. We thought that if we could cover all the children that we estimated were in that income bracket between Medicaid and double the poverty level, then we would be covering about 423,000 children. We wanted every single one of them.

Furthermore, as you all know, we had received the largest tobacco settlement in the history of the world and of all the states in the country, over $17 billion. The legislature said the first call on that money over 25 years—which means that every biennium we get $800 to $900 million to spend—should go to funding the CHIP program. So it is a major opportunity for us in Texas to really be able to get out and cover any child who is in a family who does not have health insurance through their parents' work and whose incomes are less than double the poverty level.

As you see with Medicaid, (Table One) the ages are across the bottom, and starting from being a newborn you can be covered at 185 percent of poverty, and then when you turn age one, Medicaid will cover you all the way until age six if your income is right around $20,000, and these are for a family of four. And then for the children from age 6 through 19, if you were at the poverty level (which in America today is $17,650 for a family of four, and I challenge all of us to try to live on that) CHIP, as you see, fills in almost an equally enormous area of coverage for kids, going up to $35,000 for a family of four. Now, the people who do the numbers estimated that 425,000 or so children were uninsured and fit the CHIP category. Our goal, has been to go out and find those kids and bring them in. And one other thing that I want to mention is that of all of these children that I am talking about who are uninsured and low income, 56 percent are of Hispanic origin. So the fastest growing part of our population is also the most likely part of our population to be uninsured. It raises additional challenges in terms of how to outreach to those families and into those communities, and how to find and get them to sign up. In

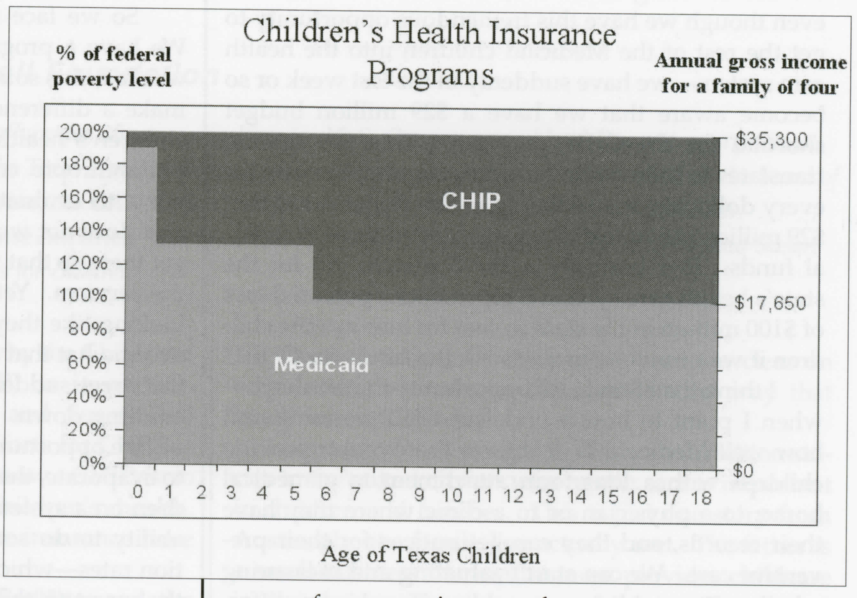
insurance, we find that many in the Hispanic population lack a basic understanding and belief in insurance as a concept. It is a big challenge and it remains a big challenge for us in Texas in our outreach to get children into the health care system.

Let me just back up one second and say that with Medicaid we had almost 1.3 million children covered. With CHIP we were looking to cover another 420,000 or so, but we still were going to have one million kids remaining uninsured. Of those we expected, or we believe today, there are over 600,000 that remain eligible for Medicaid. They are out there. They would qualify if they would come in, but they do not for many reasons. The primary reason is it has been a very complicated program to get into and because it carries the stigma of being a type of welfare. So we have to overcome all of those misunderstandings.

And 300,000 children of our uninsured rate would still never get on CHIP or Medicaid because their families make too much money. The CHIP program has provided rich preventive benefits. A very good program for prevention as well as for covering sick care is family planning as Dr. Smith was talking about. I think we are the only state in the country that does not cover family planning in our CHIP program. The legislature prohibited that. But it had very simple enrollment, minimal paperwork, and 12 months of eligibility. At the end of 12 months the family could re-enroll by mail. And we did include cost sharing for families so that the more money they had, they would contribute to the cost of their children's health care—in essence building in some of the elements of the private health insurance market, with the understanding that over time many of these families could move into that market as their incomes increased.

We started CHIP in May of 2000, and by November 2001, we actually enrolled 500,000 children. That was due to a number of reasons. One, obviously the estimates were wrong. Two, a lot of children who we thought would be on Medicaid ended up being in CHIP because their families owned things that were more valuable than the Medicaid asset test. In Medicaid, not only can you have a very low income, but they do not want you to have anything of value. They do not want your car to have value over $4,500, they do not want you to have $2,000 in your bank account, or heaven forbid, a broach from your great-grandmother that might have value. Any of those things you were not supposed to have if you were going to be on Medicaid. So a lot of those kids, who although they were below the poverty level, actually ended up in the CHIP program. And much to

Table One



many of our surprises, as of now we are still getting between 20,000 to 30,000 new applications for new enrollments in CHIP each month.

So obviously we were very successful in what we did this last year with CHIP, but we still had to try to take down the barriers of Medicaid. As I mentioned before, we knew that we still had over 600,000 children who are eligible for Medicaid out there. They are the poorest of the poor, the ones who are most likely to have the greatest medical, dental and mental health care needs, by virtue of their poverty. And so we worked with the legislature to take the CHIP system, the enrollment system, which is as I said, real simple—a simple application, no assets, easy documentation—and apply it to Medicaid.

We were able to get Medicaid eligibility for children to parallel or be virtually the same as the CHIP system. Thus, as of January we actually have this one entranceway the children can go through, whether they're Medicaid or CHIP, it does not matter. They fill out the same application, they provide the information, and they will be either deemed into Medicaid or into the CHIP program. So we have an enormous opportunity here to bring our rate of uninsured children down even further.

The success, by the way, that we have had with CHIP, getting 500,000 children enrolled, has taken our rate of uninsured children from 25 percent in the state—one-in-four—to an estimated 17 percent, which has to be one of the most dramatic improvements of any government program that we could point to in a matter of just over a year. However, the other thing that happened in the legislature is that both CHIP and Medicaid were (what we will nicely say) conservatively funded. They made estimates of what they thought would be happening with each program, what they thought would be happening in terms of health care costs and other factors, and funded CHIP and Medicaid. Unfortunately, as of now, even though

we are covering these 500,000 kids in CHIP—and even though we have this tremendous opportunity to get the rest of the Medicaid children into the health care system—we have suddenly in the last week or so become aware that we have a $29 million budget shortfall for the CHIP program. This $29 million translates to $100 million for the program, because for every dollar we spend that is a state dollar—and that $29 million are state dollars—we spend three in federal funds. It is basically a 25/75 match. So for the state's health care system it represents a potential loss of $100 million in the state to care for low-income children if we cannot come up with the funds for CHIP.*

I think the other great opportunity that we have—when I point to how wonderful CHIP is doing and how well Medicaid is doing—is that we can provide children with a long-term attachment to a medical home, to a physician or to a clinic where they have their records, and they can get notices for their preventive care. We can start evaluating and measuring whether or not what we are doing is making a difference in the real health status of the children that we are covering. We can start evaluating what works and does not work in terms of outreach and in terms of helping educate parents to use the system properly. These are all the kinds of things that we are just standing on the doorway of being able to do for the first time in our state with kids, and we now suddenly have a major budget flare-up which threatens what we may be able to really accomplish with getting kids into the system. As Peggy said, just getting them into insurance is not the be-all and end-all, but it is one factor that is very important in helping improve the overall health status of kids throughout their lives.

Unfortunately, the state has now come out with proposals to suddenly—after all the success of CHIP—whack it back. There are now proposals to start making administrative procedures more complex so it is harder for kids and families to stay in the program. Basically they want to make it such that they can get the numbers down. They want to try to get the numbers down from 500,000 kids back down to 420,000 or 430,000. And here are the kinds of things that they brought forward: 1) we can delay enrollment, meaning Johnny enrolls in January but he does not start until March or April; 2) we can freeze the program to stop it right now and then cut back eligibility to six months, so every six months you have to re-enroll (we know we lose about 25 to 30 percent of the kids when that happens); 3) we can freeze enrollments and just cap the program—just freeze it, get it down to a number, and then not let anybody else in; or 4) we can go to some open enrollment periods on an annual basis (but they've already told us that will not give them the savings they need, so it is an option, but it is not really enough of an option).

So we face in Texas this unbelievable situation. We have a program that has been successful, it has worked, it is something that gives us opportunities to make a difference in communities and families and children's health care status over time. It gives the philanthropic community opportunities to look at ways to evaluate effectiveness, to find what works and does not work in these programs, to help us target them so that we better educate families how to use the services. Yet we are facing a moment where it is looking like they are just going to turn it off. Think about what that means for us when the people out on the street suddenly start hearing that the program is shutting down. People will drop out, the continuity of care opportunities that I mentioned before will start to evaporate, the ability to actually get services to children on a systemic basis will be harmed, as will our ability to do something about children's immunization rates—which, unfortunately, we have just named the worst (50th in the country). The ability to really start using these public programs to address major issues is threatened. We will have providers who will drop out of the program as this gets to be just like Medicaid. In fact, one of our phrases now is, "Do not Medicaidize CHIP." Do not bring back all of these barriers and problems that we have just gotten rid of in Medicaid and start applying them to the CHIP program. As I said, it hurts our ability over time to make a difference and do what we can with this program.

On the financial side, we will be giving up $70 million of federal funds that are our funds, and if we do not use them they go to New York, California, Illinois, or someplace else. And those uninsured kids go back into locally funded emergency rooms or locally funded services that are mostly property tax-based, and we all know that those are already overtaxed. Thus, the issue before us for both CHIP and Medicaid is not whether we can convince our state policymakers to not make these cuts now, but to convince the Legislature to take a portion of those tobacco funds—the huge fund with billions of dollars in it—and allocate it to avoid the kinds of cut-backs that we are facing. In terms of the future of Texas really being able to get our uninsured children's rate down and to make a difference in their actual health care, we are standing at a very, very important moment after all of these years of working to improve and set up these programs.

In summary, that is a general context of what is going on with our attempts to get children insured and to provide the kinds of preventive and primary care services that they all desperately need. I appreciate your attention.

* **Editor's Note:** *The state now estimates the shortfall to be roughly $20 million in state funds and $48 million in federal funds. Responding to criticisms, Gov. Rick Perry recently suggested that budget writers cover the CHIP funding gap with the projected $19 million in savings from a new state program in which agencies purchase prescriptions at cheaper bulk prices and use drug manufacturer rebates. However, the ultimate authority for applying those funds to CHIP rests with the Legislature.*

Patti Everitt

Program Consultant, The Michael and Susan Dell Foundation

Patti Everitt has been active in public affairs for 25 years, working for U. S. Congressman Lloyd Doggett, as a political consultant, and as a staff member for the Texas Natural Resources Conservation Commission. She served on the board of directors for Austin Partners in Education, the CAN Child Care Task Force, the National Pollution Prevention Roundtable and the EPA's Common Sense Initiative. She is currently a program consultant for the Michael and Susan Dell Foundation finding new initiatives for children.

I am going to talk briefly about why the Children's Health Insurance Program (CHIP) is important. Many of you, like the Michael and Susan Dell Foundation, have supported local efforts for CHIP, so this may be information that you know. CHIP is so important as a foundation for children's health. Studies show that children who have insurance have better outcomes in many areas.

DeAnn Friedholm, Patrick Bresette, and the Children's Hospital Association of Texas have provided core leadership to ensure that we have CHIP in this state and have really taken the leadership in tracking what is going on, identifying problems, and then providing options and ways that you can get involved. This kind of leadership is not always present in this state, so I just want to thank them personally, as well as other people here today who are helping with CHIP.

Table One

Why is Children's Health Insurance Important?

