Working Together for a Healthy Texas

Texas State Planning Grant

September 2005
Texas Department of Insurance
State Planning Grant Project

Texas State Planning Grant

Supplemental Grant Activities Interim Report to
U.S. Department of Health and Human Services
Health Resources and Services Administration
September 2005

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TEXAS SUPPLEMENTAL STATE PLANNING GRANT ACTIVITIES

Prepared by SPG Staff
Texas Department of Insurance
September 2005

Executive Summary

In the spring of 2000, the Texas Department of Insurance (TDI) was asked by then Governor George W. Bush to apply for a State Planning Grant (SPG) for the State of Texas. TDI received the official notice from the Health Resources and Services Administration (HRSA) in February 2001 that Texas' grant application would be funded as part of the second round of SPG awards effective March 1, 2001. Under the terms of the grant, Texas collected both qualitative and quantitative data through a variety of survey and research activities, and used the information gathered in the research phase to develop options for expanding health insurance to uninsured Texans. The initial grant research activities were completed in 2003.

In May 2003, HRSA notified TDI that supplemental grant funds were available for states to conduct additional work as an extension of the original grant study. The Department submitted a supplemental grant application in July, and was notified in September that a grant award of $158,988 had been approved. These funds provided a critical opportunity for Texas to continue the evaluation and development of several ideas that were considered under the original grant study, but needed additional analysis. The supplemental study also includes evaluation of several options that have been implemented to determine whether they have been effective in enabling more Texans to obtain insurance. Work on these activities has been completed and is summarized in this report. Summary information is also included on activities and accomplishments under the original 2001-2003 grant.

Because Texas has a large, diverse group of uninsured citizens, the stakeholders who participated in the initial State Planning Grant study determined early on that an effective approach to the state's uninsured problem would require a multi-faceted, incremental plan. During the time of this study, Texas, like other states, faced an uncertain economy and the state Legislature struggled with large budget deficits. The working group acknowledged that a significant expansion of public programs (Medicaid or SCHIP) was an unreasonable goal and chose instead to focus on more realistic expansion ideas. After collecting and analyzing initial demographic data, certain population characteristics were apparent that directed the development of additional research activities:

- Most uninsured Texans are employed or live in a family with at least one full-time employee, but they often work for small businesses that do not offer insurance.
- While many of the uninsured are from low-income families, approximately two million uninsured Texans have incomes above 200% of the federal poverty level and may be able to afford the employee's insurance contribution if their employer offered coverage.

- More than two million of the uninsured (40 percent) are young adults ages 18-34, who are generally healthy, and may choose to go without insurance even if they can afford it.

Based on these factors and other information, both the original grant and supplemental grant activities focused primarily on ideas for expanding private insurance coverage among small employers. The supplemental grant activities also focused on coverage for young adults, particularly those enrolled in universities who may be eligible for school-sponsored insurance. Following this section is an overview of the specific grant activities accomplished under both the initial and supplemental state planning grants.

Though much of the research work has concluded, TDI will continue to work with legislative leaders and stakeholders to expand health insurance in Texas. Under a separate Pilot Project Planning Grant, TDI is working to design a small employer benefit plan that will provide an affordable insurance option for Houston-area small businesses. The plan will be developed using data from the SPG research activities to assure that the plan is realistic, affordable, and reflects the benefits small employers value the most. The Pilot Project Planning will be completed in August 2006.

Supplemental Grant Activities (2003-2005)

a) Small Employer Health Insurance Survey

One of the most valuable components of the State Planning Grant research work is the small employer survey conducted in 2001 and again in 2004 using supplemental grant funds. The original survey was mailed to 50,000 small employers to collect information on their attitudes and perceptions regarding insurance, and their ability and willingness to purchase private coverage. All work related to the development, implementation and analysis of the survey was conducted entirely by SPG staff. More than 13,000 completed surveys were received, a strong indication of the importance of this issue among small businesses. The results of the survey provided some of the most useful data obtained in the course of our study, and has been used by numerous state agencies, legislative committees and various stakeholder groups in the discussion about health care and health insurance expansion options. The data were particularly useful in the development of policy options for addressing small employers' insurance problems, some of which have already been enacted.

Despite the accomplishments under the original grant study and subsequent action by the Texas Legislature and other stakeholders, small employers continue to face problems when shopping for affordable health insurance. While Texas has made significant progress in expanding coverage options for small businesses, the majority still do not offer insurance to their workers. To evaluate the effectiveness of previous efforts and identify new issues that may have emerged within this particular population, small employers were re-surveyed in March 2004. Though some new questions were added to the survey to address changes that have since occurred, the majority of questions remained the same. Due to a more limited budget, only 20,000 surveys were mailed. A total of 4,303 usable survey responses were received, which was a response rate of over 21 percent. Some of the more significant findings are:

- The primary reason employers do not offer insurance is still because it is unaffordable; 54 percent of employers reported they can afford $100 a month or less per employee for health insurance premiums; 34 percent can pay $50 or less, and 14 percent would not purchase insurance at any cost.
- The majority of employers (81 percent) believe employers *should* provide insurance if they can afford to do so. In a separate question, however, only seven percent indicated they believe employers are *primarily* responsible for assuring people have coverage. Forty-one percent believe individuals are themselves responsible; 32 percent said the federal government is responsible, and 12 percent believe state governments are responsible.
- Of those employers who currently offer insurance, 18 percent are very likely to discontinue coverage within the next five years; 24 percent report they are somewhat likely to do so.
- The majority of employers (69 percent) said it is more important for government to focus on improving access to affordable health insurance than improving access to affordable health care (26 percent).
- When small businesses do offer coverage, employees often are unable to afford their required contribution. This is particularly true of "family coverage." Workers in small businesses often must pay a higher share of the premium cost than workers in large firms. The average cost of family coverage for small businesses is more than $11,000 a year per-employee, and many workers must pay 50 percent or more of the cost. For low wage workers, this expense is truly unaffordable. A significant decrease in cost would be necessary in order for many of these workers to "take up" the health insurance that is available to them.

b) University-Sponsored Student Health Insurance Study

Young adults ages 18-24 have the highest uninsured rate of any age group in Texas. In 2003, 40.4 percent of these young people lacked health insurance, followed closely by adults ages 25-34 (39.2 percent were uninsured). Many of these adults (1.2 million university enrollees in fall 2004) attend one of the 142 institutions of higher education in Texas and appear to be excellent candidates for a school-sponsored health insurance plan. These plans are insurance products generally offered by commercial carriers that have contracted with colleges to make coverage available to some or all of their students. However, because such programs are administered separately by each individual campus and are not coordinated through any single entity, little data exists on the availability of coverage, the insurance status of students, or their participation in student health insurance (SHI) plans. To evaluate the feasibility of expanding insurance through school-based plans, the SPG study included a comprehensive analysis of university coverage. As part of the study, three separate survey activities were conducted:

1. Universities were surveyed to collect information on health plans they offer, eligibility criteria, participation rates, benefit levels and cost data;
2. University students were surveyed about their insurance status, reasons why they are uninsured, their perceptions about the value of insurance, their level of knowledge about SHI plans offered, and how much they can afford for coverage; and

3. Health insurers completed surveys providing information on student health insurance benefit plans sold in Texas, insurance coverage premiums and losses, claims data, underwriting provisions, participation/eligibility requirements, and market viability.

The survey results provide detailed information on this insurance market segment and indicate that an effective, long-term strategy to expand coverage through SHI plans could have a significant impact on the uninsured rates for young adults. Students indicated they want insurance (78 percent said coverage is "very important") but agreed that it was often unaffordable (71 percent). Others indicated they didn't know how to obtain coverage on their own (10 percent), suggesting that more education may be needed. Only one percent said they have a medical condition that they believe makes them uninsurable. Uninsured students in schools that offered SHI were asked why they did not enroll in the plan; 54 percent could not afford it and 36 percent were not aware such a plan was available.

Of the 100 schools that responded to the university survey, 63 offered SHI plans. With the exception of health - related education institutions, Texas law does not require colleges to offer student coverage and those that do generally do not require students to participate. Student enrollment averaged 11 percent across all schools, and was generally higher at private universities than public. Student-only premium costs averaged $718 to $786 per year in 2004. Several other key data highlights from the study include:

- Thirty-six percent of surveyed students attending public colleges are uninsured and 23 percent of students at private schools are uninsured.
- Uninsured rates varied widely by college, from a low of 21 percent to a high of 78 percent.
- Students with the highest uninsured rates include older students, single parents, Hispanic students, students not in good health, students whose education is primarily financed by the military and students in their senior year.
- Colleges reported that they had no trouble finding an insurance carrier to insure the SHI plan; nine of ten carriers indicated they were considering expanding business to more schools in Texas.
- Insurers reported covering 56,000 lives in student health insurance plans at any time in 2003; they insured 37,500 lives on September 15, 2004.
- The ability to pay for coverage as part of tuition and fees (rather than directly to the insurer) and the requirement that students must accept or reject insurance during school registration are both linked to higher plan enrollment rates.

Because the research on this issue was only recently completed, options for expanding coverage are still under development. The survey results were provided to all universities, and a formal presentation is scheduled at a state-wide conference in October. TDI will continue to work with both the universities and members of the Legislature to determine what action will be taken in response to this research work. A copy of the full report on student health insurance coverage is available on the TDI website at http://www.tdi.state.tx.us/company/spg.html.

c) Study of Expansion Options for the Texas Health Insurance Risk Pool

The Texas Health Insurance Risk Pool (THIRP) is a statewide insurance program for uninsured individuals who have pre-existing health conditions that preclude them from obtaining private health insurance. The risk pool serves as the state's mechanism to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) provision which requires states to provide guaranteed access to health insurance for certain individuals. The pool provides comprehensive insurance benefits with a range of deductible and coinsurance options. Although premiums are not cheap, the pool is generally considered very successful with a current enrollment of more than 26,000 people.

Due in part to the risk pool's success, there is considerable legislative interest in expanding the pool to include more individuals and, perhaps, some groups (such as small businesses). The SPG staff completed a comprehensive study of the pool that included an actuarial evaluation of expansion options, a review of participation and enrollment criteria, an analysis of various options for alternative funding mechanisms, and options for reducing premium costs. The challenges of designing small group market changes that would comply with the federal Health Insurance Portability and Accountability Act were also considered and are discussed in the report.