Children without health insurance:

- **70 percent *more* likely to receive medical care for common conditions**
- **30 percent *less* likely to receive medical attention when injured**
- **33 percent did not see a doctor in the past year (no preventive care)**
- **25 percent *more* likely to miss school**
- **Six times *less* likely to fill a prescription because of cost**
- **Ten times *less* likely to have a regular health care provider**

What I would like to do is talk very briefly about why CHIP is important; then discuss the experience I had with the Michael and Susan Dell Foundation in working as a partner with local organizations; and then lastly, tell you what I see as funding opportunities for funding children's health insurance.

You all probably know this, but there are many statistics on why children who have health insurance have better outcomes. Children without health insurance are ten times less likely to have a regular doctor and are six times less likely to fill a prescription. You see these statistics and the picture becomes clear on why insurance makes a difference in the way that health care is delivered.

I want to offer an anecdote. There are a million stories in the naked city on why health care is important to children and families. This is just one story from Austin, about a family I've actually met. The father is a small business owner, the mom provides childcare in their home. They have two children. They found out about CHIP when an older son brought a flyer home from their church talking about insure.a.kid, TexCare Partnership and the availability of CHIP. They applied. Almost immediately after they were insured, their two-year-old developed a chronic cough that wouldn't go away. They normally would not have taken her to the doctor because it costs $75 for a doctor's visit plus the cost of a prescription. But now they had insurance, so they took her in. In a routine check-up the physician discovered a mitral valve heart defect, potentially fatal within several years. The little girl had surgery within a month, and is now doing well. There are so many stories like this, but it is important to note anecdotally how CHIP makes a difference in people's lives.

I also would challenge most of the women who are here to talk to the person who cuts your hair the next time you're in for an appointment. You'll find that there is at least one woman in that business whose children are eligible for CHIP—it happens every time. That is because the typical worker at a hair salon is often a single mom making under $36,000 a year for a family of four, which is the profile of a

Table Two

Profile of Uninsured Children

Children Without Health Insurance:

- 1 in 11 Anglos
- 1 in 6 African Americans
- 1 in 4 Hispanics
- 1 in 3 non-citizens
- 88.5 percent have at least one working parent

CHIP eligible family.

This gives you just a little bit of a profile who these kids are. You can see [Table Two] that a much higher percent of the minority community, non-citizen children, are eligible for CHIP, but either they do not know it or they are afraid of the system. It is a real potential opportunity for outreach. The other thing I want to emphasize is that these are the children of working parents. Ninety percent of the children who are uninsured and eligible for CHIP have working parents.

Why aren't children insured? We know this both from national polls as well as studies in Travis and Williamson Counties that it is cost. Seventy-five percent of parents whose children aren't insured say it is too expensive. Again, that is why CHIP is such a wonderful opportunity and a wonderful service to parents. As we all know, low-income workers have to pay more to get insurance through their job than workers who are higher wage earners—that's if it is available to them, which is a big if. Forty-five percent of low-income workers do not even have access to health insurance through their jobs versus 4 percent of higher income workers.

The other reason I think we are continuing to see increases in CHIP enrollment is because we know that in an economic downturn people lose their health insurance. Even though COBRA is available, people can seldom afford it when they lose their jobs. We know that in the last economic downturn that at least half of the workers who lost their job also lost their health insurance.

Foundation grants have really made a difference in the success of CHIP. Certainly it has helped that the program is streamlined and easy for families to access--I cannot overemphasize how important that is. But private funding has been critical in expanding the outreach, media, and enrollment opportunities available to local organizations.

The State of Texas provides about $5 million to local organizations for outreach for the whole state of Texas, an amount that just provides for very basic activities. In Travis County that translated into about $65,000 in public funding for our public outreach effort. That would pay for about one staff member, which is pretty impossible to run an entire outreach operation with that kind of limited budget. The private support from the Michael and Susan Dell Foundation and other funders has made it possible to operate an expanded and successful effort that was also able to generate thousands of dollars in in-kind donations as well.

I wanted to talk very briefly to you about insure.a.kid, which is the program that the Michael and Susan Dell Foundation funded in Travis and Williamson Counties to enroll more children in health insurance. I will talk a little bit about how it began and how it is a little bit different from traditional grants. Funding went through the Seton Health Care Network to create a community collaboration which became insure.a.kid. Much of the initial planning was done by a group of partners that included the Indigent Care Coalition and all the major health care organizations in Travis and Williamson Counties, as well as city/county health care districts, and Texas Healthy Kids. This effort was initiated by the Michael and Susan Dell Foundation based on research and needs assessment that we did in the community. It was very clear what the health benefits were for children who had health insurance. And there was an incredible potential for cost savings in the community if the number of children with insurance increased. So, in response to this data and research, the foundation identified and recruited its lead partners, asking them to partner with the foundation to create a community collaboration which would build the infrastructure for an initiative in advance of the CHIP program. Insure.a.kid began about nine months before CHIP implementation. It has been able to leverage private dollars to increase the success of a public program.

Clearly, public dollars are always going to be insufficient to fund a program like this to scale. The foundation saw insure.a.kid as an investment in public capacity that wasn't going to happen otherwise. We were able to set up the infrastructure necessary for a successful program and keep it operating -- training workers, printing materials, getting computer and tracking systems in place, recruiting business partners, developing a sustainable school outreach program, etc.

Another thing that has been very interesting is that private dollars have made it possible to recruit additional business support for CHIP by adding credibility to the effort and helping businesses see the link between their own health insurance issues and CHIP. Businesses have not only helped with retail promotions and volunteer support, but they have begun to incorporate information about CHIP into their Human Resources process.

The other way insure.a.kid has been different is that the foundation partnered with the grantee. We organized the start-up of an advisory committee and provided ongoing technical assistance. We still do joint planning on program goals and strategies and help them do partner recruitment. In addition, measurement and accountability have been a very important part of the effort. We do a monthly review of our key metrics. We look at a quarterly review of data and we do program alignment based on biannual reports. We also do sustainability planning on how we are going to fund this effort after our grant period is completed.

That gives you a general overview of where we have gone with insure.a.kid. Now, I wanted to talk very briefly about some of the opportunities for funding for children's health insurance in both Medicaid and CHIP and some of the enrollment challenges. There's

no question that the projected state budget shortfall throws a wrench into things related to CHIP if the state responds by limiting CHIP enrollment in some way. Just to give you an example, insure.a.kid has developed a workforce initiative that works with companies to integrate CHIP into their human resource process so that, as these companies look at employee benefits, CHIP is just one of those things that routinely is presented to employees as an insurance option. But it is hard to go into a private company and say, "Here's a great opportunity, but your employees cannot enroll for six months," or "They cannot enroll for a year." You just cannot do that. They will basically say, "This is another government program that does not work." And that is one of the fears that I have. We have had incredible cooperation from chambers of commerce in Austin but we cannot continue to work with them if our program suddenly does not work.

But there is still great opportunity for increased outreach—not just for enrollment but also for increasing utilization of services for those families who are enrolled. We know that a family that has used CHIP insurance is 50 percent more likely to renew their coverage. So utilization is incredibly important issue to target for public education campaigns, stressing common place health problems like asthma or immunizations.

There is also an opportunity to target outreach to specific groups like immigrant children. There is interest in how we deliver a specific message to those populations. I was recently looking at some work that has been done in Los Angeles and San Antonio, and have seen how health care messages are delivered in villages in Mexico using painted murals on walls of buildings. If we can duplicate some of those familiar methods, we may see enrollment increase among eligible immigrant children. In addition, some local organizations have begun a promotora program—in which local women who live in a neighborhood are trained to do health care outreach and enrollment in their own community.

There are some additional components in a successful initiative that need additional resources. Integrating enrollment into institutions is a critical task, and schools and workplaces are obviously natural places. Families also need strong advocacy when they get caught in the system. They may be determined to be ineligible, but when a trained staff person looks at their application it is often the case that a very minor technical detail has kicked them out of the system. With some intervention, the child is often determined to be eligible. Free press and marketing is another need. Many non-profit social service agencies coordinating CHIP or Medicaid have no idea of how to create a public education campaign or to get free press. Houston has done an incredible job through the Children's Defense Fund in bringing people together and creating issues, events, and getting free press. So having people involved in an initiative who know how to get the message out is critically important and private dollars will pay to create the necessary partnerships and coalitions.

How we communicate about CHIP to policy makers is another critical area. We must be able to help them understand the impact CHIP has had on the lives of children in Texas. Finding funding for a documentary film or a report would help in that effort, especially as we begin the next legislative session when state dollars are short and competition for them is strong.

Some other key issues are the effect CHIP has on health care financing. We are trying to work on what difference CHIP makes to hospitals' funding streams—particularly tracking the increase in the number of patients who have insurance--but this kind of research and evaluation takes funding to plan and implement. Most hospitals are not tracking this data related to just children. We also have problems in reimbursing providers. No one that I know of has done a real study that talks to providers and finds out what it would take to get them involved. We need to understand the story of the doctor out there who is a pediatrician, and finding out what he is getting back from CHIP and Medicaid, what it does in terms of the number of people in his office, and what it takes to process the claims. I do not know if anybody has really told that story, and yet that is going to be the next trouble spot for both CHIP and Medicaid. We have many doctors who will take CHIP and Medicaid, but we have to tell their story so that we can provide support for them and increase financial support.

In closing, there are many opportunities for foundations to play a crucial role in ensuring that children continue to have access to health insurance, know about its availability, and use their coverage once they are enrolled.

Patrick J. Bresette

Associate Director, Center for Public Policy Priorities

Patrick Bresette, associate director of the Center for Public Policy Priorities in Austin, is responsible for welfare policy and child care issues. He has led the Center's efforts to influence state level welfare and workforce reforms so that they support successful transitions from public assistance to self-support. Before joining the Center in 1991, Patrick worked in the Texas House of Representatives for former State Representative Libby Linebarger. He has a master's degree from the LBJ School of Public Affairs at The University of Texas at Austin.

I have been asked to talk a little bit about the history in Texas—particularly since 1995—of major welfare reform changes in state and federal policies, how those changes have affected families in those programs, some of the characteristics that we see now, and—in particular—what we are facing in the next couple of years.

This year Congress will have to "reauthorize" the welfare reform changes they set in motion in 1996; this includes Temporary Assistance for Needy Families (TANF), child care, and food stamps. These programs are all on the table for rethinking about policy, service definitions, eligibility, and funding. A lot of questions are up in the air and the answers will certainly have a huge impact on Texas. I also want to provide a perspective, as we've seen this six-year history, of where do we really need to go from here. What does that mean for needed services, local approaches, funding ideas, that kind of thing. So that is what I'll try and do over the next 15 or 20 minutes.

As a brief recap, in 1995 Texas put in motion its own state changes to its welfare programs, in particular, the Aid to Families with Dependent Children (AFDC) program. This was quickly followed by federal changes in 1996. Texas really paralleled much of what was happening in the rest of the country and the federal changes in 1996 mirrored many of the state reforms that lead up to them. A lot of what you have heard about is the new focus on work, new work requirements, time limits on benefits, and a whole set of personal responsibility measures—all sorts of things that clients had to agree to do, or not do, in order to get benefits. There are some broad federal requirements to these rules, but individual states differ in their specific requirements. For example, the time limits system in Texas is much different than from any other state, as well as from the federal time limit requirements. Texas' time limits are relatively short. They are either one, two, or three years based on the recipient's education and work history. Someone with a high school degree and some recent work history will have a 12-month time limit; less education and work history results in slightly longer time limits. The federal law has a five-year lifetime limit, so as soon as you have accumulated 60 months of benefits under the new program, you are permanently ineligible for TANF funded assistance. The overlap of state and federal policies has created confusion for caseworkers and clients alike.

One of the major changes that we have seen—you have heard this story nationally, and it is been mirrored here—has been significant caseload reduction among welfare recipients. There are much fewer people actually receiving assistance today than in 1995.

The total caseload declined from a peak in 1995 of almost 750,000 individuals, to about 341,000 in 2000 (Table One). It is now projected to begin increasing slightly over the next few years. That is raising some flags for both budget reasons and as to whether the program is designed sufficiently to deal with the increases we are beginning to experience.

I want to again reiterate. Table One represents individuals, two-thirds to three-quarters of whom are children. So this is not just the "cases." These are actually individual people receiving services. Of this total, there are only about 80,000 adults currently getting TANF assistance, while programs like Medicaid and food stamps continue to serve more than 1.4 million people. Our TANF program is so restrictive that we have very few, extremely poor families who can get access to that program. However, food stamps and Medicaid are the programs that low-income working families in Texas (who have time to find some assistance) are theoretically supposed to have access

Table One

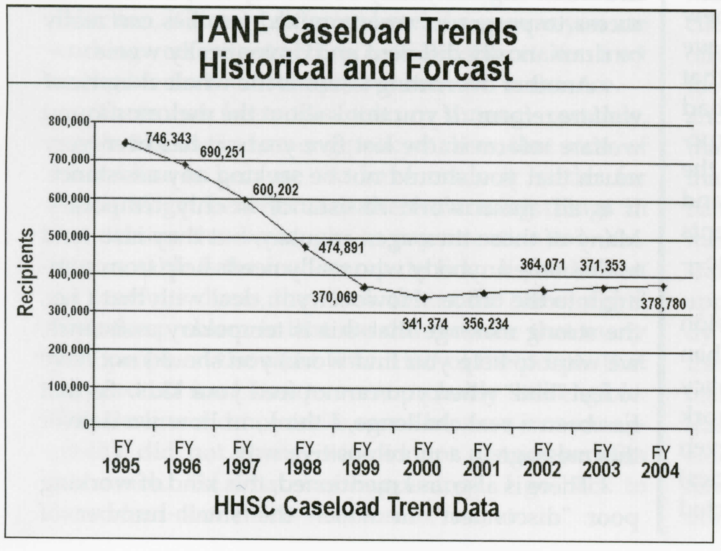
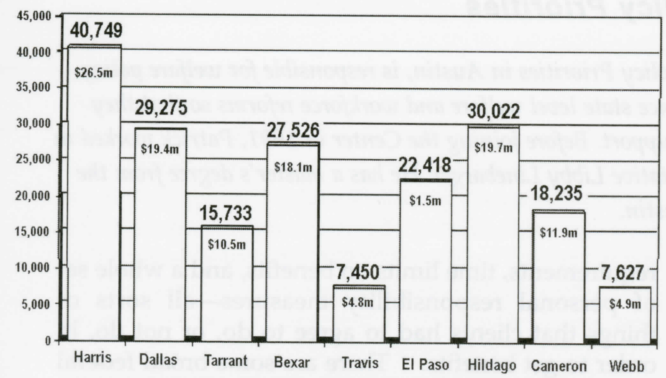


Table Two



Caseload Data is From Texas Department of Human Services FY 2000 Annual Report, Dollar Amounts Reflect Value of TANF Cash Payments

to. However, much of the policy focus and thrust of policymakers has been on that one small program. That has created some problems for us in the way we think about these services, and I will talk about that in a minute.

You have in your packet (See Table Two) from the DHS Annual Report, the dollar value of benefit programs in major urban counties. You can see Harris County has the largest caseload, $26.5 million in benefits. And if you look at food stamps, it is almost $140 million in actual food benefits going into that community. This gives you a sense of the relative impact of these programs. It would be a similar story if you looked at Medicaid spending.

So why are caseloads declining? What have we been seeing happening? Obviously, the kind of economic boom we saw, with new opportunities for work—particularly the low-end workforce—created a lot more opportunities to find initial jobs and stay employed. There was also a significant increase in federal funding for work supports, like child care and earned income tax credit, which made it easier for low-income families to hold down a low-wage job.

However, one of the side effects of all the big new policy changes is the ripple effect that confuses its way through the system; things like new policies, new procedures, new paperwork that happen when we have lots of policy changes. We had new forms that clients had to sign, new work requirements they had to meet, the whole multi-layered time limit structure—a whole new layer of things that, first, the state's caseworkers had to learn and then to try and explain in an intelligible way, and, second, that clients had to try to understand. That has been a big issue—red tape requirements and widespread confusion.

Another big downside to this general confusion has been a lot of confusion among programs. When you consider that most of the attention and policy focus has been TANF's new time limits and work requirements, many clients, (and, I would argue, even some of the front line caseworkers in the agencies) were confused about whether those changes affected other programs, like food stamps or Medicaid. So in the last few years we have had group informing sessions made up of people applying for benefits who ended up thinking that they had time limits on their Medicaid and work requirements for their food stamps. That was not true. Yet, that was the impression that was left with them because of the vast amount of information and changes being delivered to them. When clients walk into a DHS office, all they are thinking is that they need help. "I need some cash right now to pay my bills that are going to be cut off," "I need some food for my pantry, and my kids are sick." That is what they conceive of as the benefit they are receiving. The term welfare to them often means all three specific programs – TANF, Food Stamps and Medicaid. It is hard for them to grasp what is going on when the message they keep hearing is, "Well, these little requirements attach to this program; they do not attach to this one, but they do attach to that." That kind of confusion has been a real problem in these programs over the last few years.

At the same time, we are also facing big immigration worries. I do not want to understate that. New statistics have really been startling in Texas. There were major restrictions to benefits for immigrants, specifically for food stamps, but also in these other programs. When you think about who is that really affecting, however, it is not just 100 percent immigrant families. Look at the numbers; 18 percent of all Texas children live in a family with at least one non-citizen parent. That is nearly one in five, and then if you look at low-income children—those most likely to be in families needing help or seeking it—it jumps to 27 percent of those in families under 200 percent of poverty. That is just remarkable, when you stop and think about it. All these changes in the programs combined with big fears among the immigrant community about their access to these benefits, and that one in four kids are in families that may be eligible for assistance, but may be worried about their immigration status. You can see that while the actual reduction in benefit eligibility may be one number, the effect on access to programs among mixed families can really be dramatically different and dramatically worse.

Another overriding issues is the whole rhetoric of welfare reform. If you think about the rhetoric around welfare reform in the last five years, it has been very much that you should not be seeking any assistance. It is all about work. Assistance is only temporary. Many of those messages are okay, but they also tend to dissuade anybody who really needs help from coming into the office. However you deal with that (i.e., the strong message that this is temporary assistance, we want to help you find work) you should not have to feel "bad" when you cannot feed your kids. So that has been a real challenge, I think, in how we deliver this message in a more positive way.

There is also, as I mentioned, this kind of working poor "disconnect" in which the small number of

unemployed people seeking cash assistance and who would benefit from this employment focus is actually dwarfed by those who may be working, but not earning enough to pay for health care or to put food on their table. Yet many of the programs are still geared toward a non-working population. Not until recently did the Department of Human Services begin to really try and expand access after hours and on Saturdays for benefits. You know, we provide cash assistance that is equal to 17 percent of the poverty level, a maximum grant of $208 a month. If you want the maximum you cannot have more income or cash than about $2,500. So the people who actually have access to that program are really, really in a different kind of scenario than those in working poor families.

Audience Question: Patrick, your first two are positives, your last four are kind of negatives of why those caseloads... What's your bottom line feeling on that? Is it the positives or the negatives?

There are big debates on this among the research community. Everything I have read suggests that easily one-half to two-thirds of the impact has been economic. There has been more opportunity, more jobs to be had, so that really drove down the caseloads. Now, that is debated. Like I said, you can find ranges of people's opinions about this. Another chunk then is definitely that more childcare funding and the Earned Income Tax Credit has made those low wage jobs more livable, so those kinds of positive changes really add to that side. And then, actual time limits, new requirements, etc., is really a smaller portion of the caseload reduction drivers. Now, there are people who would argue that stricter requirements had a stronger impact. Again, the research has quite a range. But I still think from what we have seen, particularly in a state like Texas—you have to remember how different it is here—a part-time job makes you ineligible for TANF, right? Now, in other states it would not be true. With your part-time job you would still be getting some cash assistance and other benefits. So it is also real important that when you see national assessments of the impact of the economy on caseload reduction, it is very different here. As soon as you are working you are not getting cash assistance. You may be eligible for food stamps, but not cash assistance.

There has been this concern among, certainly, people like us, and among policymakers, that some of the decline is because we have made it harder for clients to get benefits. Are there alarming things in that decline that we ought to pay attention to? Yes. Most notable is the food stamp decline. If you look at the previous charts, they look almost the same, right? Well, the problem is that we did not lose that many poor people at the same time. Half of the people that dropped off food stamps were probably still eligible. That decline did not make sense because income eligibility did not change—it did not restrict benefits that much. So what was happening? I go back to these bleed-over effects—confusion, fear, etc.

In response to many of these issues there emerged a new focus in the last couple of legislative sessions—and some success this past session that parallel what you heard about in children's Medicaid—in making these programs more logical to families who are trying to hold down a low-wage job and need some help. There is also an effort to focus better on what happens to people when they leave. Are we getting what we think we are getting? A quick anecdote about that is that the research—and Laura [Lein] will talk some more about a new report that is coming up—that basically people who left welfare were working in dirt poor jobs. You have heard some of that research nationally, but they were earning an average of $6.34 an hour, working just over 30 hours a week. That is $3,000 below poverty for the average family. They are probably still eligible for these other programs, and they certainly are not really being able to support their family with any kind of economic security.

Given this, a set of concerns has begun to gel in policy circles, and that we have certainly pushed hard on. We need better outcomes—we have to start focusing on how people are doing once they get off the program—and you have to start making it easier for families to stay connected to these programs when they still need them. Some of those things really happened this session. One particular bill focused on actual wage outcomes. You might be surprised to learn that our current employment services program for welfare recipients has no wage outcome measures. We reward placement. Get them out and you get your check for doing that job. We do not say to our employment service contractors, "Yes, we want them off the program but they have to be making at least $8.00 an hour, then we will pay you." That is not the way we measure success in our current program. The bill that passed would begin to create an incentive payment for placements that are not just below poverty, so that is a good step.

Also, there are food stamp improvements similar to the kinds of things you have heard about in Medicaid. You can actually have a whole subset of clients who may have barriers to coming into the office, who can now phone in and get certified for food stamps. We raised some of those vehicle limits and asset limits we talked about in other programs so that you are not going to be penalized by having a car that runs or if you have a little bit of savings in your bank account. We do have a finger imaging requirement. Anybody who wants to get assistance in food stamps now has to get fingerprinted as a theoretical approach to prevent fraud. Unfortunately, this "remedy" costs us millions of dollars a year—much more than the cost of any fraud it might be deterring. We really thought it was entirely a waste of money, but at least there were some modifications to make it so the elderly and other people in the program that might have a real problem coming into the office to get it done would not have to go through that process.

So significant problems remain. There are still budget pressures (as always in Texas) on these issues. But one of the remarkable things to me is all the rhetoric there has been about helping people to get work, and yet our per capita spending in our "work first" program has dropped in each of the last five years. So while we have talked about helping people get employment, we essentially cut the amount of money we spent per person on helping them do that at the same time these stricter requirements have been in place. That just does not make any sense in my mind. We also reversed some of our funding for childcare in the last legislative session. A few other things that seem to be counter to the progress you would hope to be making in some of these programs.