Because the various options considered are technical and complex and include detailed actuarial analysis that is not easily summarized, those who are interested in health insurance risk pool expansions are strongly encouraged to review the full report, which is available at: http://www.tdi.state.tx.us/reports/pdf/grthirp04.pdf.
Expansion options that were considered and are described in detail include:

- Small employer buy-in options that would allow small groups to obtain risk pool coverage under various scenarios;
- Risk pool eligibility revisions that would loosen the participation requirements to allow more individuals (including some with other coverage) to enroll;
- Changes in risk pool operational and funding mechanism that would allow the pool to qualify for federal funds;
- Assessment methodology changes that would enable the pool to spread excess claim losses over a wider population that includes both fully insured and self-funded groups; and
- Premium cost reduction alternatives that would enable more people to afford coverage.

Several options outlined in the report were considered by the Texas Legislature in 2005, but were not enacted. It is likely that changes will be considered again when the Legislature convenes in 2007.

d) Analysis of Small Employer Consumer Choice of Benefit Plans

Throughout the course of the initial SPG study, focus group and survey participants expressed an interest in a less expensive health insurance plan, even if some benefits had to be reduced or

eliminated. Insurers also advocated for lower cost benefit plans and freedom to eliminate certain mandated benefits. In response, the Texas Legislature in 2003 abolished the two standard small employer plans and enacted legislation allowing insurers/HMOs to market "Consumer Choice Health Benefit Plans" to both small and large employer groups, and individual insurance applicants. These new plans provide comprehensive benefits, but carriers may eliminate or reduce coverage of specific mandated benefits such as contraceptive drugs and devices, coverage of AIDS/HIV, home health care services, and treatment for chemical dependency. Carriers decide which benefits to exclude or reduce from a list of mandated benefits selected by the Legislature. Insurers and HMOs now have additional flexibility to develop more customized benefit plans and are no longer required to offer the standard plans which they believe limited their ability to compete with other carriers. The new plans also allow insurers/HMOs to offer higher deductibles and coinsurance requirements, which can produce significant premium reductions.

Insurers and HMOs were authorized to begin selling the Consumer Choice Plans (CCP) as of January 1, 2004. However, many companies failed to develop the new policies until months later; many did not begin marketing the plans until 2005. As a result, the 2004 experience reports filed by insurers/HMOs did not reflect a full 12 months of enrollment activity. In 2004, a total of 17,445 Texans were insured under a group or individual CCP, including 4,283 people who were previously uninsured.

As part of their analysis of the Texas small group market, the actuarial firm Milliman, Inc. also reviewed the CCP benefits and actuarial data to evaluate their potential impact on the insurance market and the uninsured. Included was a review of insurers' and HMOs' estimates of CCP cost savings due to the elimination or reduction of mandated benefits and increases in cost sharing requirements. The analysis shows that few carriers chose to exclude all the allowed mandated benefits, but chose instead to leave most benefits in the policy. The most commonly excluded benefits at the time of the review were contraceptive drugs and devices; chemical dependency treatment; and coverage for acquired brain injury treatment and services. Preferred Provider Organization (PPO) plans also frequently eliminated coverage of prescription drugs in CCP plans, which are not a mandated benefit but are commonly included in all other PPO plans. Many insurers/HMOs also elected to not offer any of the mandated *offerings* in CCP plans which, in non-CCP plans, must be offered to an employer/individual, but can be excluded if the purchaser chooses.

In addition to excluding certain mandated benefits, carriers are also allowed to impose higher cost-sharing requirements, including higher deductible and coinsurance limits. Milliman reviewed the estimated cost savings projected in company filings to determine how CCP premium costs compare to non-CCP benefit plans that include all the mandated benefits and are not subject to the increased cost-sharing provisions. In their analysis, Milliman provided the following observations on the cost impact of CCPs:

- Cost savings reported by carriers for Consumer Choice Plans varied significantly, from less than one percent to over 35 percent;

- Very little of the estimated savings is due to elimination or reduction of mandated benefits; generally insurers/HMOs reported less than three percent savings due to changes in mandated benefit provisions.
- The largest portion of savings is due to increases in cost-sharing requirements and in material benefit exclusions. Other benefit changes, such as the exclusion of prescription drugs from CCPs, produced significant savings for insurers that chose to take this approach.

Despite the absence of complete data for 2004, the numbers that have been reported are encouraging. Long term effectiveness of this strategy for expanding coverage is difficult to predict, but the initial numbers indicate that previously uninsured Texans are interested in this product. As more carriers and agents begin marketing the new option, we anticipate that enrollment will increase significantly.

e) Statewide Symposium

In May, 2004, a symposium was held in Austin to allow stakeholders across the state an opportunity to discuss the uninsured problem in Texas. Due to the size limitations of the facilities, attendance was limited to 120 people. The one-day working forum was attended by legislative staff and state policymakers as well as advocates representing the insurance industry, physicians, hospitals, consumer organizations, public health officials, employers and other stakeholders. Separate break-out sessions were held to discuss topics including: 1) public programs and options for expanding coverage; 2) employer sponsored insurance; 3) the Texas Health Insurance Risk Pool and options for better meeting the needs of the "uninsurable;" and 4) health care access, education and improvement.

The symposium also included a "poll the audience" activity using an electronic voting system that allowed the audience to express their response to a variety of questions related to uninsured Texans. The audience was first asked to provide some demographic information so that responses could be analyzed based on what type of organization each respondent represented (such as insurers, physicians, hospitals, state government, etc.). Responses to each question were displayed immediately, allowing the audience to better understand the opinions of various stakeholder groups. For example, one question asked "Where do you think governmental efforts should be most focused: a) improving access to affordable health care, or b) improving access to affordable health insurance?" One hundred percent of the physicians responded "a," compared to 50 percent of the hospital representatives and 63 percent of the insurers. Other questions addressed specific expansion options, perceptions about the factors contributing to the high uninsured rate, insurance affordability, and personal responsibility. A complete report on the polling responses is available on the Texas SPG website at http://www.tdi.state.tx.us/company/spg.html.

f) Focus Group Discussions

To supplement the survey activities and obtain more detailed information on uninsured individuals and small employers across the state, focus groups were held in seven Texas cities: Houston, El Paso, Dallas, Amarillo, Laredo, Harlingen and Corpus Christi. Cities on the

Mexican border with predominately Hispanic populations were selected specifically to determine whether those communities face unique factors that affect insurance rates differently than in other parts of the state. Two focus groups were held in each town; uninsured individuals met during a morning sessions, and small business owners met at noon.

Each group was asked to discuss a series of identical question designed to provide information on factors that contribute to Texas' high uninsured rate, ideas for improving accessibility and affordability, and comments on local community factors that might influence perceptions and purchasing patterns related to health insurance. Participants shared numerous personal stories and experiences that often highlight the difficulties uninsured people face. While the circumstances and concerns varied somewhat across the state, several common themes emerged:

- Cost is the primary reason why individuals are uninsured, and why small business owners are unable to offer coverage.
- Participants often have a negative perception of the insurance industry as a whole. Small employers in particular reported difficulty finding an agent who appears to be knowledgeable and is willing to work with employers to find the best coverage, particularly if the group has only a few employees.
- Many participants expressed frustration with state and federal government's inability to help "average, working citizens." They feel there are few options available to them, as they cannot afford private coverage and do not qualify for government assistance.
- Small employers want standard benefit plans and a streamlined application process. They believe the process of shopping for insurance is too complex and time consuming, and discourages small business owners from adequately evaluating options that might be available to them.
- In communities with large Hispanic populations, some participants felt that the ability to obtain low-cost care in Mexico discouraged local efforts to address the problem. As long as residents have an "affordable option" for receiving medical care across the border, they feel it will be difficult to convince residents to spend money on American health insurance.

Activities Under the Original State Planning Grant (2001-2003)

a) Survey of Households above 200 Percent of Federal Poverty Level

Under contract with the SPG program, the Texas A&M University Survey Research Laboratory (SRL) conducted a telephone survey of uninsured households above 200% of federal poverty level (FPL). Modeled after a similar study conducted by the California Health Care Foundation, the survey questions were modified to address the need for specific information from Texas' uninsured residents. Individuals above 200% of FPL were selected due to the fact that most studies have concluded that families below 200% of FPL require some type of subsidy or substantial premium assistance from employers or other entities. More than 1.8 million uninsured Texans reside in families with incomes above 200% of FPL, but very little statistical data is available regarding why this large group of people remains uninsured. The household

survey was designed to provide a more detailed picture of this population, including: the reasons they are uninsured; whether employment-based insurance is available; the reasons they decline such coverage; how much they are willing to pay for insurance; the extent to which they desire health insurance; the types of medical benefits they prefer in a health plan; their interest in a variety of public and private insurance options; and other important demographic and attitudinal information. Significant findings from the survey are:

- More than half of the non-poor uninsured adults are under the age of 40; 29 percent are between age 19 and 29, with 25 percent between 30 and 39.
- Though overall statewide rates of uninsured are highest among minorities in Texas, the majority (68 percent) of non-poor uninsured Texans are white non-Hispanic individuals.
- Sixty-five percent of the non-poor uninsured report they have not purchased insurance because it is too expensive.
- When looking at a number of different factors, sixteen percent of the non-poor uninsured can be considered reluctant to buy insurance at any cost; the majority of these individuals are young males who are healthy, prefer other job benefits to health insurance, and are satisfied with obtaining health care in low-cost public clinics.
- By occupation, the largest amount (42 percent) of non-poor uninsured adults are employed in professional jobs; other employment categories include sales (13 percent), clerical (12 percent), service jobs (11 percent), skilled blue collar (9 percent), laborers (7 percent) and semi-skilled workers (3 percent).
- Most of the non-poor uninsured are employed in small firms; 39 percent work in firms with less than 5 employees and 20 percent in firms with no more than 30 employees.
- More than half (58 percent) of the non-poor uninsured are employed by firms that offer health insurance, but 53 percent of those are not eligible for the coverage. Of the remaining 47 percent who are eligible, most report the coverage is too expensive.

b) Survey of Health Insurance Carriers and Health Maintenance Organizations

All licensed HMOs and 40 of the largest health insurers in Texas (writing approximately 70% of all health insurance premiums) were surveyed to collect information on the fully-insured health insurance market in Texas. Companies provided information on health insurance premium rates and how those costs vary by group size; claims cost information; data regarding small employer plans required to be offered under Texas law; the prevalence of stop-loss coverage and administrative-services-only (ASO) contracts; the extent to which managed care plans are offered; and other information. Some of the survey findings based on calendar year 2002 data include:

- Average premium rates were generally higher for small groups than large groups; the average annual premium for individuals in a small employer plan was $2,621 compared to $2,274 for individuals in a large employer plan.
- Average annual premium costs varied significantly among carriers; small employer premiums ranged from a low of $1,381 to a high of $3,138, a difference of more than 127 percent. Even wider ranges were reported for large employer groups with an average annual premium rate as low as $1,031 to a high of $4,642, a difference of more than 350 percent.

- Insurer claims for 16 mandated benefits represented 4.48 percent of all claims paid. Each of the mandated benefits represented less than one percent of total claims paid, and 13 of the benefits represented less than one half of one percent of all claims paid. The two most expensive mandated benefits were diabetes supplies and educational training (0.80 percent of all claims), and serious mental illness (0.74 percent of claims).
- The number of small employers with fully-insured health coverage has continued to increase since 1993, but the rate of increase has slowed considerably since 1999. Insurers and HMOs reported 36,952 small employers offered health insurance in 1993; in 2002, carriers reported issuing fully-insured health plans to 89,201 small employers, covering 1,192,386 people.

c) Focus Group Activities

Working with SPG staff, the Texas A&M University Public Policy Research Institute (PPRI) conducted focus group meetings in 15 cities across Texas representing all of the major geographical areas of the state. Three sessions were held in each location (a total of 45 sessions statewide), including one each for uninsured unemployed individuals, uninsured employed individuals, and small employers both offering and not offering health insurance. Initially, the staff planned to only include small employers who do not offer health insurance, but at the request of various groups decided to also include small employers who do offer health insurance since many expressed concern that they will be forced to drop the coverage they currently offer if costs continue to rise. The personal stories expressed at these focus group sessions were both poignant and disturbing, and underscored the importance of continuing this effort to expand insurance to include all Texans. The more important findings obtained from the focus group sessions were:

- Cost is the primary barrier to obtaining health insurance for both individuals and small employers.
- Both individuals and small employers felt the state should be more involved in creating standard packages that are affordable and available regardless of an individual's health status.
- The uninsured are very willing to help pay for their insurance, but cannot afford the costs under the current system.
- Both individuals and small employers feel overwhelmed by the complexity of the insurance market and suggested that the state provide more educational assistance to help people shop for insurance and answer questions about benefits and coverage; and
- Focus group participants often suggested that Texas should create a system of universal health care that is based on what they refer to as a "socialized" model.

d) Carrier Telephone Survey

During the first year of the SPG study, carriers repeatedly expressed concern with the small employer market, but many of the comments were anecdotal or lacking in detail. To obtain more qualitative information, the actuarial consulting firm Milliman USA conducted a series of discussions with six of the largest carriers representing approximately 68% of the small group

health insurance market based on the percentage of premiums written. Milliman worked with SPG staff to develop a survey form which was mailed to the carriers in advance of the phone interview. Milliman spent several hours speaking with representatives from each company to discuss the survey questions and obtain input from the carriers on various issues related to improving the insurance market for small businesses. Major findings from the survey include:

- Carriers believe the current standard basic and catastrophic insurance plans they are required to offer small employers are outdated and do not fulfill their intended purpose to guarantee availability of a lower cost plan.
- Carriers indicated that several provisions of the current small group statutory and regulatory requirements contribute to higher premium costs. They specifically mentioned mandated benefit requirements, clean claims legislation that requires timely payment of insurance claims, and rate band restrictions as contributing factors.
- Carriers expressed no interest in participating in purchasing alliances, despite the high interest expressed by small employers. Carriers do not believe alliances will result in lower premium rates for small employers.
- Several carriers are concerned that not all insurers are complying with state requirements, and are using the system to obtain an advantage over carriers that do comply. One carrier stated "There needs to be a level playing field…. We would support audits to ensure this."

The surveyed insurers offered a wide range of suggestions and recommendations for improving the market. Companies generally supported: wider rate bands; revisions of the standard plans to make them more appealing to employers, less expensive, and more consistent with other policies offered in today's market; and stricter monitoring and enforcement of carrier activities to ensure uniform compliance.

e) Agents Survey

During the second year extension, SPG staff conducted a survey of group health insurance agents to obtain information related primarily to the small employer group market. During several focus group meetings and in discussions with agents attending the small employer insurance fairs, insurance agents repeatedly complained about carrier activities that penalized agents for writing certain types of small businesses, and appear to be in violation of legislative and regulatory requirements. However, very few agents were willing to go "on record" with a formal complaint due to concerns that the company would retaliate against the agent since closed complaint records are not confidential under Texas law. Carriers that participated in the survey mentioned above also acknowledged that agents were reluctant to identify specific companies, and suggested that TDI conduct an anonymous survey to protect agents' identities.

The agent survey was initially sent to approximately 350 active agents. Due to a low response rate, an additional 300 surveys were distributed. Agents were encouraged to return the surveys anonymously, though many agents voluntarily included their name and contact information in case staff needed additional information. Where possible, agents were asked to include supporting documentation of certain activities, and were instructed to delete any information that would identify either the agent or the client. At the end of six weeks, 94 completed surveys were

returned. Though the response rate was lower than expected, the agents that participated provided excellent information and frequently attached supporting documentation. Information on specific claims against various carriers has been provided to staff at the Texas Department of Insurance for appropriate investigation.

In addition to providing information on specific carrier activities, agents also responded to several general questions regarding the small employer market. Suggestions agents offered for increasing the number of insured small firms include:

- Develop cost-effective plans that provide employers with less comprehensive coverage and more affordable rates;
- Reduce participation and contribution requirements to allow more small businesses to meet carriers' requirements;
- Allow carriers to offer a benefit plan that does not include the mandated benefits required by law;
- Increase oversight of carriers' activities that are in violation of state law and are designed to discourage agents from submitting higher risk groups; and
- Assist and protect agents through better enforcement of laws and regulations related to agent commission payments that are intended to encourage agents to write more small businesses.

f) Small Employer Health Insurance Fairs

In order to obtain more information from agents, carriers and small business owners, nine health insurance fairs were held in towns across the state. The fairs provided an opportunity for carriers and local agents to join together to provide information on small employer health insurance options available on a local basis. The endeavor was a unique public/private partnership opportunity involving the insurance industry, local chambers of commerce, business associations, and thousands of small businesses. The fairs provided information for business owners looking for insurance, and allowed grant staff a chance to meet with local business people to discuss the uninsured from a regional perspective, identifying common issues as well as any problems or experiences that were unique to a particular area of the state. Many of those who attended expressed appreciation for recognizing that local communities want to be involved in addressing the problem of uninsured citizens, and were interested in working with the state to hold such events annually.

Working Group Participation

Throughout this process, the SPG staff worked with a supportive stakeholder group officially referred to as the Oversight and Implementation Working Group. This diverse group of people represents numerous organizations that have a crucial interest in the provision of health care in Texas. Members of the Working Group include staff representing the Governor, Lt. Governor, and Speaker of the House; members of key health-related committees in both the Texas Senate and the Texas House of Representatives; the Director of the Texas Legislative Budget Board; state agency representatives from eight different agencies, including the Department of Health, the state Medicaid Office, the Children's Health Insurance Program, the Health and Human

Services Commission, the Texas Health Care Information Council, and the Office of Public Insurance Counsel; other representatives of consumer organizations such as the Texas Mental Health Association, Consumers Union, and Advocacy, Inc.; provider representatives from the Texas Hospital Association and the Texas Medical Association; representatives of the insurance industry and agent associations; public health and indigent care coalition advocates; and public health policy researchers and experts. All Working Group meetings were broadcast via the internet and were open to the public.

Statewide Conference

To provide all Texans with the opportunity to participate in the SPG process and to provide a forum for discussing the various policy options that were developed as part of this study, the SPG staff hosted a statewide conference on January 31 - February 1, 2002. The focus of the conference was to review all survey and research activities and discuss the potential options for expanding insurance. Presentations were made summarizing highlights of the surveys and focus groups, and a detailed overview was provided for each of the policy options under consideration. Nine breakout sessions were held on the second day to allow participants to discuss the policy options and to obtain feedback on the feasibility of each option. Though no consensus was obtained as to the best programs for expanding health insurance in Texas, the discussion generated some very worthwhile information and provided insight into some of the challenges that must be overcome to implement the various programs.

Development of Policy Options

Throughout the process of developing policy options for expanding coverage, the Working Group and SPG staff maintained an open and receptive attitude towards a variety of public and private options. As time progressed, however, it became clear that developing consensus on possible solutions would require more detailed analysis and a long term commitment of significant resources. Changing economic conditions impacted the feasibility of several options, and Working Group members acknowledged that any program requiring additional funding was not realistic at this time. As such, the focus shifted from attempting consensus to developing a variety of options that would appeal to a broad audience, including low-cost alternatives that would require little if any state revenue as well as those that could be considered in the future as the economy improved. The study yielded several options that have already been implemented and several others that are still under consideration or development. Options that received significant support from a majority of the Working Group include:

- Redesigning the two small employer standard benefit plans to make the plans more affordable and more attractive to both employers and insurers;
- Creating a statewide small employer purchasing alliance;
- Publishing a small employer rate guide;
- Conducting community "health insurance fairs" in cities throughout Texas to provide assistance to small employers and, perhaps, individuals seeking health insurance; and
- Expanding coverage under CHIP to allow parents to "buy-in" to the program.

Section 1: Uninsured Individuals and Families

Throughout much of this section, the U.S. Census Bureau's annual Current Population Survey (CPS) is the primary source for data on Texas' uninsured population. Other resources include the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) and information obtained through various surveys and data calls at the Texas Department of Insurance.

Texas' Uninsured Population History (1.1)

Consistently over the last decade, Texas has experienced one of the highest uninsured rates in the nation. CPS data for 2004 shows there were 5.58 million people without health insurance in Texas, or about 25 percent of the total population. Table 1.1 depicts the growth rate of Texans without health insurance since 1995.

Table 1.1: Number and Rate of Texas' Uninsured:
Ages 0 through 64: 1995-2004

Year	Uninsured Rate	Number Uninsured
1995	24.5%	4,615,000
1996	24.3%	4,680 000
1997	24.5%	4,836,000
1998	24.5%	4,880,000
1999	23.3%	4,664,000
2000	21.4%	4,500,000
2001	23.5%	4,960,000
2002	25.8%	5,556,000
2003	24.6%	5,374,000
2004	25.0%	5,583,000

Source: Current Population Survey, United States Census Bureau.

* **Important Note:** In the Medicare, Medicaid and State Children's Health Insurance Program (CHIP) Balanced Budget Refinement Act of 1999, Congress allotted $10 million to the United States Census Bureau's FY 2000 budget to address weaknesses in CPS data. In an effort to increase the precision of states' insurance estimates, the Census Bureau expanded the number of households sampled by 34,000 and added a verification question to the survey that is intended to correct the high rate of over-reporting of uninsurance. As a result, the estimated uninsured rates are significantly lower in 2000. You may visit www.shadac.org for tables that compare CPS insurance rates with and without the verification question and for issue briefs that assess the impact of CPS revisions on state health insurance estimates.