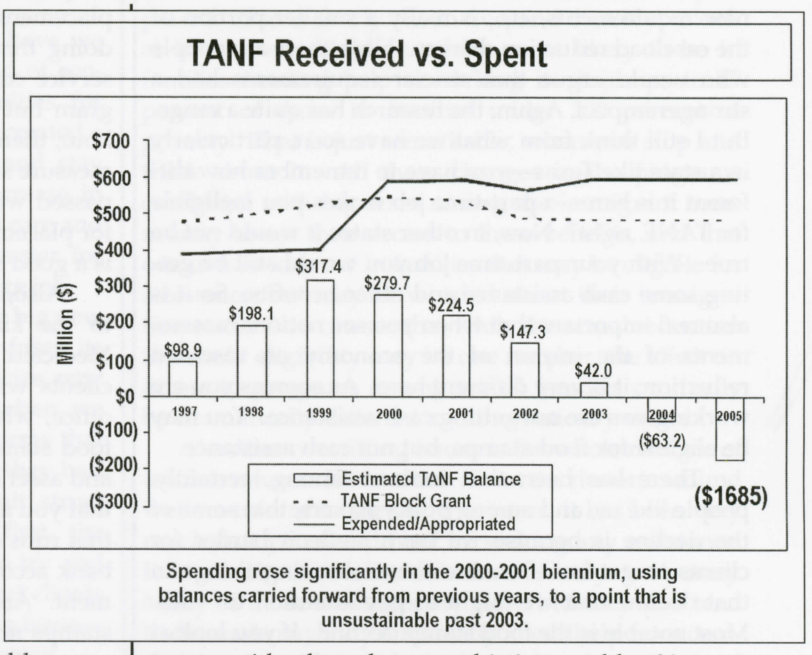
Okay, so the main issue coming up and why some of this background is important, is what Texas is going to be facing. In addition to the next legislative session where challenges to funding in these programs and continuing some of the successes forward will exist there is the Congressional reauthorization of these programs in 2002. As I said, it is not just TANF—this new block grant that was basically authorized for six years and has to be reauthorized or brought back online—it is also food stamps and childcare. So if you think about Texas' reliance on federal funds, in particular, and these major programs and the millions of people they serve, this debate in Congress is really critical to many of these services in Texas.

Interestingly enough, it appears that this time, unlike last time, there is really an engagement by states to try and tell their stories about what has happened in the last five years and to actively participate in congressional decision-making. Advocates across the country are really engaging and I think that is good. Researchers are involved, there is a sense that we need to know what has happened in the last five years before reauthorizing this program, and that is encouraging.

The wild cards—foreign terrorism, the economy and federal budget issues—are very real, however, and could mean that all this stuff gets stalled. No matter what, reauthorization of these programs centers on significant budget items in the federal budget and presents another kind of question mark. Do we continue to get the funding levels we receive now or are we also facing some federal reductions that could exacerbate our upcoming state budget problems?

I think that Texas is vulnerable in particular during congressional reauthorization, for a couple of reasons, and mostly it is around money. The TANF block grant that we receive to serve low-income families is roughly equal to what is cost us to serve the amount of people we had in the program prior to welfare reform five years ago. But now, our caseloads dropped off the chart by 50 percent over that period of years. So, basically, we had huge surpluses built up in 1997 and 1999, nearly $600 million in 1997, and we found ways to spend that money. That was not a big problem. But now, things have changed. If you look at (Table Three) you'll see that the dotted line is how much money we get from the federal government. The solid line is what we were spending. So in the early years, as caseloads declined dramatically, we were spending much below what we were getting in our block grant. The bars are the surpluses we built up each year. We were just carrying that forward, essentially. Starting in fiscal year 2000 we began to spend above the annual block grant we get, and that is the pattern we are on right now. And so, before anything else happens, when we come back in the next legislative session, they will have to figure out a way to cut some $60-plus million of TANF out of the budget. This is based on caseload projections in April, so if we have caseloads that continue to increase, and anything else happens where the Congress does not reauthorize the block grant at the same level, in addition to all of the other kinds of general revenue funding problems we are having, one of the first things they will have to do is figure out how to reduce where we have TANF in the budget now. And so that puts huge pressure for us on reauthorization today on the money side alone, because this is unstable. You cannot spend money you do not have (obviously) and so that is one of the big questions that is out there for us. And it is not going to be easy, obviously.

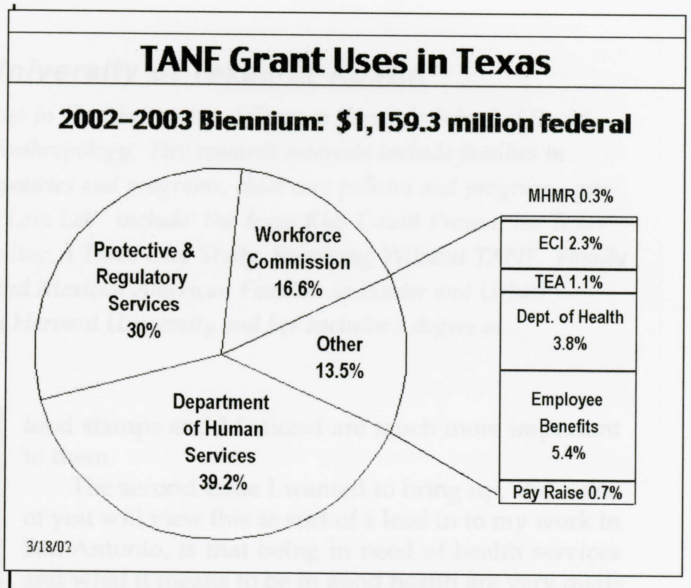
Table Three



Spending rose significantly in the 2000-2001 biennium, using balances carried forward from previous years, to a point that is unsustainable past 2003.

In 1998 and 1999 most of our federal TANF dollars went to the Department of Human Services, basically for cash assistance and some other support services, nearly a fourth was at the Texas Workforce

Table Four



Commission, which was primarily the employment services program, and then we began to ratchet up spending at the Department of Protective and Regulatory Services through a small loophole in the TANF block grant law that allowed us to spend money in some programs we had been spending in before.

For this current biennium, take a look at what has happened in (Table Four). Protective and Regulatory Services now has a third of the block grant, the Workforce Commission—where you think most of the money would be spent in helping people to find work—is actually down to 16 percent, and DHS's share is also reduced. So where do you cut $60 million? This pie has already squeezed down what we are doing to actually help low income families get work and other assistance.

Question: Where does the money for Protective and Regulatory Services go?

It is primarily in foster care and some other youth services and Child Protective Services related efforts.

Question: It is kind of enhanced foster care payments and something like that?

Yes, it actually helped underwrite much of their budget. You know the year that everybody was really proud that Texas funded all of DPRS' exceptional items? Every one was funded with TANF dollars.

Question: So they shifted some of the money?

Yes. A big chunk of it was new money and some of it was "supplantation" where we found ways to pull out the general revenue in those programs and put in the federal dollars. So it is not a pretty picture about where you decide to reduce funding, and what we are worried about is that CPS services, foster care services, absolutely essential services for children, probably won't get cut, and should not receive reductions. But then what happens to continuing caseload increases in TANF and the need for more childcare and employment services—what happens to those services. Despite this bad news about funding, the opportunity under reauthorization is to highlight these challenges, get the state to play a part in the federal debate, move us away from thinking so much about caseload reduction, to thinking about poverty reduction. How do you turn this program toward the next logical step? If we have really done a good job with getting people off of the program, how do you reshape it to focus on helping people get jobs that pay well so they can stay off?

Another issue for reauthorization relates to clients with "barriers" to work. There is a lot of evidence that many clients, particularly in a state like Texas, have other barriers—mental health, substance abuse, domestic violence. How do you shift the program to better address some of those issues and not just basic cash support? Also, there is going to be an enormous amount of focus on family formation and marriage promotion. That is going to be a very lively debate, as you might imagine. And so how do you shape those to be realistic policies that focus on helping families, and focus on children, and not on the marriage per se as the ultimate goal? How do you support that child best? Those are going to be very, very hot topics for debate.

The last thing I want to say to you before I turn it over to Laura is that one of the things that we think is needed to move welfare reform to its next stage is really to focus more on what it takes to help families make it. So the Center for Public Policy Priorities actually has a new report—you can pick it up on your way out in the hall—that essentially profiles basic family budgets for every MSA in the state. We took the most conservative aspect of what it would take for a family to pay for housing, for food, for child care, for health care, and translate that into the income it needs to be making, and—lo and behold—too many people do not make that income. Things go by the wayside—health care won't be paid for, food is short. Once you see this in black and white the next logical question is: what is the combination of wages, programs like food stamps and Medicaid, and other community supports that can, together, make low wage jobs livable? There are tables for every MSA that show, for eight different family types, what the real costs are, and these are absolutely the most conservative costs. They do not include any extras—they do not include savings, they do not include things that ought to be in families' budgets, but this offers an alternative way to measure our success. And so instead of, "Are you not receiving benefits anymore?" We should be asking: "How can we assist you in building family security? What benefits do you still need with a low-income job and with other private support to be able to survive and prosper?"

I can talk some more about this later, but there are copies for everybody outside, and this is one of our organization's next priorities, both in the reauthorization debate and in the next session—shifting the debate to how you help families make it. Thank you.

Laura Lein

Professor, School of Social Work, The University of Texas at Austin

Laura Lein, Ph.D., is a Senior Lecturer and Research Scientist in The University of Texas at Austin's School of Social Work and has a dual appointment with the Department of Anthropology. Her research interests include families in poverty, families on the Texas-Mexico border, social welfare policies and programs, child care policies and programs, gender, race and ethnicity. The current research projects at the "Lein Lab" include: the Texas Kids Count Project, the Texas Market Rate Child Care Survey, Welfare, Children and Families: A Three-City Study, Surviving Without TANF, Family Involvement Among Low-Income, Non-Custodial Fathers, and Mexican American Families in Border and Urban Settings. She earned her doctorate and master's degree from Harvard University and her bachelor's degree at Swarthmore College.

I am an anthropologist by training, and anthropologists, as most of you know, like to do their work by going out and living with families in communities and trying to figure out what is going on there. I am going to be talking from my own experience doing that in San Antonio, and also from a larger study that I am involved in which teams of us were out talking to families in Boston, Chicago, and San Antonio. Both the Hogg Foundation here in Texas and the Kronkosky Foundation were participants in that with us.

One of the things that I want to look at is life experience. I am going to be taking us a little bit back to health and Medicaid coverage, but I hope from a different perspective. One of the things that Patrick explained is that families in Texas often are more concerned with Medicaid and food stamps than with Temporary Assistance to Needy Families (TANF), and there are a couple of reasons for that when you talk to them.

One is that Texas TANF payments are really low, and even for a very poor family, the ability of the cash payment to make a real difference is much more limited than a cash payment in other states just because it is small. The other thing is—when you think about what a cash payment is supposed to do for a family—is to give them enough money that they can depend on. With all of the different regulations and penalties, most families that we talked to who are receiving TANF find that the payment is quite irregular, and they cannot explain it. They know they probably did something wrong; they do not know what it is, and they do not know when it was.

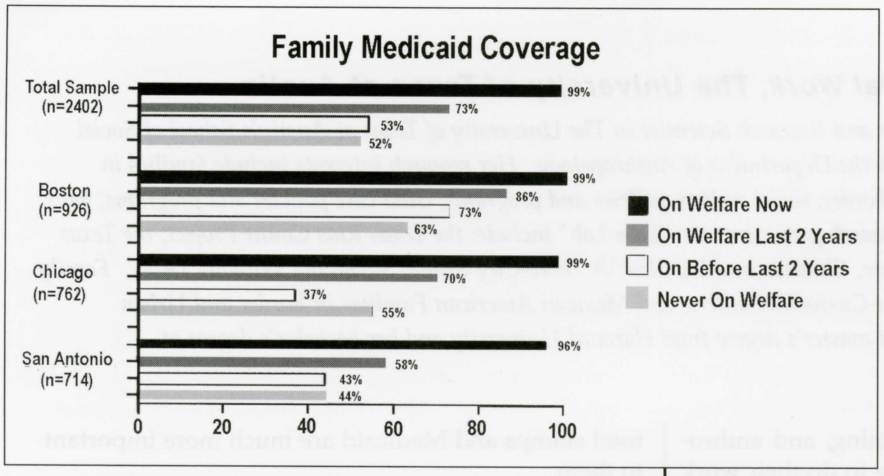
It is also the case in many communities in Texas that welfare offices particularly under pressure to correct any errors in TANF payments—go back and take back from families what were overpayments because of inaccurate records. So families can also find that their TANF payments are going down because of previous "overpayments." They can also find that once they are off of TANF they are still susceptible to being billed for payments that were made to them that should not have been made prior to their going off TANF. So there are all kinds of reasons why families do not look at the cash payment as the be-all and end-all of being on this program. Other programs such as food stamps and Medicaid are much more important to them.

The second issue I wanted to bring up, and some of you will view this as sort of a lead in to my work in San Antonio, is that being in need of health services and what it means to be in good health are very qualitatively different for low-income families. This is true in every urban area, although San Antonio has some special issues and problems.