The 2004 rate of uninsurance in Texas was nine percentage points higher than in the nation as a whole, which was estimated at 15.7 percent. Table 1.2 illustrates how Texas' uninsured rates have compared to the overall United States average since 1995.

Table 1.2: Texas Uninsurance Rates
Compared to U.S. Average: 1995-2004

Year	United States Uninsured Rate	Texas Uninsured Rate
1995	15.4%	24.5%
1996	15.6%	24.3%
1997	16.1%	24.5%
1998	16.3%	24.5%
1999	15.5%	23.3%
2000	14.0%	21.4%
2001	14.6%	23.5%
2002	15.2%	25.8%
2003	15.6%	24.6%
2004	15.7%	25.0%

Source: Current Population Survey, United States Census Bureau.

Characteristics of the Uninsured (1.2)

Income/Poverty Level

Eligibility for Texas' public health programs is determined by the federal poverty level guidelines, which are established by the U.S. Department of Health and Human Services. The 2004 FPL guidelines appear in Table 1.3.

Table 1.3: 2004 Federal Poverty Level
Income Guidelines

Family Size	100% FPL	133% FPL	150% FPL	185% FPL	200% FPL
1	$9,310	$12,382	$13,965	$17,224	$18,620
2	$12,490	$16,612	$18,735	$23,107	$24,980
3	$15,670	$20,841	$23,505	$28,990	$31,340
4	$18,850	$25,071	$28,275	$34,873	$37,700
5	$22,030	$29,300	$33,045	$40,756	$44,060
6	$25,210	$33,529	$37,815	$46,639	$50,420
7	$28,390	$37,759	$42,585	$52,522	$56,780
8	$31,570	$41,988	$47,355	$58,405	$63,140

Source: "The 2004 HHS Poverty Guidelines," United States Department of Health and Human Services and Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

Table 1.4 exhibits Texas' uninsurance rates by poverty level as of 2003. Sixty-one percent of uninsured Texans have household incomes below 200 percent of FPL, and 27.1 percent earn below 100 percent of FPL. However, it is important to note than more than a third – 39 percent – of the uninsured have incomes above 200 percent of the FPL, indicating that the non-poor uninsured are a major concern as well.[i]

Table 1.4: Texas Uninsurance Rates by Poverty Range

Income/Poverty Level	Number Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
Under 50%	619,243	11.6%	44.3%
51% to 99%	831,628	15.5%	36.0%
100% to 149%	971,920	18.1%	38.1%
150% to 199%	844,229	15.8%	35.5%
200% to 249%	585,382	10.9%	29.9%
250% or Higher	1,505,906	28.1%	13.4%
Total	**5,358,308**	**100.0%**	**24.5%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Although many children from families with incomes at or below 200% of poverty level are eligible for either Medicaid or TexCare CHIP, many remain uninsured despite significant enrollment outreach efforts across the state. Nearly 71 percent of uninsured dependent children under the age of 18 live in families and/or households with incomes under 200 percent of FPL (Table 1.5). The uninsurance rate is highest for children between 150 and 199 percent of FPL, with 30 percent uninsured. The uninsurance rate decreases significantly to about 10 percent for children from families with incomes of 250 percent of FPL or higher, but these children still represent 20% of the state's uninsured children.

Table 1.5: Distribution of Uninsured Dependent Children by Poverty Level

Poverty Level	Estimated Uninsured Population	Percent of Total Uninsured	Percent Uninsured within Income Category
Under 50%	133,734	10.9%	25.4%
51% to 99%	234,278	19.1%	24.5%
100% to 149%	249,615	20.4%	27.4%
150% to 199%	243,856	19.9%	30.0%
200% to 249%	113,577	9.3%	19.5%
250% or Higher	248,327	20.3%	10.1%
Total	**1,223,389**	**100.0%**	**19.6%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Age

The Current Population Survey data in Table 1.6 shows that certain age groups are much more likely to be uninsured than others. Just over 98 percent of people ages 65 and older have health insurance due largely to Medicare eligibility, while only 74 percent of Texans under 65 are insured. Children generally have higher rates of insurance than adults, but still represent 23.6

percent of the state's uninsured population. Young adults have the highest uninsured rates, with 40.4 percent of 18-24 year olds uninsured in 2003, up from 38.7 percent in 2001. The increase among adults ages 25-34 years is even higher; 26.7 percent were uninsured in 2001 while 39.2 percent were uninsured in 2003. The total number of uninsured adults between 18 and 34 increased by more than 674,000 from 1,522,330 in 2001 to 2,196,868 in 2003.

Table 1.6: Texas Uninsurance Rates by Age

Age Range	Number Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
Ages 6 and Younger	438,532	8.2%	16.9%
Ages 7 - 17	825,914	15.4%	22.1%
Ages 18 - 24	876,978	16.3%	40.4%
Ages 25 - 34	1,319,890	24.6%	39.2%
Ages 35 - 44	893,645	16.6%	28.3%
Ages 45 - 64	977,591	18.2%	20.5%
Ages 65 +	41,134	0.8%	2.0%
Total	**5,373,684**	**100.0%**	**24.6%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Gender

Table 1.7 indicates that the uninsured are almost evenly divided by gender, with males representing 49.9 percent and females 50.1 percent of the uninsured. Males are slightly more likely to lack insurance than females; 24.9 percent of males are uninsured compared to 24.2 percent of females.

Table 1.7: Texas Uninsurance Rates by Gender

Gender	Number Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
Male	2,681,763	49.9%	24.9%
Female	2,691,921	50.1%	24.2%
Total	**5,373,684**	**100.0%**	**24.6%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Employment Status

Contrary to public perception, most uninsured Texans are either employed or live in families with an employed adult. Nearly 67 percent of all uninsured, non-retired adults ages 18 and older are employed (Table 1.8). Only 7.4 percent of uninsured, non-retired adults are unemployed, and the remaining 25.8 percent are not currently in the labor force.

Table 1.8: Texas Uninsurance Rates by Employment Status
(Non-retired persons 18 and older)

Employment Status	Number Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
Employed	2,672,274	66.8%	26.6%
Unemployed	296,977	7.4%	47.6%
Not in Labor Force	1,031,443	25.8%	35.6%
Total	**4,000,695**	**100.0%**	**29.5%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

One of the primary explanations for Texas' high uninsurance rate is that Texas workers generally are less likely to have access to employment-based health insurance coverage than workers in other states. The Current Population Survey indicates that, in 2004, 53.2 percent of Texas workers had employment-based health insurance coverage, compared to a national average of 59.8 percent. In 2001, 55.9 percent of Texans had employment-based coverage, confirming that the rate of employment-based insurance is on the decline in Texas.

The occupational composition of Texas workers has long been recognized as a contributing factor to Texas' uninsured problem. Studies conducted by the Texas Department of Insurance indicate that most insurers or employers have provisions that exclude part-time employees, contract workers, and seasonal employees. This partly explains why certain occupations with large numbers of temporary or seasonal workers are more likely than others to remain uninsured. Texas also has a higher than average employment in both the retail trade and service industries, which traditionally are the least likely to offer insurance, and a lower than average employment in the manufacturing sector, where health benefits are more frequently provided. See Section 2 for more detailed information on insurance rates by industry sector.

Availability of Private and Public Coverage

Despite the relatively high number of uninsured residents, Texas is widely recognized as having one of the healthiest commercial insurance markets in the country. In 2003, accident and health insurers and HMOs reported more than $19.7 billion in fully-insured health insurance premiums written in Texas. An estimated 3.8 million Texans were covered under fully-insured health plans regulated by TDI. An additional 1.6 million Texans were enrolled in state regulated commercial HMO plans, and an estimated five million were covered under self-insured employer group plans not subject to state regulation. When combining these figures with the Medicare, Medicaid and CHIP populations, the total number of Texans with some type of insurance coverage (public or private) is more than 16 million.[ii]

Although some states have experienced a critical shortage of commercial carriers, Texas has not suffered the drastic reductions that other states have reported. The state has 17 active HMOs providing comprehensive coverage to several million Texans, and more than 800 insurance companies are currently licensed to offer some type of health insurance. While a few insurers

hold a relatively large share of the total market, 39 insurers reported premiums in excess of $50 million in 2003, and 18 had premiums of $100 million or more. In addition, Texas has continued to maintain a healthy market for small employers. Although the number of carriers is lower than it was 10 years ago when small group reforms were first implemented, this reduction is typical of the market consolidations that have occurred throughout the country. Today, Texas has 48 insurers and HMOs writing coverage for small businesses.

Availability of private insurance – either group or individual – has not been a problem for most Texans, although affordability is a significant concern. Due to revisions in the regulation of group insurers and implementation of the Texas Health Insurance Risk Pool, even individuals with serious pre-existing medical conditions are guaranteed access to insurance. However, contribution and participation requirements continue to have an impact on the availability of coverage for some employers, and particularly for the smallest businesses.

Public insurance programs – Medicaid and SCHIP – also insure millions of Texans who generally fall into two categories: low income adults and children, including certain pregnant women; and medically needy individuals, including the aged and disabled. In calendar year 2002, Medicaid reported an average monthly enrollment of 2,077,655 Texans. As of January, 2005, the number of Medicaid enrollees had increased significantly to 2,693,287 and the number of CHIP enrollees was 326,770 for a combined total of 3,020,057.

Race/Ethnicity

Table 1.9 reveals that 69.2 percent of Texans without health insurance are African-American or Hispanic. Hispanics alone comprise 59 percent of uninsured, and they are nearly three times more likely to be uninsured as people classified as Anglo.

Table 1.9: Texas Uninsurance Rates by Race or Ethnicity

Race/Ethnicity	Number Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
Anglo	1,456,602	27.1%	14.3%
Black / African American	548,236	10.2%	22.7%
Hispanic	3,171,660	59.0%	38.6%
All Other	197,187	3.7%	19.3%
Total	**5,373,684**	**100.0%**	**24.6%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Immigration Status

Non-citizens are almost three times as likely to be uninsured as are native US citizens. Over 60 percent of non-citizens went without insurance in 2003, compared to 20 percent of US native citizens and 28 percent of naturalized citizens. However, it is important to note that most of Texas' uninsured are legal residents; of the state's uninsured, almost four million (68.1 percent) are legal residents.