When I first started doing this work in Texas, as many of you know, my family and I moved into a community on the near west side of San Antonio and lived there for a summer while I got my bearings. When I was trying to figure out where I was going to live there—this was ten years ago—one of my colleagues at UT, an epidemiologist, listened to my explanation and said, "Oh, Laura, you are going to live in one of my hot spots." Now, when an epidemiologist tells you that, you are certainly going to be a little concerned. What he explained was that he was doing research on neighborhoods in the urban United States that had health profiles that were more similar with developing countries than health profiles for the normative United States. I was right in the middle of one of those neighborhoods. He said, "The neighborhood you are living in," and this was nine or ten years ago, "looks more similar to Bangladesh than it does to the mainstream United States health profile."

What does this mean for a family? And this is one of the cases where being there made the difference. I watched my family, over the three months we lived there, deteriorate from what would look like a middle-class health profile, to what looked like the health profile of a family in a developing country. We were unable—my husband and myself—to protect our children from the impact of the health status in that community. My oldest child tested positive for tuberculosis and went through a year-long treatment. I had a son with a vicious disease that comes from pests and fire ants in the house, which I won't get into here—it is too yucky. But it was a really fascinating and devastating experience. It really opens your eyes to what it means for parents to be trying to protect the health of their children in communities where the community itself is one of the health hazards that you are dealing with.

Table One



So with that in mind, I want to look at, first of all, what it means to have health coverage and not have health coverage in San Antonio compared to some other cities. I also want to talk about how it is that in Texas, work—particularly the kind of work you get as you are on the cusp between welfare and work—can actually be bad for both your health coverage and your eventual health. Why are these families looking more at risk? What we are seeing in the three-city study is that Medicaid coverage itself varies significantly by what city you live in, where you live (San Antonio is representing Texas here) by the race and ethnicity of the respondent (we have a heavily Hispanic, heavily Mexican-American population we are looking at); and by employment status, whether or not people in the household are employed. As everyone has suggested here, it can get harder to get health insurance and health coverage as you move off of public services and into those first jobs—most of which are unlikely to have health insurance themselves, but they still render you ineligible.

It is also the case that families really value Medicaid. This is a kind of typical statement that we got over and over again from interviews: that Medicaid was really important. It paid for what they needed, and people interviewed about these services brought up the amount of money. It was through these interviews that we learned also that low-income families are often carrying medical debts that stem back to periods when they were not covered. So it is important to realize that it is not just whether someone is covered now, but the impact of a sustained period of not being covered. Medical bills will last a poor family's lifetime if they accumulate them.

Let me give you an example. One family we interviewed was off of welfare. This was a family that believed they were not eligible for Medicaid. They had a little girl who was having one of those rounds of frequent ear infections. The doctor said, "You know, she is going to be a lot healthier if you can get tubes put in her ears." So they had talked about how much that would cost as an outpatient procedure; roughly around $400 or $500. This two-parent family borrowed some money and got the $400 or $500 together over a two-month period, and they took the little girl in for the procedure. In the course of the procedure the physician discovers there is a more serious condition and the little girl is hospitalized for three days. The family has a $6,000 medical bill which they are completely unable to pay for. At the time we interviewed them, they were paying it back at $30 a month, which they anticipated will basically go on for the rest of their earning life. And that was a real typical story of medical debt. You accumulated it at some period when you were not covered, but it lived with you forever.

As people have already mentioned, Texas' situation is not terribly great if we look at Medicaid figures by city and by welfare history. What we are trying to show in Table One are the people who are on welfare now, and those families, who are likely to have Medicaid coverage. What we see is that the less experience you have on welfare, the less likely your are to be on Medicaid. And these interviews are all being done in poor neighborhoods where the population is dominated by people who are probably eligible.

Let me just talk here about what the cost, comparatively speaking, between families on Medicaid in San Antonio and families in Chicago and Boston. At every level of poverty there was lower coverage in San Antonio than in our other two sample cities. The other thing we learned from families, which was very interesting, is not only was there a difference in coverage, there was a difference in families' access to care. A couple of our speakers have mentioned that insurance coverage is important, but it is not medical care. If you can get insurance but not medical care, then it is still not doing its job. When we compared notes on what neighborhood settings were like in Boston and Chicago compared to San Antonio, there was a real difference—and we've done some geographic mapping—in how close to a household was the nearest health care facility that would take on a Medicaid patient. And what you found in both Boston and Chicago was a relative ease in getting to medical care if you had the coverage. In San Antonio, families faced much greater difficulty in getting to providers.

We also found, moving over to the race and ethnicity issues, that families were much more likely to be uninsured if they were Mexican-American or Mexican-origin. Most of the children in these families are citizens; they were born here, so we are not looking at the children who themselves are immigrants, although their parents may well be immigrants.

On the other hand, there was some nervousness among families who feared pressing for services if they thought someone in the family might be susceptible to immigration problems. There is another factor

in families in poor neighborhoods: the fear that your children may be taken away from you by the state for neglect. Today we have talked about the importance of Child Protective Services—and they are important—but in almost every interview, families would allude to the fact that if they were on record as not being able to care for their children adequately, they might lose their children. The mere act of applying for assistance was seen as a potential admission of failure as parents. So there was always tension as families went after services.

Particularly, again, in the foreign minority communities, we also saw an interesting result—and you can see it from the policies that have already been described to you—that it is quite likely in some families that some children are eligible and others are not. You remember in DeAnn's [Friedholm] presentation which showed that different eligibility rules meant that children within certain age groups could be on Medicaid , some on CHIP, and some without any assiatance at all. So a family might find two children are on Medicaid, one child's on CHIP, and one child's not on services at all.

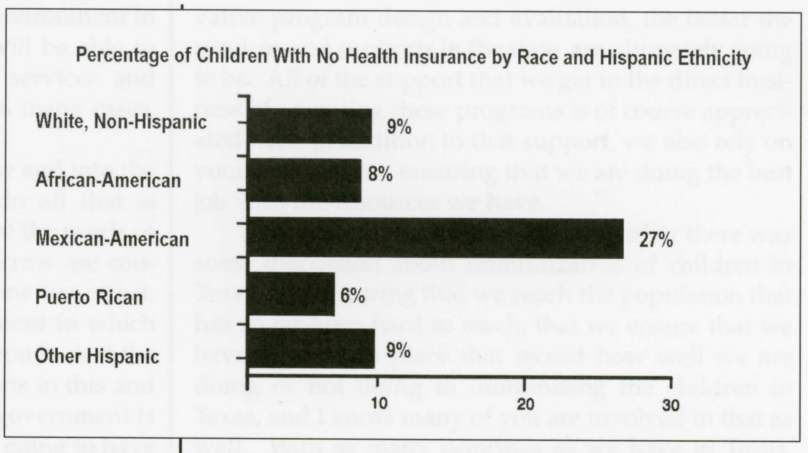
What we found was a very active market in San Antonio for prescription drugs being sold and traded around the community to get drugs to those children who were not on coverage. So some parents have gone in, knowing that their youngest child who is covered has strep throat and gotten a prescription for that child. But they also have two other children who are not covered and are making the decision as parents that the uninsured children probably have the same thing the covered child has. So they go out into the neighborhood market to try to duplicate the treatment that they received through Medicaid for the youngest child. Everybody following that? So I remember during my first interview that I was getting more and more confused by this story. So I asked, 'Can I see what you are talking about? Can you show me the pharmaceuticals in this house?' And they brought out a whole drawer full of 30 different bottles of prescription drugs that all had little notes on them about who they got them from and what they thought they were good for. That was their protection against not being able to get the kind of insurance that they needed.

Table Two shows Medicaid by race and ethnicity. As I said before, as parents go into employment, the children fall off of Medicaid. You get very complicated stories as families try to explain the interaction between their employment history and their ability to get medical coverage.

There are several threats, many of which Patrick has already alluded to, that come into these stories that families have. They include the fact that it is very unlikely that the adult's first job will give them medical coverage. If it does, it may include expenses the family cannot pull out of their income (i.e., co-payments and employee contributions) and may not include all members of the family. You also find in blended families (where there are adults who have their non-biological children), that the way that employees deal with access to health care varies by the relationship. So once families are in the workplace, it can be every bit as complicated to try to orchestrate medical insurance coverage for everyone.

So we have found that as families moved into work—and their access to health care became shakier—

Table Two



it became shakiest of all for their children, because the employers were first and foremost insuring the working adult. So one of the things, I think, to keep in mind as we move forward is looking at the degree to which we have got a labor force problem as well as a welfare problem tied up in the nature of the jobs people have access to and the services they can get through those jobs. We tend to act as if health care was going to be available eventually to families through their employment, and it simply is not. Let me stop there.

Don Gilbert

Commissioner, Texas Health and Human Services Commission

Don Gilbert is the Commissioner of the Texas Health and Human Services Commission. He was appointed by then-Governor George Bush in 1998 and then reappointed by Governor Rick Perry last February. Mr. Gilbert and the THHSC oversee eleven health and human service agencies and Medicaid. The Commission is responsible for agency operations and interagency coordination and represents roughly $35 billion in state spending.

Good afternoon. The first thing I want to do is say thank you. I have been in health and human services for many, many years and most of those years in the mental health field. I know firsthand that we could not do what we do in the state without the support of foundations. Grantmakers like you have made a difference and we should all be appreciative, and I want to take this opportunity to say thank you, and hopefully you will continue to support the state's efforts in meeting the health and human service needs of the people of Texas. It is a daunting challenge; the needs are huge.

Let me start by saying that it might be helpful to understand, from my perspective at least, the environment in which we operate and the environment in which you as grantmakers hopefully will be able to support and encourage cost-effective services and supports for people in this state who, in many cases, desperately depend on our efforts.

Certainly in Texas we see an era now and into the future in which government cannot do all that is needed. I think we must understand that the needs of today and the projected needs of tomorrow are considerably greater than government alone can meet. That helps us understand the environment to which grant support might be most useful. If you look at the revenue projections and at programs costs in this and the next several funding periods, state government is going to have to do a better job. We are going to have to be, in some cases, more selective about the services we provide to ensure we are addressing the problems that government can address and encourage the support from the private sector—including foundations—for those problems cannot.

These are very, very difficult times in health and human services in terms of managing the incredible demand for our services. I think DeAnn [Friedholm] talked earlier about CHIP and perhaps Medicaid, and I will specifically address her questions about those two programs. All that said, we have got to know with certainty that the way we spend our money in state government is making the optimal difference. Those things that foundations do that lead us toward best practices and the development of effective services—both in cost and in ultimately meeting needs—form the description of services for the future.

In times of tight resources state agencies usually have the least ability to conduct outcome studies and program evaluations. We tend to squeeze down every possible nickel just to continue the same level of services always have. I think where foundations have been particularly instrumental is helping find ways in which we can make services work at an optimal level. My experience is that foundation support aided in our making the best use of new generation atypical and psychotic medications in mental health care. To me that serves as a useful example of how you as grantmakers can help us ensure effectiveness of state dollars at a time of enormous demand. I just want to simplify this by saying that as you consider the many, many needs of Texas, it is better that you help us learn how to fish as opposed to just giving us extra fish. In other words, the more resources dedicated for innovative program design and evaluation, the better the services and supports in the state are ultimately going to be. All of the support that we get in the direct business of operating these programs is of course appreciated. Yet, in addition to that support, we also rely on your assistance in ensuring that we are doing the best job with the resources we have.

In specific areas, I do not know. Earlier there was some discussion about immunization of children in Texas, and ensuring that we reach the population that has so far been hard to reach; that we ensure that we have systems in place that record how well we are doing or not doing in immunizing the children in Texas, and I know many of you are involved in that as well. With as many priorities as we have in Texas, when we are sure we have children who are not being attended to as children need to be, it is an important priority and must be observed.

I'll wrap up with just a few comments about CHIP and Medicaid. The CHIP Program. Many of the foundations in this room have been instrumental in the very, very exciting success that we have had in seeing half a million children in Texas with insurance where before they had none. It is exciting also trying to figure out how we are going to pay for that as we see the challenges ahead. None of us, had any idea at the beginning that the program could be as successful as we have seen in Texas. I think if you look at the enrollment levels in Texas compared to any other state, it is phenomenal the size of the CHIP program in Texas and it continues to grow. We also underestimated, as we put this program together, the demand for health services represented by this population.