Table 1.10: Texas Uninsurance Rates by Immigration Status

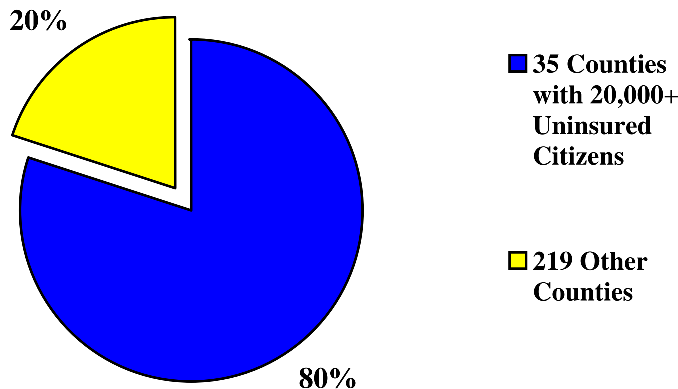
Immigration Status	Number Uninsured	Percent of Total Uninsured	Percent Uninsured within Income Category
U.S. Citizen (Native)	3,657,478	68.1%	19.7%
U.S. Citizen (Naturalized)	243,676	4.5%	27.5%
Not a U.S. Citizen	1,472,530	27.4%	60.3%
Total	**5,373,684**	**100.0%**	**24.6%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Geographic Location

A widely held misconception is that Texas' uninsured population is primarily concentrated in the Texas/Mexico border counties. While the uninsured rate per capita is indeed significantly higher in the border region, only 25 percent of uninsured citizens reside in this area. Chart 1.3 and Table 1.11 show that the heaviest concentration of uninsured persons live in the larger urban areas, as an estimated 80 percent of uninsured Texans reside in 35 of the state's 254 counties.

Chart 1.3: Texas Counties with More than 20,000 Uninsured Citizens



Source: Texas Health and Human Services Commission, 2000.

Table 1.11: Texas Counties with the Ten Largest Uninsured Populations

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

Source: Texas Health and Human Services Commission, 2000.

According to CPS estimates, over 88 percent of the uninsured population resides in metropolitan areas. This group has an uninsurance rate of 27 percent, which is considerably higher than the 21 percent uninsurance rate of people living outside metropolitan areas.

Target Population Groups (1.3)

Though the SPG research activities were designed to focus broadly on the entire population of Texans, four groups received particular attention:

1) Small Employers - Because 75 percent of the firms in Texas with fewer than 50 employees do not offer insurance, small businesses were the subject of both qualitative and quantitative research activities that yielded specific policy options. Statewide surveys were mailed to 50,000 small businesses in 2001 and to 20,000 small businesses in 2004, and focus group sessions were conducted with small employers in 20 cities across the state in 2002 and 2005. The information obtained from the 2001 survey and the focus group sessions led to a series of policy options that specifically address the concerns of small employers and the difficulties they encounter when trying to obtain insurance.
2) Non-Poor Uninsured – 2004 CPS data indicates that more than two million uninsured Texans reside in families with household incomes above 200 percent FPL. Research indicates that families below 200 percent generally require significant subsidies to afford the cost of private insurance. Since the non-poor uninsured are more likely to benefit from private insurance expansion options, this population group was also targeted for expansion efforts.
3) Low Income Adults – Low income adults who are not eligible for Medicaid are the third group identified for specific policy options. Many of these adults have children who are already covered under Medicaid or CHIP, which makes them likely candidates for an expansion of public programs.
4) Young adults – Thirty-nine percent of Texas' uninsured are young people between the ages of 18 and 34. As a group, this population is generally healthy, and an attractive risk

for private health insurers. However, many are either attending school or beginning new careers that either do not offer health insurance or require contributions they cannot afford.

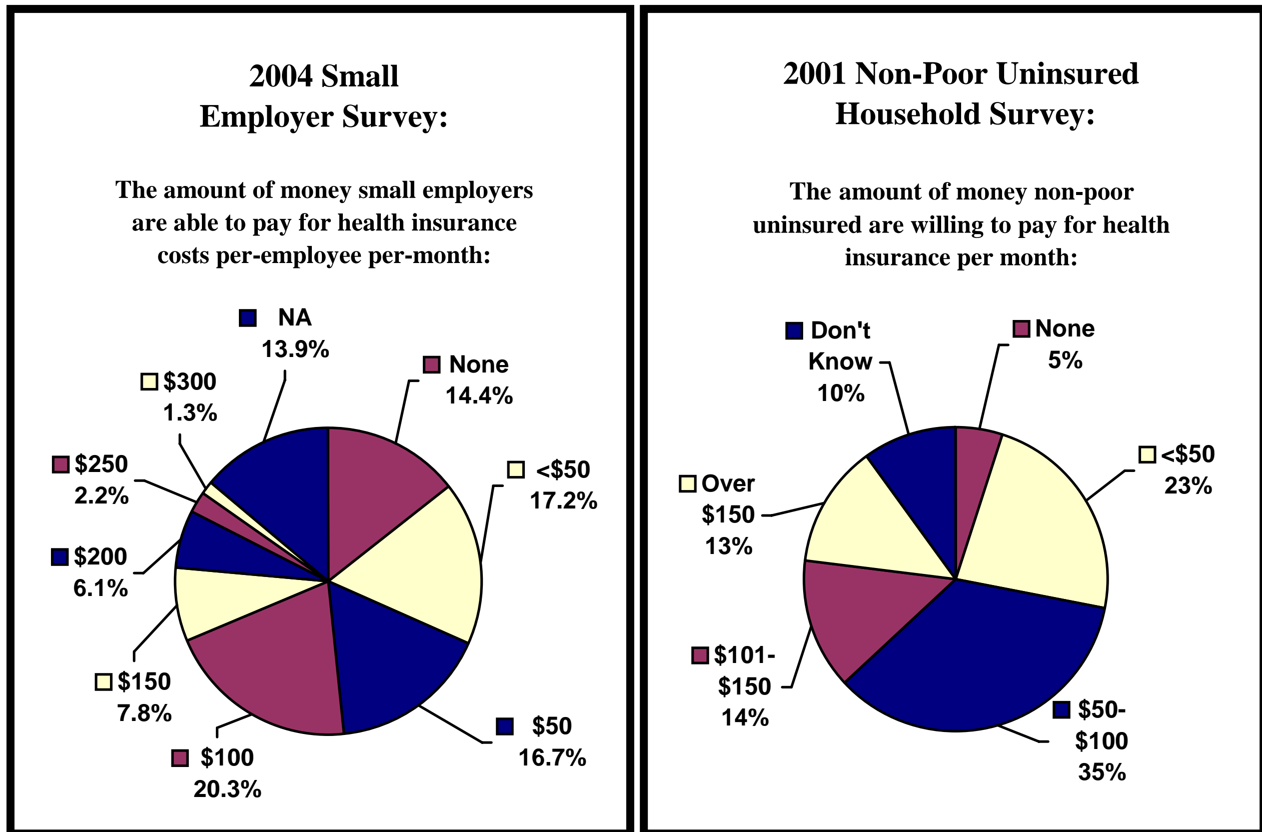
Insurance Affordability (1.4)

Some of the most important data obtained in the course of this study concerns how much money uninsured businesses and individuals can afford to pay for insurance. Though anecdotal evidence strongly suggests that cost is a primary factor in Texas' high uninsured rate, virtually no attempt has been made until now to determine how much these two groups can afford to pay for coverage. Affordability data collected through grant survey activities has been used throughout the state by legislators, insurers, business groups and others involved in efforts to expand health insurance. The data collected in the 2001 small employer survey proved so useful that a similar survey was a major component of the supplemental grant activities.

In both the 2001 and 2004 small employer surveys, respondents were asked how much they would be able to contribute toward employee health insurance benefits. In 2001, 23 percent could only pay less than $50 per-employee-per-month, and 22 percent could pay a maximum of $50. Another 14 percent would be unable to offer insurance at any price. In 2004, 17 percent said they could afford less than $50 per month; 17 percent can afford no more than $50 a month, and 20 percent can afford $100 a month. Less than 10 percent indicated they can afford $200 or more a month. Fourteen percent will not offer coverage at any cost. This data is particularly significant when compared to current average monthly premiums, which exceed $300 per-employee-per-month. This data suggests that some form of premium assistance or a significant cost reduction is necessary in order for most small employers to purchase insurance.

The 2001 household survey of non-poor adults also asked respondents how much they would be willing to pay for insurance. Twenty-three percent said they would pay less than $50 per month and 35 percent would pay between $50 and $100 per month. Only 13 percent could pay more than $150 a month for insurance. Charts 1.4 and 1.5 reveal the complete distribution of responses to these survey questions.

Charts 1.4 and 1.5: Amounts that Small Employers and Non-Poor Uninsured are Willing to Pay for Health Insurance Each Month



Public Program Participation (1.5, 1.6)

A significant number of uninsured Texans are eligible for Medicaid or CHIP but are not enrolled. Though the grant study did not directly evaluate the reasons for non-participation, discussions with focus group participants suggest several reasons why people may not participate in public programs:

- Many uninsured people residing in areas near the border seek medical care in Mexico due to significantly lower costs; because they do not utilize U.S. health care, they do not believe they need public programs.
- Language barriers may be a factor for those not enrolling, with participants reporting difficulty completing applications and communicating with public program representatives.
- The complexity of enrollment requirements and the need for documentation with the appropriate signatures has deterred some from enrolling.

More than 900,000 Texas children may be eligible for Medicaid or CHIP but are not enrolled. Some explanations for non-participation provided by public health officials include:

- Many families do not realize they may qualify for these programs.
- Many families think of Medicaid as a "welfare" program instead of a health insurance program, and do not enroll due to the stigma associated with welfare.[iii]
- Some parents believe the application process is too burdensome, and they are not aware of recent changes made to simplify the process.

The cumbersome application process was one of the most commonly expressed reasons for people not enrolling in public programs in Texas. Federal law and rules adopted by the Centers for Medicaid and Medicare have minimal requirements for states related to children's Medicaid eligibility, including only a signed application, a social security number, a declaration of citizenship or immigration status, and verification of income and program eligibility requirements. Additionally, re-certification for Medicaid is only required every 12 months. Before 2002, Texas also required an assets test (the family could not have total assets valued over $2,000), a face-to-face interview at the local Texas Department of Human Services (DHS) office, and a more restrictive six-month re-certification period. Studies indicate that these requirements acted as an enrollment obstacle for many Medicaid-eligible individuals.[iv]

To address the various obstacles in providing coverage to Medicaid-eligible children and streamline the enrollment process, the 77th Texas Legislature approved legislation to simplify Medicaid enrollment for children. Under Senate Bill 43 passed in 2001, the Medicaid program adopted a one-page application as well as a simplified enrollment procedure that eliminates the face-to-face interview. These reforms dramatically improved the enrollment of children in Medicaid as indicated by the continued growth over the past three years.

In April 2002, the Texas Health and Human Services Commission (HHSC) published the results of a study that examined the reasons why Texas CHIP enrollees leave the program. Conducted by the Institute for Child Health Policy at the request of HHSC, the study "An Analysis of Disenrollment Patterns in the Children's Health Insurance Programs in Texas" used several types of data to develop information on disenrollment patterns. The report indicates that, based on enrollment files examined over a 22 month period, 20 percent of the children disenrolled from the program. Of those who disenrolled, 19 percent later re-enrolled.

In a telephone survey of disenrollees, families were asked to indicate reasons why they disenrolled their children. Families were allowed to give more than one reason but were asked to also give a single primary reason for disenrolling. The most frequent response given for disenrollment was because they could not or did not renew the coverage (29%). Twenty-eight percent of disenrollees moved from CHIP into Medicaid; 28% were no longer eligible because their incomes were too high; and 20% indicated that they obtained other insurance coverage. When asked to give the *primary* reason for disenrolling, 19% of families said the child moved from CHIP to Medicaid. Eighteen percent of children were no longer eligible due to an increase in income. Sixteen percent of families indicated they did not or could not complete the renewal process. For more information, the complete study results are available at
http://www.hhsc.state.tx.us/chip/cnews/DisenrolleeRpt0402.pdf.

In November 1999, the Texas Healthy Kids Corporation (THKC) conducted an enrollee satisfaction survey in part to determine the reasons why parents terminated the subsidized

coverage of their children provided through THKC. Of the 228 total families participating, 35 percent reported that they discontinued their coverage because they could no longer afford the premium payments, and an additional nine percent were canceled by THKC because they were late on their payments. Seventeen percent of the children dropped out because their parents received a new job offering insurance benefits, ten percent found another source of insurance, and five percent became eligible for Medicaid. A total of ten percent of those discontinuing coverage cited poor service and problems with benefits.[v]

Employer-Sponsored Insurance Participation (1.7, 1.8)

Respondents to the 2004 small employer survey who offered health insurance were asked why employees most commonly declined coverage. Fifty-four percent of the companies surveyed in 2004 indicated that employees who turned down coverage already had insurance through a spouse's or parent's plan, or under another employers' plan. Another 22 percent of employers indicated that employees did not purchase employer-based health insurance because of cost, and six percent reported the employee did not want coverage. The SPG household survey of the uninsured above 200 percent FPL revealed that cost was a primary factor; when asked the main reason they had not obtained insurance through their employer if it had been offered, over 57 percent said that the plan was too expensive. Another 11 percent indicated they were not interested in purchasing health insurance.

The 2004 small employer survey asked respondents not offering health insurance to describe their employees' level of interest in health insurance. Nearly three-quarters (73 percent) indicated that employees were at least somewhat interested in whether employer-based health insurance will be offered, and 32 percent were very interested. When asked which entity they believed was primarily responsible for assuring people have health insurance, only eight percent of companies not offering insurance believed that the companies themselves were responsible. Forty-one percent placed the primary responsibility on individuals, while one-third believe the federal government is responsible. However, in a separate question, 81 percent of employers said they believed employers should provide insurance for their employees if they can afford to do so.

Health Insurance Incentives (1.9)

Both small employer surveys and the household survey asked respondents to indicate what types of insurance expansion policy options and incentives to purchase health insurance they would support. Twenty-two percent of small employers in 2004 (20 percent in 2001) expressed strong support for a government subsidy to help low-income employees purchase insurance, and 30 percent generally supported the idea (29 percent in 2001). However, 19 percent were strongly opposed to the idea in 2004, which was a significant increase from the six percent who opposed it in 2001. When asked how they felt about financial incentives to encourage small employers to provide insurance, 61 percent strongly supported the idea and 26 percent generally supported it.

Individuals who participated in the household survey likewise showed strong support for employer tax breaks. Thirty percent of respondents strongly agreed and 62 percent generally

agreed that small employers who offer health insurance should be given tax breaks. Only seven percent disagreed.

Focus group participants frequently suggested the state should assist low-income workers with the cost of health insurance. Both individuals and small employers expressed a strong desire to participate in the private insurance market and want to pay their fair share. But the high cost of coverage precludes their participation, and most indicated they would welcome any assistance from the state or federal government in the form of subsidies.

Insurance Barriers (1.10)

Individuals and employers participating in focus group meetings were asked why they believe such a high percentage of Texans are uninsured. Cost was the most significant factor, but other barriers were mentioned as well, including:

- Pre-existing conditions that make it impossible for individuals to find commercial coverage if they have any history of illness;
- Difficulties comparing the wide array of policy benefits and prices;
- The technical nature of insurance and the inability to understand how health insurance works, how to shop for coverage, or how to use it;
- The lack of employment or the availability of employment-based insurance;
- The tendency to rely on low-cost or free health care clinics;
- Language barriers and the lack of information available from the state or health insurance companies in languages other than English; and
- Restrictions on the availability of insurance coverage for part-time employees.

Employers participating in the 2004 small employer survey cited cost as the primary reason they were uninsured, but other factors also are important. Fourteen percent (15 percent in 2001) reported that the majority of their employees did not want insurance because they already have coverage; four percent (five percent in 2001) reported their employees prefer higher wages; and two percent (1.4 percent in 2001) do not want to deal with the administrative hassle.

Resources for the Uninsured (1.11)

Although numerous studies have documented the fact that uninsured individuals delay or go without medical care in some cases, many of the uninsured are successfully accessing the health care system through public clinics and emergency rooms, as demonstrated by the high levels of uncompensated care reported by hospitals. Others use traditional physician offices but pay for their services out-of-pocket. In Texas/Mexico border communities, focus group participants reported residents commonly obtain services in Mexico, where medical care and prescription drugs are considerably cheaper. For some uninsured people who are healthy and rarely see the doctor, the expenses for occasional health care needs are considerably less than the cost of insurance. They have no trouble finding care when they need it, and are willing to gamble that they will not become seriously ill or suffer a serious accident rather than pay monthly insurance premiums.

Though the grant research did not attempt an assessment of health care services for the uninsured, the household survey did ask respondents several related questions. It is clear from their responses that many of the uninsured feel that insurance is not a necessity. More than one-third (36 percent) of the non-poor uninsured report that they are satisfied with receiving their health care through public or free clinics. Furthermore, 25 percent report that they agree with the statement "people who don't have health insurance have an easy time getting proper medical care."

Insurance Benefit Provisions (1.12)

While the original SPG research did not attempt to define what benefits must be included in order for insurance to provide "adequate" coverage, groups have attempted to do so in the past with little success. Several of the Working Group members pointed out that many Texans with health insurance do not have coverage for prescription drugs or mental health care. Others mentioned that plans with high deductibles and coinsurance requirements may also prevent or discourage some insured people from seeking necessary care. Other members, however, felt that benefit plans are too "rich", and encourage over-utilization of services. Generally, the Working Group agreed that "adequacy of coverage" is a subjective concept that varies according to what services an individual needs and, to some extent, personal preferences. Determining the extent to which current benefit plans are adequate would involve significant time and expense, and was not a part of the grant activities.

In both small employer surveys, employers were asked to indicate the types of benefits they feel are most important in a health plan. There was very little variation in the responses received in 2001 and those in 2004. Table 1.12 on the following page summarizes the responses received in both years.

Under the Consumer Choice Plans (CCP) which replaced the standard Basic and Catastrophic small employer plans, insurers/HMOs are allowed to eliminate or reduce specific mandated benefits. Most carriers have chosen to leave intact most mandated coverage rather than remove them. Benefits most commonly eliminated include contraceptive drugs and devices, chemical dependency treatment and acquired brain injury treatment /services. Carriers/insurers also commonly do not offer any of the mandated offerings in the CCP plans.

(1.13 – No data was collected on underinsured Texans.)

Table 1.12: Employers' Opinions on the Importance of Various Health Insurance Benefits

A= Extremely Important
B= Very Important
C= Somewhat Important
D= Not Very Important
E = Not At All Important
NR = No Response

Type of Health Insurance Benefit	Survey	A	B	C	D	E	NR
Visits to a primary care physician, such as a pediatrician or family doctor, but only when sick	2004	46%	31%	14%	4%	3%	4%
	2001	41%	31%	15%	4%	3%	6%
Visits to a primary care physician when sick and for annual well-person check-ups	2004	39%	29%	20%	6%	2%	4%
	2001	37%	30%	19%	6%	3%	5%
Visits to a specialist physician, such as a cardiologist or surgeon	2004	39%	35%	17%	4%	2%	4%
	2001	40%	33%	16%	4%	2%	5%
In-patient hospital care (for surgery, illness, emergencies, etc.)	2004	56%	29%	8%	2%	2%	4%
	2001	57%	28%	8%	2%	2%	4%
Maternity care for pregnant women	2004	19%	22%	22%	16%	18%	3%
	2001	20%	21%	23%	14%	16%	6%
Laboratory services (such as getting blood work or having a biopsy analyzed)	2004	35%	36%	19%	5%	3%	3%
	2001	35%	36%	18%	4%	2%	6%
Mental health services	2004	9%	16%	30%	23%	17%	4%
	2001	12%	17%	29%	22%	15%	6%
Prescription drugs	2004	40%	31%	18%	4%	3%	4%
	2001	41%	30%	17%	4%	3%	5%
X-Rays or MRI's	2004	36%	39%	17%	3%	2%	4%
	2001	36%	37%	17%	3%	2%	6%
Alcohol or drug abuse treatment	2004	6%	10%	27%	27%	26%	4%
	2001	7%	11%	27%	26%	23%	6%
Well-child care, including coverage for immunizations and routine check-ups	2004	26%	27%	23%	10%	11%	4%
	2001	26%	25%	23%	10%	10%	6%
Chiropractic services	2004	7%	12%	30%	24%	23%	4%
	2001	8%	14%	29%	22%	21%	6%
Preventive screenings (such as mammograms or prostate cancer testing)	2004	33%	32%	22%	6%	4%	4%
	2001	35%	31%	19%	6%	3%	5%
Vision care (visits to the eye doctor, glasses, contacts)	2004	14%	21%	31%	16%	14%	4%
	2001	14%	24%	30%	14%	12%	6%
Dental benefits	2004	13%	21%	31%	16%	15%	4%
	2001	15%	23%	30%	14%	12%	6%
Surgical treatment for obesity*	2004	3%	4%	16%	26%	46%	4%
Diet programs to treat obesity*	2004	5%	7%	19%	25%	40%	4%

Note: Questions related to surgical treatment for obesity and diet programs to treat obesity were not included in the 2001 Survey.
Source: Final Results of the 2001 and 2004 Texas Small Employer Survey, Texas State Planning Grant.

Section 2: Summary of Findings: Employer-based Coverage

Since many of the uninsured in Texas work for small employers who do not provide health insurance, the SPG study focused particular attention on the small employer market (2-50 employees). However, where possible, comparative data is also included on employer-based coverage provided by medium and large firms with more than 50 employees.