We assumed, as many other states did, that services among the kids qualified for CHIP would mirror

in some form the Medicaid population, differentiated simply by income levels per family. What we have seen instead is a tremendous demand for services that has caused the cost of the CHIP program to be considerably higher than we first thought. We have been able to make adjustments in the rates that we pay for the CHIP program, and, hopefully, we have found a level of reimbursement that will meet our needs and allow insurance companies and health plans to meet the needs of children under the CHIP plan. At the same time we have a higher enrollment than we had forecast, and it was a complicated mix in determining how we could reliably estimate what the true size of this eligible population would be. But what we know in all this is the considerable work—the very good work—that has been done by community-based organizations (in many cases supported by foundations) that in bringing forward many, many, many families without insurance. And the good news is they have been able to sign up for the CHIP program and enjoy insurance today that they did not have not long ago.

Our challenge, of course, is how do you work with limited resources to meet the needs of children while also meeting the increased cost of doing business in the program? That is the challenge that we face. There has been a lot of speculation in the media about what is about to happen with the CHIP program. The truth is—and I can tell you this is the truth because these are discussions I am involved in—we do not know what we are going to do in terms of managing the costs of the CHIP. That has not been decided. What we were asked to do—and I think it is our duty—is to lay out options that would allow us to stay as close to the budget allocation as we possibly can, and then let the leadership of this state decide how they want to respond.

Now, what happens when you try to do that in an inclusive way—in other words, be as open as you can and recognize the input of various stakeholders—is that people pretty quickly jump to conclusions that this is a foregone deal. The assumption is that we have already made up our minds about what we are going to do, and we are just running these ideas by the public as a way of making a preliminary announcement. That is not the case at all. What we diligently try to do is invite ideas and suggestions about how we can make this program as viable as Texas children need it to be. And so we are far from finally deciding what's going to happen with the CHIP program, but I think the sum of all this is it only underscores CHIP's success. It is a sought-after program that I think is going to turn out to make a huge difference in the health outcomes of children. We are pleased with the progress, even while we struggle to manage the costs of the program.

Similarly—and I think this is probably past due here—the Medicaid population in Texas has also grown considerably beyond what the Legislature projected over a two-year period. We expect that Medicaid, perhaps influenced by a cooling economy in Texas and other factors, may result in a considerably higher demand, mostly among children for the Medicaid program. We will have what is estimated today to be about 79,400 more Medicaid recipients this year, most of whom are children in the Medicaid program, followed next year by 173,500 more children than we scheduled and budgeted for in the second year. I will tell you that it is not altogether unusual to project increases this early in the operating period, and it is certainly too early to offer a prediction on how big the program's going to be.

I say all this to suggest to you that it looks as though that with the economy slowing and our children's health insurance outreach efforts being so successful, it is not surprising that we will see an increase in demand for the Medicaid program. Medicaid is a huge, huge part of the state's budget, representing nearly 24 percent of all state spending. So you do not have to move more than just a little bit the volume of services in Medicaid to produce huge financial consequences, and that is in addition to CHIP and some other things that we are struggling with.

So now that I have exhausted way more than my allotted time, let me stop and I will entertain questions.

Ray Bishop

Regional Director of State and Tribal Programs
Administration of Children and Families
U.S. Department of Health and Human Services

Ray Bishop is director of the Office of State and Tribal Programs in the Dallas Office of the Administration for Children and Families, which is under the U.S. Department of Health and Human Services. Mr. Bishop serves as the direct representative of, and key advisor to, the Regional Hub Director on matters pertaining to the Administration of Children and Families' mandatory grant programs for a five-state area that includes Texas. He has received numerous awards in his career, including one for writing proposed regulations for the Personal Responsibility and Work Opportunities Reconciliation Act of 1996.

Thank you. I want to express my appreciation to the Texas Grantmakers In Health and Human Services for inviting the federal government to be here. I am going to be brief, and that is sometimes difficult for me. I teach a government class at a community college in Dallas, and what I love about that is sharing with young people things that are going on in government. But I also love a captive audience.

What I want to share with you is the federal perspective on welfare reform. I am with the Administration for Children and Families. We are primarily responsible for a lot of programs that are heavily involved with welfare reform, whether it is, the Temporary Assistance for Needy Families (TANF) program, the childcare fund block grant, child welfare programs, the child support enforcement program, or the developmental disabilities program. I think with so much going on now it might be useful for you to hear how we have continued to evolve the federal perspective on the direction we are going with these programs and what the goal of reauthorization is.

As Patrick [Bresette] said this morning, welfare reform will be reauthorized this year in Congress, not just TANF, but the childcare and the food stamps programs. These are going to be important issues, and there will be a lot of debate. I think what is interesting is that the White House is bringing a fresh set of initiatives and goals to the table and the president is outlining what he wants to see in next round of welfare reform.

I think the key focus, if I could boil it all down to one thing that the Administration for Children and Families wants to see in regard to all the programs that we administer is making a difference in children's lives. I do not say that in a matter-of-fact sort of way. Our actual performance measurement is to ask ourselves what each of the programs we administer is doing to improve the lives of children. If we cannot answer that question positively, then that a beginning point for us to take a different look at what we are doing. With that as a guide, there are three key areas I want to focus on this afternoon.

The first focus is "positive youth development." That means continuing to make what we think have been successful strides in improving the well being of children in welfare reform over these last few years, and making certain that we are not leaving out, any problems that exist there. I think the data show great improvement in child well being—for example,.the reduction in African-American poverty to the lowest rates ever recorded. But at the same time, studies show us is that families with adolescents, where the parents are unemployed and in the TANF program, are having less success in combatting substance abuse and crime, or staying focused on school. So one of the priorities for the federal government is to take a look across all of our programs and make sure that we have got a focus on positive youth development, so that we support not just the well being of children, but also that of adolescents. That requires a major refocusing in some ways of what we do in the TANF program. Again, from our perspective, those are choices that states make—in Texas decisions are even passed down to the Workforce Boards—and with the involvement of organizations across many levels. The issue becomes what kinds of programs are being funded, what local communities are doing, and what kinds of monies are grantmakers committing to support well-being measures for youth.

A second key issue for us is promoting the involvement of faith-based and community organization and welfare reform. This is a major thing, of course, to the administration of President Bush. What we are talking about—particularly when it comes to the more controversial focus on faith-based organizations—is not set-asides or preferences or monies devoted or committed particularly for faith-based organizations (largely because none of that exists) Rather, what the President is referring to is leveling the playing field and making sure that the barriers that exist to full participation by faith-based organizations are looked at and addressed. You have heard the expression of "charitable choice," which is part of the 1996 law that basically says states and agencies using TANF dollars should not discriminate against these faith-based organizations delivering social services. That is all it says: We should not discriminate. So the White House wants to encourage a level playing field for those organizations that provide services and that are willing to meet the caveats not to use funds to

proselytize or for sectarian purposes.

The charitable choice provision at this point also applies to some substance abuse treatment funds etc. Part of what has been a very controversial debate this last year—particularly prior to September 11th—was the expansion of charitable choice to other federal program funding streams. The House did pass legislation that the administration proposed, but as you know the Senate never acted on that legislation. Those kinds of things will be coming up again obviously in this next year.

What we want to promote is not, again, set aside preferences or quotas for faith-based organizations, but leveling the playing field and partnering with those entities that can really provide services.

Yesterday I heard an individual with the Tarrant County local Workforce Board speak about her involvement with faith-based organizations in Tarrant County. She had some very fascinating things to say about the need to explain to those communities areas where the government wants to partner with them and what responsibilities they will have for building infrastructure and for auditing the use of those funds. But what she said was fascinating. That local Workforce Board had done a survey of its clients in the Fort Worth area to ask them about delivering social services and what they wanted. It was surprising because it found that in many cases those folks who lived in the area said that they were very comfortable with their local churches and local community organizations, but that they just did not like government—which is interesting. That survey helped them to realize that services that can be provided in a manner consistent with the law and which meets the civil rights of the clients are exactly what people want. I think you all have a vital role to play in seeing that those things happen at a local level.

I really think that is a significant part of the next phase of welfare reform: to continue to evolve down to the local level. That is happening in Texas. It is been a slow process. It has not been without some pain. But I think now we are seeing some local Workforce support (Tarrant County is a good example, and one that has been recognized for doing a good job) for being a network in the local community to use those resources and funds to meet customer needs.

A third key is what the Administration for Children and Families is calling "Strengthening the Family." Dr. Wade Horn is the assistant secretary for the Administration for Children and Families and is very committed to doing research-based social service delivery and design of public policy at the federal level. One of the things that he is particularly keen on is what research shows us about two-parent families—particularly about marriage and its relationship to the well-being of children. In almost every way that you can measure—whether it be economic, health, academic or substance abuse—there are positive associations with the father being involved in his children's lives and also the existence of two-parent families among married couples.

This is an interesting area because I have good friends in state government who have a real philosophical problem with the "M" word. An individual in a meeting just this week said, "I cannot even say that word. I do not know if I am comfortable with the government promoting marriage, and what does that mean?" Well, I think the concept that we see is the concept of the government's role in supporting and promoting healthy marriages. Now, do not ask me to define that. I do not think you want the federal government to do that. But many public policies, seem rather benign, like those creating tax disincentives for marriage (the famous marriage penalty tax), or those policies that evolved over the last 50, 60, 70 years that say to a young mother, "If you get married you are going to lose your benefits, become ineligible for low-income housing and reduce your food stamps." All these built-in disincentives to two-parent family formation are what the administration is saying we need to address in terms of being able to promote and strengthen families.

And as it was put fairly openly this past week in Washington, we are not talking about the federal government promoting a dating service or telling people who they have to get married to. What we are talking about is sharing information about communication skills, conflict resolution skills, with individuals who are voluntarily willing to hear that information and letting them choose for themselves what they want to do. Let me give you one example. The Child Support Enforcement Program in Texas has done an excellent job with voluntary paternity status at the time of the child's birth in the hospitals. You have people at the moment of birth voluntarily talking about their relationship with that child. The fathers agreeing that they are indeed the father of this child. This helps paternity for lots of reasons—for the legal protection of that child and for the benefits protection down the road should child support be necessary.

Texas Attorney General John Cornyn was in Dallas this very week recognizing the paternity establishment staff at Medical Center Hospital for their outstanding paternity establishment program. However, we know from research that 80 percent of couples who are new parents of a child have some sort of romantic relationship at the time of birth. Fifty-one percent of those are even contemplating the possibility of getting married. So what we are asking is, would it be legitimate, at the time of the paternity establishment program, to ask a couple a simple question—"Are you even thinking about marriage?" And if they said, "No, we are not," then you say, "Well, thank you very much." But if they said, "Well, we are not sure. We are looking into it," shouldn't we be able to share information with them or refer them to a resource that would provide them skills and positive resources to

help them build a healthy relationship and possibly a marriage.

Obviously, we do not want to promote people being in dysfunctional or abusive relationships, nor do we want to promote the government using its leverage to try to coerce people to do things that they do not want to do of their own volition. But I think it is important that we look at what research tells us and that we not be afraid to share information if it is deemed appropriate for the individuals involved.

In the interest of time, I am going to skip over a lot of stuff and I am going to wrap this up. What I want to do is offer a brief look at reauthorization and how what I have been offering here is going to help frame welfare reform reauthorization. I think one of the things that we are promoting at the federal level is to make sure that welfare reform reauthorization is focused on what we know has been proven to work and has been effective.

In other words, the states' experiences with the TANF program—what works and what hasn't. Not just what gets people off welfare and into a low-paying jobs, but what works to sustain them and help them move up the career ladder. What kinds of supports have proven most effective? What combination of services? What does research tell us? We are on the verge of getting a whole bunch of research (federally funded and state funded) on everything from studies to tell us who is leaving welfare and what has become of those folks, to what kinds of program practices that really work. Research will help us determine what have we learned in the last five years since welfare reform, and will obviously help frame what we do in reauthorizing the program.