Employer Characteristics (2.1)

Industry Sector

An analysis of Texas-specific Medical Expenditure Panel Survey (MEPS) data highlights the large disparity in offer rates between large and small employers. As shown in Table 2.1, 96.1 percent of large firms in Texas offered insurance in 2003 (up from 94.6 percent in 2000), while only 31.4 percent of small firms offered coverage, down from 37 percent in 2000 and 34.8 percent in 2003. Furthermore, only 32 percent of all small-firm employees were actually enrolled in coverage, while 61.5 percent of all large-firm employees were enrolled.[vi]

Table 2.1: MEPS Data for All Private Sector Employees

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Firms	425,925 100.00%	312,000 73.25%	113,925 26.75%	6,285,662 100.00%	4,727,002 75.20%	1,558,660 24.80%
Firms Offering Insurance	207,425 48.70%	97,968 31.40%	109,482 96.10%	3,532,542 56.20%	2,042,065 43.20%	1,486,962 95.40%
Total Number of Employees in All Firms	7,838,737 100.00%	1,948,995 24.86%	5,889,741 75.14%	110,876,535 100.00%	31,382,001 28.30%	79,494,534 71.70%
Employees in Firms Offering Insurance	6,694,281 85.40%	933,569 47.90%	5,760,167 97.80%	96,240,832 86.80%	19,331,313 61.60%	76,950,709 96.80%
Employees Eligible for Insurance in Firms Offering Insurance	5,167,985 77.20%	778,596 83.40%	4,389,247 76.20%	75,549,053 78.50%	15,175,080 78.50%	60,406,306 78.50%
Employees Eligible for Insurance that are Enrolled in Insurance in Firms Offering Insurance	4,258,420 82.40%	624,434 80.20%	3,625,518 82.60%	60,665,890 80.30%	11,730,337 77.30%	48,929,108 81.00%
Percent of Total Employees in All Firms Eligible for Insurance	65.93%	39.95%	74.52%	68.14%	48.36%	75.99%
Percent of Total Employees in All Firms Enrolled in Insurance	54.33%	32.04%	61.56%	54.71%	37.38%	61.55%

Source: TDI Analysis of the 2003 Medical Expenditure Panel Survey

Data from the March 2001 Current Population Survey indicates that the level of uninsurance varies significantly across different industry sectors in Texas. Table 2.2 shows that several industries, including educational services, communications, public administration, mining, and utilities, experience an uninsured rate of less than ten percent. Other industries, however, report significantly higher uninsured rates; these include construction, personal services, entertainment, and agriculture, where more than 30 percent of the employees are uninsured. In fact, workers in construction, manufacturing, and wholesale and retail trade account for more than half (53%) of all uninsured Texas workers.[vii]

Table 2.2: Employer-Based Health Insurance Enrollees by Industry Sector

Industry Sector	Number Insured	Number Uninsured	Percent Uninsured Within Industry	Percent of Total Uninsured
Private Households	32,443	52,592	61.9%	2.5%
Construction	386,245	365,284	48.6%	17.5%
Personal Services, Excluding Households	164,241	94,300	36.5%	4.5%
Entertainment and Recreation Services	66,633	37,141	35.8%	1.8%
Agriculture	169,613	85,044	33.4%	4.1%
Wholesale and Retail Trade	1,362,708	552,955	28.9%	26.5%
Business, Auto, and Repair Services	507,699	187,829	27.0%	9.0%
Social Services	177,989	60,820	25.5%	2.9%
Transportation	333,838	86,350	20.6%	4.1%
Hospitals and Medical Services	594,752	146,301	19.7%	7.0%
Manufacturing	1,029,517	189,037	15.5%	9.1%
Other Professional Services	396,863	49,658	11.1%	2.4%
Finance, Insurance, and Real Estate	564,293	64,469	10.3%	3.1%
Educational Services	754,544	71,695	8.7%	3.4%
Communications	173,891	12,486	6.7%	0.6%
Public Administration	360,391	24,796	6.4%	1.2%
Mining	159,000	5,527	3.4%	0.3%
Utilities and Sanitary Services	73,773	1,471	2.0%	0.1%
Forestry and Fisheries	4,730	Not Available	Not Available	Not Available
Total	**7,313,163**	**2,087,755**	**22.2%**	**100.0%**

Source: Analysis of 2001 Current Population Survey, Texas Health and Human Services Commission, Research and Forecasting Department.

In the 2004 small employer survey, 52.2 percent of the respondents report they do not offer health insurance to their employees. Employees working in service-related jobs represent 41 percent of all uninsured workers. Employers in the food services industry are the least likely to offer health insurance (84 percent do not offer coverage), but they only account for about six percent of the total firms not offering insurance. Table 2.3 provides a detailed breakdown of the surveyed firms not offering insurance by industry.

Table 2.3: Companies Offering Employer-based Health Insurance by Industry Sector

Industry	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Industry	Percent of Total Firms Not Offering Ins.
Agriculture, forestry, fishing	53	82	60.7%	3.7%
Construction	185	256	58.0%	11.4%
Food service	25	130	83.9%	5.8%
Manufacturing	153	119	43.8%	5.3%
Retail	184	346	65.3%	15.4%
Services	945	912	49.1%	40.7%
Wholesale	114	67	37.0%	3.0%
Other	372	311	45.5%	13.9%
No Response	22	20	47.6%	0.9%
Total	**2,053**	**2,243**	**52.2%**	**100.0%**

Source: Final Results of the 2004 Texas Small Employer Survey, Texas State Planning Grant – Texas Dept. of Insurance

Employee Income Brackets

Over half (63.5 percent) of small employers participating in the 2004 SPG survey that do not offer health insurance have average annual employee salaries below $25,000. In contrast, more than 62.9 percent of small employers that do offer health insurance have average annual salaries over $25,000. Companies with average employee salary ranges between $50,001 and $75,000 are the most likely to offer health insurance (73.8 percent), while companies with average salaries of $15,000 or less rarely offer insurance (12.2 percent). Table 2.4 further demonstrates the relationship between average company salary and whether employer-based health insurance is offered.

Table 2.4: Average Annual Salary of Small Businesses Employees

Average Employee Salary	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Insurance within Salary Category	Percent of Total Not Offering Insurance
Less than $10,000	18	126	87.5%	5.7%
$10,001-$15,000	43	312	87.9%	14.2%
$15,001-$20,000	205	470	69.6%	21.3%
$20,001-$25,000	419	491	54.0%	22.3%
$25,001-$50,000	1120	677	37.7%	30.7%
$50,001-$75,000	155	55	26.2%	2.5%
More than $75,000	43	23	34.8%	1.0%
No Response	91	48	34.5%	2.2%
Total	**2,094**	**2,202**	**51.3%**	**100.0%**

Source: Final Results of the 2004 Texas Small Employer Survey, Texas State Planning Grant – Texas Department of Insurance

The small employer survey also confirms a definite relationship between the **type** of workers employed by a company and whether or not it provides health insurance benefits. As shown in

Table 2.5 below, only 8.7 percent of companies with a majority of minimum-wage workers offer health insurance, and companies primarily hiring independent contractors offer health insurance only 30.4 percent of the time. On the other hand, companies predominantly having salaried employees are the most likely to offer coverage at 64.9 percent, and those predominantly paying between $15 and $20 per hour follow closely behind with 62.1 percent.

Table 2.5: Predominant Wage Type of Small Business Employees

Predominant Employee Wage Type	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Wage Category	Percent of Total Not Offering Insurance
Minimum Wage	6	63	91.3%	2.8%
Hourly, more than minimum wage but less than $10 per hour	294	796	73.0%	35.5%
Hourly, between $10 - $15 per hour	595	624	51.2%	27.8%
Hourly, between $15 - $20 per hour	275	168	37.9%	7.5%
Hourly, more than $20 per hour	72	54	42.9%	2.4%
Salaried	746	404	35.1%	18.0%
Independent contractors	35	80	69.6%	3.6%
Hourly plus tips	2	27	93.1%	1.2%
No Response	29	26	47.3%	1.2%
Total	**2,054**	**2,242**	**52.2%**	**100.0%**

Source: Final Results of the 2004 Texas Small Employer Survey, Texas State Planning Grant.- Texas Department of Insurance

Percentage of Full-Time, Part-time and Seasonal Employees

A detailed analysis of MEPS data for **full-time** private sector employees appears in Table 2.6. This data confirms that a significantly smaller percentage of small-firm employees in Texas are currently enrolled in insurance (40.3 percent) in relation to large firms (74.9 percent). Nationally, 49.4 percent of full-time small-firm employees are enrolled. Eligibility rates for Texas' small-firm employees (49.38 percent) are also lower than the national rate (62.6 percent). However, both eligibility and enrollment rates for large firms in Texas are slightly higher than the national averages.

Table 2.6: MEPS Data for Full-time Private Sector Employees

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Full-time Employees in All Firms	6,231,680 100.00%	1,530,683 24.56%	4,700,998 75.44%	87,657,095 100.00%	22,981,101 26.22%	64,675,994 73.78%
Full-time Employees in Firms Offering Insurance	5,402,867 86.70%	806,670 52.70%	4,592,875 97.70%	78,716,071 89.80%	15,719,073 68.40%	62,994,418 97.40%
Full-time Employees Eligible for Insurance in Firms Offering Insurance	4,867,983 90.10%	755,850 93.70%	4,110,623 89.50%	69,899,871 88.80%	14,382,952 91.50%	55,498,082 88.10%
Full-time Employees Eligible for Insurance that are Enrolled in Insurance in Firms Offering Insurance	4,142,653 85.10%	617,529 81.70%	3,522,804 85.70%	57,946,993 82.90%	11,348,149 78.90%	46,562,891 83.90%
Percent of Total Full-time Employees Eligible for Insurance	78.12%	49.38%	87.44%	79.74%	62.59%	85.81%
Percent of Total Full-time Employees Enrolled in Insurance	66.48%	40.34%	74.94%	66.11%	49.38%	71.99%

Source: TDI Analysis of the 2003 Medical Expenditure Panel Survey

More than three-quarters of all **part-time** employees in Texas work in firms that offer insurance, but only 23.4 percent of part-time employees are eligible for coverage (Table 2.7). Of those who are eligible, only 39.4 percent are actually enrolled, a significant drop from 69.4 percent in 2002. Of all part-time workers employed in both firms that do and do not offer health insurance, only 7.4 percent enrolled in employer-sponsored plans. In small firms, less than two percent of workers were covered. Workers in large firms fared slightly better; 9.4 percent of part time employees were insured. However, this number is significantly lower than the national rate of 26.4 percent.