Mention has already been made earlier today of the specter of the federal deficit—frankly, we do not know. The economy, as well, has been a factor. What has been the impact of the economy on welfare caseload declines? If what I believe I heard—I do not want to misquote Patrick [Bresette]—what I think I heard was that some research indicates that one-half to two-thirds of the caseload reduction was due to the economy. That is a scary thought, because the conclusion—the only one I can draw from that—is if that is true, then what will happen to caseloads if the economy does not improve soon? However, data to date do not suggest a striking increase in caseloads.

There will be debates about that and it is healthy that we have these debates. It is also healthy that we have debates about what has worked and what has not and what should be the role of government in promoting and strengthening families. And I think in Texas, for example, we have been at the forefront of this, in terms of promoting fatherhood. There was a time when that was very controversial—for the government to promote fatherhood. People want to know, "What is this all about?" I think that debate has pretty much been settled. Most people now agree that it is a healthy, positive thing for children to have fathers involved in their lives. And Texas, with its Texas Fragile Families program has done an outstanding job of leading the way in terms of demonstrating the efficacy of fatherhood.

We want to see the investment maintained. You all—and by that I mean the state administrators that came to Dallas November 13th in a listening tour in which HHS was getting input from state partners about what should we do to reauthorize TANF—made it very loud and clear that your intent is to maintain the investment, keep the levels of funding, and to avoid doing anything that would dampen the state's flexibility to use those funds. I think we got that message at the federal level loud and clear.

I think I'll stop at this point, because I know I have gone over my allotted time, and you have a copy of my outline, whether it involves demonstrations, charitable choice legislation, etc. and maybe there are some questions you want to ask.

Jim Hine

Commissioner, Texas Department of Human Services

Jim Hine is chief executive and administrative officer of the Texas Department of Human Services. As head of DHS he oversees a $4 billion agency that manages nearly three dozen state and federal programs for low-income families, including Medicaid. Hine was appointed in August 2001 to his current position after serving nearly six years as executive director of the Texas Department of Protective and Regulatory Services. While at PRS he was awarded the Bob Bullock Award for Outstanding Public Stewardship, which is given to outstanding public employees who strive for innovative government that improves the lives of Texans.

Thank you. First, I would like to also echo Don's thanks for the contributions that foundations such as yours make to social services in Texas. When I was at Protective and Regulatory Services I was actually surprised to find out the extent of private contribution and systems of care that private foundations provide the state. if you include volunteer time, about 16 percent of child protective services is funded through private efforts. I think the state owes a debt of gratitude to those of you who pick up the tab for those kinds of services.

I wanted to first of all give you a little history. I may be preaching to the choir, but I am not sure how familiar you are with welfare reform in Texas. Beginning in May 1996 Texas began to make its own plans for welfare reform under a federal waiver. Well, that waiver expires March 31st of 2002. The Texas program includes a requirement to encourage personal responsibility, time limits on past assistance, work requirements for clients 16 to 59 years of age (unless they qualify for exemption), Medicaid and childcare benefits for those transitioning from welfare to work, and child support enforcement. Texas has actually been pretty successful in reducing Temporary Aid to Needy Families (TANF) caseloads. Our caseloads have declined by over 50 percent since the 1995 baseline period. What we are now seeing in current economic conditions—and I think this mirrors what Patrick [Bresette] told you earlier today—are slight increases in Food Stamps, TANF and Medicaid caseloads. So we are starting to see slight upward trends in caseloads.

We have learned quite a bit since 1996, and what I wanted to do is focus on today is the TANF perspective. I am going to offer five particular areas of street-level kind of services where we think we can partner up with private foundations and private grants to try to make a difference.

In Texas, welfare reform is actually a joint effort with the Department of Human Services (where we focus primarily on the eligibility component) and the Texas Workforce Commission. The workforce commission delivers services through a network of 28 local workforce development boards, and they deliver employment services to welfare recipients through a program called Choices.

Recently, at the last board meeting at DHS, we discussed waiver exemptions from work, which would have expired absent any action by the state. The board chose to reinstate some exemptions, to put them back in place, so that when welfare reform expires, some of those exemptions will continue. The category of exemptions that were retained primarily deal with individuals who are disabled, need in-home care, are over 60 years of age, are a single grandparent 50 years of age or older caring for a child under age three, or are a pregnant woman who is under a doctor's order not to work. So those are the areas they chose to target for categorical exemption.

Although an individual can be exempt from a work requirement, they may nonetheless volunteer to participate. Texas has had a very low volunteer participation rate in this categorical exemption group. Typically about 10 percent volunteer to participate in the choices program. The first opportunity we see is to try to work with grantmakers and with the workforce commission—is to try to promote greater participation at that level. So people, even if they are in a disabled category, or are in a category where they may get categorical exemption, can still fully develop who they are—if they can just get a sustainable wage. We have been pretty good so far at getting people out and putting them to work, but they are going into low-income jobs. If you can raise their employability level to get them into like an $8.50-an-hour or higher job where they can really have self-sufficiency, we think we can actually help transition a greater population.

So one of our challenges is to develop programs and provide services to those potential volunteers who are disabled or aged to prepare them for employment placement services to help them to become self-sufficient. Let them see the benefits of going beyond a TANF receipt. Let them see the benefits of getting a wage that is above and beyond TANF, and a wage that gives them some insurance benefits. So we want to work with the workforce commission and local workforce boards to try to accomplish that.

Another area is where many of the TANF recipients have barriers to employment. A lot of these problems deal with things like substance abuse and domestic violence. DHS is participating in a project being evaluated by the Manpower Development Research Corporation, which provides specialized case management services to TANF recipients. We've got that going in four local workforce districts in Houston, Corpus Christi, Fort Worth and Abilene.

This model provides an earning stipend of $200 a month for up to 12 months for TANF recipients who go to work and continue to participate in post-employment activity designed to continue to improve their employability. So we are trying to not just to get them into an earnings job, but get them up into a job where they can become self-sufficient. And while that model is showing good results—and the earning supplement has been a good motivational tool—the staff development at the four sites really focused on caseload management. It is individualized case management by a team including an eligibility worker from DHS and a Choices worker from the workforce board. That approach has provided significant post-employment follow-up services with a focus on long-term success.

So we want to build on the early success of that experience by this program and fund expansion of specialized case management services beyond the current resources that DHS and local workforce development boards have. So we would be interested in increasing employment retention of former welfare recipients and also improving their self-sufficiency.

The third opportunity that I want to talk to you about is the successful venture that was actually undertaken by the Dallas Workforce Development Board. The Dallas Board used a federal grant to develop an in-home learning system that has been highly successful. This is a learning system within a closed network offering Internet access as well as over 700 training modules. The training may include basic adult education, English as a Second Language, GED preparation or occupational skill training. The Dallas board, working through its contractor, Business Access, has placed computers in homes of 800 former welfare recipients who are now employed. They have achieved remarkable results. Listen to this: 63 percent received a wage increase in the last quarter, 44 percent self-report getting a better job or a promotion due to the computer services, 50,000-plus hours have been spent online by those 800 people, and more than 6,000 online courses have been taken. So our clients are motivated. We just need to give them the opportunity to move beyond a bare level of subsistence.

Multiple users have signed on, and one of the interesting things is that it has also become kind of a family literacy tool. Its effect has gone beyond the individual on welfare, and has caught on within the family. It moves people who are on poverty (and who typically might not have the education or computer literacy) into a realm where each member of the family is employable and better educated. I want to make one comment on this, too. I thought it was interesting. We have got a project going at DHS that almost dovetails with this project. We get private corporations—like Dell Computers or other private corporations to contribute computer equipment; sometimes used computers, sometimes new computers—and try to reach that same welfare clientele. That seems like a good match—that DHS and some private foundation money could allow expansion of that concept.

The fourth investment opportunity that I wanted to talk to you about is in the area of transportation barriers. From my Texas Workforce Commission and Texas Employment Commission days, I know that there were two big barriers to employment for many low-income families—transportation and child care. So any inroads we can make in the area of transportation, will open up access and the ability of clients to accept offers of employment that don't necessarily have to be on a bus line or transportation avenue and therefore not limit their availability. I wish I had several successful models to talk to you about on that one. I really do not. You probably know better than I the implications of that. A lot of times you are dealing with a county or city government structure to work through those transportation issues, but we would be interested in any ideas, or foundation money that might be available to help in that area as well. Particularly in rural areas as opposed to big cities, this is much more of a challenge. It is a challenge enough in big cities. But if there is anybody out there who knows of opportunities or successful models in rural areas, we would be interested in that as well.

Finally, I wanted to commend the Hogg Foundation for its role in the Greater Houston Collaborative for Children. In particular I would like to mention the opportunity for further replication of the program known as The Bridge. The Bridge provides high-quality early childhood experiences for immigrant children in southwest Houston. These experiences are described as laying the foundation for later success in school and life. DHS offers services to refugees, and Texas is among the top five states of refugee resettlement. We anticipate receiving approximately 6,000 refugees this year. Typically, those refugees settle in Amarillo, Austin, Dallas, Fort Worth, Houston, and San Antonio. Texas and others will see a shift in the countries of origin for the new refugee population. New arrivals are primarily coming from Africa, Eastern Europe, and the former Soviet Union. Our refugee social service contractors are astoundingly successful with their employment services and achieve a 97 percent placement rate. So we would like to see some efforts made, or maybe some private foundation money targeted, toward reaching more of that population.

That concludes my remarks. Those are the five opportunities we ask you to focus on, and where I think private/public efforts can make a difference.

Question and Answer Session

Following the brief presentations of Ray Bishop, Don Gilbert, and Jim Hine, the floor was opened for questions from the audience, moderated by Jeff Patterson, director of communications for the Hogg Foundation for Mental Health. Below is a transcript of that session.

Patterson: We are going to open it up to questions from the people in the audience. I would encourage you to take advantage of this opportunity. There is not much time to begin to ask questions of the gentlemen who are up here on the panel. If you would like to take advantage of that, please raise your hand.

Questioner: *Ray [Bishop], I'd like you to go a little deeper on your comments and be real specific about what you see as leveling the playing field and faith-based organizations. What I see, is that if you look out over the last 10 or 12 years, there has been a monumental increase in the role of faith-based organizations in the delivery of health and human services; some supported by government, others supported by philanthropies. In fact, I often wonder whether we are reaching a point of saturation in the faith-based area. I think that's one of the reasons that there is really no massive authorization for this kind of movement. From my perspective, one of the reasons for that is because I do not know where those real barriers are. I think talking about that would help me and a lot of other folks.*

Bishop: Okay. Well, let me say that you have to dichotomize between those religious, faith-based organizations like Catholic charities and Lutheran services that have been doing a lot over the years. They have 501(c)(3) organizations and they are very certainly definite. What we are talking about more is at the local levels, where there is not a 501(c)(3) organization, but a lot of inner city churches, or other community organizations capable of providing mentoring services. A lot of times one of the barriers is ignorance on their part. They do not even know how to approach a program to receive funds. Even if they know how to do that, they would not know how to go about writing an application for funding or whatever. They would not know anything about it. In some cases, they would not have the infrastructure. In a lot of cases there are churches that are capable of providing the service, but in and by themselves they do not have any of the features that lend themselves to keeping records or infrastructure. That is one of the things that Tarrant County—I listened very intently to that discussion because they said that was a great [defect]. They have got to let faith-based organizations know that this is not just money being handed out so you can do what you want to do with it. You have got to have accountability and infrastructure.

I would disagree with the notion that there is not any opposition. I remember all the news coverage I watched last year of folks who were opposed to the President's expansion of charitable choice. There was some deep-seated opposition to faith-based organizations, even in regards to what exist in Title I of the 1996 legislation at this point. But I think in many cases when you get to the local level, it is not so much opposition, it is bringing people together that do not know how to connect. It is the local workforce board not knowing what faith and other community organizations provide. I think that it is a partnership opportunity, mostly because there is so much to be done, and as welfare reform has evolved to the local level, these are just folks that have resources to offer. I think those are the main barriers.

Questioner: *I am going to take this opportunity to ask Commissioner Gilbert about the CHIP Program. What we have heard is there is going to be a perhaps 29 million dollar shortfall this biennium and people are wondering about what that is going to change the program. Certainly we are still early in the process, but what do you see is the most likely scenario? Would we be able to come up with that $14.5 million each year to cover that shortfall?*

Gilbert: Well, let me tell you what we have done so far and I will work my way back into the answer to your question. First of all, to assume that the shortfall is $29.4 million, you have to see we are four months into the fiscal year with 20 months remaining in this operating period. So as you would expect, we do projections early, and this is very early. So that is the first point I will make: that there is no absolute certainty on the projection of $29.4 million. It assumes a continued rate of enrollment, which may or may not materialize. It assumes a rate of increasing costs for the program, which may or may not materialize. And so I guess I would first say that understanding the $29.4 million shortfall should be a marker in time and not a prediction for the program expenditure. Nevertheless, what we have to do is start modeling remedies in case there is no new money to operate within that budget allocation that we have—which again, if things go exactly the way things started off going and nothing changes—would be about $29.4 million more than we have got to spend.

The remedies that we have talked about to slow the cost of the program—we are today offering enrollment every day—which is different than the private insurance model generally works—continuously through the year. Frankly, at the beginning of the program thought we needed to do that to make sure we got up and hit our enrollment target of 428,000 kids by September, which we did. Now one of the options under consideration is limiting the enrollment periods, much like the private insurance market does, to certain times during the year as opposed to every day.

One of the other things we have considered is requiring participants to periodically their continued eligibility for the program. The way it works now is you are determined eligible when you get into the program and there is no redetermination for 12 months. We have asked the question, "what would it look like if we rechecked every six months?" That is, what if we make the enrollment period continuous for six months and then recertify the income eligibility at that point? We have modeled what it would mean to cap the size of the program and say we are just not going to have it enroll X number of kids. Another option is determining the fiscal impact of delaying the enrollment 30 days or 60 days following the application. What would be the fiscal consequence of that?

All of those things are absolutely alive and under consideration. I won't predict for you how it is going to turn out. I will share with you, though, that my boss, the governor, is absolutely concerned about anything that would close this program down. He is committed—as I think the leadership offices across the state are—to finding ways to keep this program viable. My job is to model out the different interventions that may allow us to work within the amount of money that we are assuming that we may have. I am not encouraging or promoting any particular approach, but it is my job to make sure if we have to stay within the budget, this is how we might go about it. I will also tell you that all possibilities continue to exist on how we will continue this CHIP program and where we may need to find other resources to cover the cost if it continues on the pace that it started. I won't predict for you any of those, but I will tell you that there is a great sensitivity among the leadership of this state for the protection of this program, and no one would enjoy initiatives that might slow the program's growth.

Questioner: *When you talk about the other resources, does that also come with the federal drawdown of more matching dollars?*

Gilbert: Yes. It is actually a little confusing if you follow this in the newspapers. In my experience, at least, newspapers like to do is make numbers as big as they can possibly be, and so where we have talked about a $29.4 million shortfall, that is tobacco money or state money. . . if you figure out how much federal money that is out there that would match that, you would get to $100 million, and $100 million sounds a whole lot more impressive than $29 million. The fact is the federal money is there. We do not lose that. It is in the allocation to Texas. We will either use it or carry it over, but it is not a loss of that.

So there is no anticipation of more federal money, nor is there any anticipation of spending more than the federal allocation that is already available to Texas. The real question is whether we can find the state money—tobacco money, state money—to justify drawing down that additional federal money that is already allocated to the state? And if all these other things happen in the sequence that I talked about earlier, we might need to find as much as $29 million.

Questioner: *I have a question for Mr. Hine. Part of the criticism of some of the workforce programs has to do with the difficulty just to get the job, as opposed to a living wage. I think you touched on that briefly, but I wanted you to expand on that.*

Hine: Yeah, I think clearly that there has been some good success in putting people to work, though we typically put them to work in minimum wage, low-income programs without much opportunity to advance that wage. So what we want to focus on now is more of what I see as kind of the second wave: consistently taking those people from minimum wage to self-sufficiency; trying to do things that would enhance their opportunity to advance their career and become employed at higher paying jobs.

Questioner: *I wanted to clarify something Mr. Gilbert said. If we do not draw down the matching federal dollars or whatever might happen, you said those dollars just stay with the Texas allocation. Do they roll over indefinitely at this point?*

Gilbert: No. That is a good question. I believe it is two or three years after the year they are intended to be spent that they are allowed to roll forward. I think there is one concession that allows states to carry it a further year than the two years that are specifically allowed for. So there is a point in time, I suppose, that if we did not spend the money this year or next year, and then perhaps the third year we would be at risk of losing that. As many of you are aware, because the federal dollars were available really from day one the program was launched, and it took many states (including Texas) a good while to get a fully operational program once the federal dollars were available and could not be spent. So Texas, like about a handful of states, has a collection of money that was carried forward. Recently those federal dollars have been swept. But it has not offered any kind of challenge to our program because, frankly, we have not reached the point at which we exhaust the federal allocation, even with 500,000 kids on the program.

Questioner: *May I ask one follow-up? As you calculate the different scenarios and what those might save, do you have any—and I know this may be difficult. I do not know if anyone knows—but do you have an index on what the cost is to local health care delivery systems for every million dollars that isn't spent in CHIP or every 1,000 children who are not insured? Obviously the burden of payment gets shifted, certainly not on a dollar for dollar basis, since some children do not get care, but obviously the costs do shift.*

Gilbert: Yes. The short answer is no, I do not have an index for that, but I think it is irrefutable that as you are unable to cover the health care needs from the

CHIP program or elsewhere, health care needs do not stop. The place where those costs are borne is at the local level, the county hospitals, and the emergency rooms, and so forth. So how you calculate the relationship between what we do or do not do in the CHIP program and the impact at the local level, can be done a number of ways. But the reality is, any way you do it, is that there has to be a material cost at the local level when you cannot meet the needs through the state and federal programs.

Questioner: *I hate to keep pounding on CHIP, but... The question I have is if there are dollars earmarked for this program from the federal government and you are running out of state funds, why is it impossible to use—we have more than enough to cover that amount in federal dollars. Cannot the federal government go back and say, "Well, maybe we do not need it—one-third, three-quarters..." Isn't there a way to resolve that?*

Gilbert: We would certainly go for that. [laughter]

Questioner: *It seems that the money is already there. It seems silly for it to go away if you cannot find the matching dollars. Even foundations will go back to their agencies and work out issues.*

Bishop: Just to jump in. In many cases it would take congressional legislation to do that very thing you are saying, to change the criteria within the program. That is just a very slow process. Then, of course, what we usually say is, "Why does not the federal government pay more," and that is going to be an issue too. Questioner: I am new to this, so everybody please forgive me. On that match, does the state contribution have to be taxpayer-owned?

Gilbert: As opposed to...

Questioner: *Foundation money.*

Gilbert: Are you talking about Medicaid, for example?

Questioner: *No, CHIP.*

Gilbert: I would agree with Jim. I do not think so. Some programs Congress writes into law whether it can or cannot be, but in most cases it is just monies that have been allocated. I could site multiple instances across multiple states where foundation grants have be used to meet the federal matches. I think it is just that the state has to be in receipt of the dollar and that it is the state's dollar.

Patterson: We have time for about one more question.

Questioner: *One of the things that brought me to this meeting was that I feel like traditionally in Texas foundations have done their giving, and although they've been aware of what the state public context was of dollars coming down, we've never really tried to work real hard to make sure that our funding matched the priorities that you all had. I see that changing very, very much because of the limited dollars that we have on both sides now. Within the last couple of years we have been able to see two or three wonderful contexts where we were able to take private foundation dollars and use those to leverage federal funds into the state, sometimes even at two-to-one, or one-and-a-half-to-one, something like that. I feel like that we as foundations, we love to leverage our funds. We love to be able to say that our money put more money on the table, but we do not know how to start that dialogue with you at your end to let us know where those opportunities are, so when I hear, Jim, talk about, "You can do this and this and this," that still does not give me any context for saying, you know, "We are going to have some money coming down the pipe, and it is going to be going to these kinds of non-profits, and they're going to have the opportunity to pull down some money if you guys can come up with some..." Those are the kinds of really pragmatic things we—and until we start to dialogue, I think, on those levels, we are still going to be held captive by the proposals that come over our transom, not knowing what context their dealing in, and I just feel like we need to start much more very specific dialogue of the challenges you are dealing with and the challenges we are dealing with, if that makes sense.*

And in addition there are opportunities in the potential for transparency about the budget process and how decisions are made in the allocation of that budget. Even if you were to bring philanthropic dollars to the table, you would probably need to bring the state and federal dollars in a way that everyone can see truly how those dollars are being allocated. It would require a certain level of opening up the process for that type of discussion to occur.

Many of us still think the state needs to put their money on the table. It cannot be all private money. We have a role to play, but the state needs to come up to the plate, too, when these federal dollars come down. But I wish you could have heard the kind of gasping reaction that happened when the philanthropic community heard that we sent $25 million back in childcare dollars to the feds. Most of the people here today were in those meetings and we just went, "I cannot believe we sent $25 million back." We didn't use it for childcare dollars. It came down to the Texas Workforce Commission that we didn't have. I mean, that kills us.

Patterson: That is an excellent point. I think most of it is kind of understanding and communication. I think philanthropies and state agencies work in kind of separate spheres and they do not really consider each other, and as we go forward we do think about what's the way that we can best leverage either state funds or how foundations can leverage their own funds with state agencies. I hope with dialogues like this—this is what Texas Grantmakers is all about, to bring together these kinds of people to talk about these issues so that we understand you guys and you guys understand us and we can build some kind of dynamic collaborations together. But that is going to have to be the final word because they made it to the end. We got off schedule a little bit. I would like to

extend my thanks, and hopefully yours as well, to Dr. Ralph Culler and Mr. Reymundo Rodriguez who helped bring together the program that we had today, as well as Maria Bumpass and Mary Vance with our foundation for making this all possible and the lovely lunch that we had. Members of the Texas Grantmakers group, we were going to have a business meeting, but we are going to just go ahead and end this session for today.

Families in Crisis:

Coping with a Changing Political Environment

In 2002, two of the most significant public family welfare programs in Texas—the Children's Health Insurance Program (CHIP) and the Personal Responsibility and Work Opportunity Act of 1996 (PRWOA)—could potentially face dramatic changes in policy and direction. For CHIP, higher than expected enrollment costs and services could mean state policymakers may need to either increase appropriations to the enrollment program or cut back on services. For welfare policies, the U.S. Congress will begin the reauthorization process based upon their assessments of what parts of the 1996 welfare reform worked or not, and what further changes may be necessary.

The effect of these changes could be significant to needy families and low-income communities across the state, possibly determining whether some families will continue to be eligible for health insurance or welfare benefits.

In order to inform Texas grantmakers about the challenges and opportunities confronting both programs—as well as to inform their philanthropic efforts across the state—the Texas Grantmakers In Health and Human Services (TGIHHS) held a conference entitled *Families in Crisis: Coping with a Changing Political Environment* in Austin on January 10, 2002, to bring together some of the leading experts on these issues to discuss the difficult challenges facing Texas families. This document is a proceedings of that conference and is being distributed by the Hogg Foundation for Mental Health to broaden understanding of the issues discussed and to facilitate what are certain to be difficult and consequential decisions for the state.

Hogg Foundation for Mental Health

Since 1940, the Hogg Foundation for Mental Health has pursued its mandate to develop and conduct ". . . a broad mental health program of great benefit to the people of Texas" (Miss Ima Hogg, 1939). For six decades the Foundation has funded mental health service projects and research efforts across the state, with priority given to its three primary program areas: Children and Their Families, Youth Development, and Minority Mental Health.

For more information about the Hogg Foundation or its grants program, call (512) 471-5041; visit the Foundation's web site at www.hogg.utexas.edu; or write to: Hogg Foundation for Mental Health, The University of Texas at Austin, P.O. Box 7998, Austin, Texas 78713-7998.

Texas Grantmakers In Health and Human Services

Hogg Foundation for Mental Health