Table 2.7: MEPS Data for Part-time Private Sector Employees

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Part-time Employees in All Firms	1,607,057 100.00%	418,313 26.03%	1,188,744 73.97%	23,219,440 100.00%	8,400,901 36.18%	14,818,540 63.82%
Part-time Employees in Firms Offering Insurance	1,292,074 80.40%	126,749 30.30%	1,164,969 98.00%	17,530,677 75.50%	3,620,788 43.10%	13,914,609 93.90%
Part-time Employees Eligible for Insurance in Firms Offering Insurance	302,345 23.40%	22,181 17.50%	279,593 24.00%	5,627,347 32.10%	792,953 21.90%	4,828,369 34.70%
Part-time Employees Eligible for Insurance that are Enrolled in Insurance in Firms Offering Insurance	119,124 39.40%	6,721 30.30%	112,117 40.10%	4,518,760 80.30%	612,952 77.30%	3,910,979 81.00%
Percent of Total Part-time Employees Eligible for Insurance	18.81%	5.30%	23.52%	24.24%	9.44%	32.58%
Percent of Total Part-time Employees Enrolled in Insurance	7.41%	1.61%	9.43%	19.46%	7.30%	26.39%

Source: TDI Analysis of the 2003 Medical Expenditure Panel Survey

Taken together, Tables 2.6 and 2.7 reveal a significant disparity in insurance coverage between full-time and part-time workers. While 78.1 percent of full-time Texas workers are eligible for insurance, only 18.8 percent of part-time workers are eligible. The numbers are even more discouraging for the percentage of part-time workers who actually enroll - only 7.4 percent compared to 66.5 percent of full-time employees.

The SPG small employer survey asked respondents to indicate their total number of employees, full-time employees, part-time employees, and contract employees. Employers were not asked for the number of seasonal employees. Survey results show that the average percentage of part-time and contract employees for companies that do offer health insurance is about 19.8 percent. Companies that do not offer health insurance have a significantly higher percentage of part-time and contract workers at 31.7 percent.

Geographic Location

Each company responding to the SPG small employer survey was asked to provide its zip code. By doing so, we expected to be able to isolate companies' locations in the state and provide analysis to that effect. Unfortunately, a large percentage of respondents did not provide this information. As a result, any analysis with regard to business location would be skewed and unreliable. Therefore, we were unable to pursue further evaluation in this area.

Cost of Policies and Level of Contribution

Like many other states, health insurance rates in Texas are generally not subject to regulation. While some restrictions apply to the range of rates that may be charged for small group health plans, insurers are not required to obtain approval from the Texas Department of Insurance for health insurance rates, and they file only limited information with TDI on health insurance costs. The Department does, however, collect quarterly rate information from licensed HMOs, and both HMOs and the largest indemnity/PPO carriers are required to provide average rate information as part of an annual group accident and health insurance data call.

While aggregated average insurance rates are useful, particularly when comparing rates by state or when analyzing rate trends over an extended time period, averaging does not adequately reflect the huge variations that can occur among groups due to various rating factors, such as group size, age and sex of the insureds, health status of the group members, and the geographical location of the group. In order to provide a clearer picture of these wide rate variations and how they may affect employers attempting to purchase insurance, Texas insurance carriers writing nearly 70 percent of Texas' total accident and health insurance premiums were required to report both average and maximum annual premium costs per person for both small employer and large employer group plans. The sample figures in Table 2.8 demonstrate the significant variation in costs among different insurers. Though these rate differences do not take into account various policy differentials (such as deductibles and coinsurance requirements) that can impact average rates, the rates quoted do apply only to major medical products, which are very similar in scope of coverage. The rate variations emphasize the need for consumers to obtain quotes from numerous carriers as costs can vary dramatically from company to company.

The data also underscores the significance of the fact that "average" rates clearly do not apply to all groups. The maximum rates quoted by carriers for both large and small group plans illustrate that some group insureds pay rates that are more than 1000 percent higher than the "average" rate. These rate disparities are likely due to a combination of factors such as an older-than-average group of employees and pre-existing health problems, but are a dramatic picture of how certain factors can negatively impact a group's ability to obtain "affordable" insurance. In evaluating the "average" cost of coverage and relative affordability, it is critical to acknowledge that many groups do not qualify for "average" rates, and are paying significantly higher premiums. These rates also illustrate why many small employers who have attempted to purchase insurance report that they cannot afford coverage. While even "average" costs are difficult for many small firms to afford, employers that must pay higher than average rates face even bigger challenges when trying to provide insurance for their employees.

Average premiums also vary significantly based on whether the group is a small employer or a large employer with more than 50 employees with one exception. Every company listed in Table 2.8 reports higher average costs for small firms as compared to large firms. The aggregate average rate for small firms is $2,996 compared to $2,458 for large firms, more than a 20 percent difference in costs. On a per-company basis, the difference between large and small group rates ranged from ten percent up to 70 percent.

Maximum annual premium costs, however, were much higher for small groups than large. In small groups, the maximum premium cost averaged $14,532 compared to $5,330 in large groups. One company reported maximum rates that are five times higher than average rates for other small groups.

Table 2.8: Texas Small and Large Employer Health Plans
Average and Maximum Annual Premiums

Co. ID	Small Employer Premium Costs		Large Employer Premium Costs	
	Avg. Annual Premium Cost Per Person	Maximum Annual Premium Cost Per Person	Avg. Annual Premium Cost Per Person	Maximum Annual Premium Cost Per Person
A	$3,505.30	$16,578.96	$2,843.80	$6,292.92
B	$3,861.00	$20,446.00	$2,276.00	$4,109.00
C	$2,816.00	$8,125.00	$3,104.00	$6,259.00
D	$2,906.72	$21,132.00	$2,624.17	$6,491.04
E	$2,329.00	$12,899.00	Not Applicable	Not Applicable
F	$3,081.00	$16,716.00	$1,896.00	$3,048.00
G	$3,260.00	$5,930.00	$2,870.00	$5,781.00
H	$2,214.00	$14,411.00	$1,596.00	Not Available

Source: Texas Department of Insurance Annual Group Accident and Health Data Call, 2003

Employee and Family Health Insurance: Average Premiums

The TDI accident and health survey also collected information on the average premiums for the most popular benefit plan sold to small employers. Premium rates are provided for employee-only, employee and children, employee and spouse, and employee and family. A sample of rates is provided in Table 2.9, below. These rates also emphasize the significant rate variations among carriers and the importance of comparing prices when shopping for coverage.

Table 2.9: Texas Small Employer Most Popular Health Plan
Average Annual Premiums (2003)

Co. ID	Employee Only	Employee + Children	Employee + Spouse	Employee + Family
A	$4,037.00	$7,003.00	$8,798.00	$11,609.00
B	$2,945.00	$5,378.00	$6,514.00	$8,948.00
C	$1,871.84	$4,383.56	$3,999.60	$4,975.52
D	$3,112.92	$5,914.44	$6,225.72	$9,961.20
E	$2,701.00	$5,432.00	$9,313.00	$9,051.00
F	$4,878.11	$9,628.28	$11,219.54	$15,609.71
G	$3,973.00	$7,489.00	$9,859.00	$12,172.00
H	$4,604.00	$9,407.00	$11,053.00	$15,858.00

Source: Texas Department of Insurance Annual Group Accident and Health Data Call, 2003.

The national Medical Expenditure Panel Survey provides average insurance rate information for Texas and most other states. As the table below shows, average annual insurance premiums are provided for single coverage (employee-only) and for family coverage (employee and dependents). Rates are provided for five years, including 2003, which is the most recent year for which data is available. Average family premiums for all businesses (large and small combined) were lowest in 1999, and have since increased 54 percent from $6,209 to $9,575. A slightly lower rate increase of 45 percent was experienced for employee-only premiums.

Table 2.10: Average Single and Family Premiums in Establishments that Offer Health Insurance by Firm Size

Size of Business	Texas					United States				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Average Single Premiums										
All Businesses	$2,336	$2,627	$2,925	$3,268	$3,400	$2,325	$2,655	$2,889	$3,189	$,3481
Small Businesses	$2,539	$2,955	$3,299	$3,580	$3,793	$2,475	$2,827	$3,031	$3,375	$3,623
Large Businesses	$2,261	$2,538	$2,809	$3,195	$3,310	$2,269	$2,595	$2,845	$3,133	$3,438
Average Family Premiums										
All Businesses	$6,209	$6,638	$7,486	$8,837	$9,575	$6,058	$6,772	$7,509	$8,469	$9,249
Small Businesses	$6,486	$6,784	$7,974	$8,800	$9,831	$6,062	$6,868	$7,704	$8,502	$9,321
Large Businesses	$6,161	$6,618	$7,423	$8,841	$,9545	$6,057	$6,752	$7,473	$8,463	$9,235

Source: Analysis of the 1999-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Although MEPS data is only available through 2003, another annual survey of employers provides more recent information. The Employer Health Benefits Survey conducted annually by the Kaiser Family Foundation and the Health Research and Educational Trust reported average premium rate increases of 11.2 percent in 2004. These increases are national averages; state-level information is not available under this survey. However, discussions with Texas employers and limited rate information provided by several large insurers indicate that the increases reported in the Kaiser/HRET survey are consistent with what Texas employers are experiencing. If we apply those rate increases to the data in Table 2.10 above, the average rates for 2004 would increase as follows: the average single employee-only premium for all businesses would be $4,138; for small businesses, $4,533; and for large businesses, $4,046. The average family premiums in 2004 would increase to $11,192 for all businesses combined; $11,145 for small businesses; and $11,196 for large businesses.

Employee and Family Health Insurance: Contribution Levels

Payment for the premiums of employer-based health insurance is usually divided between the employer and each employee. As indicated in Tables 2.11 and 2.12, average employer contributions in Texas were generally higher than the national average in 2003. However, contribution levels paid by employers for family coverage were lower in Texas than the national average during the entire five year period. This is particularly true for workers in small firms.

Table 2.11: Average Employer Contribution per Employee for Single and Family Coverage by Company Size

Size of Business	Texas					United States				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Average Employer Contribution per Employee for Single Coverage										
All Businesses	$1,888	$2,219	$2,451	$2,738	$2,852	$1,904	$2,205	$2,391	$2,624	$2,875
Small Businesses	$2,138	$2,586	$2,802	$3,153	$3,306	$2,098	$2,414	$2,579	$2,896	$3,085
Large Businesses	$1,796	$2,120	$2,343	$2,641	$2,749	$1,833	$2,133	$2,333	$2,542	$2,811
Average Employer Contribution per Employee for Family Coverage										
All Businesses	$4,410	$4,877	$5,524	$6,539	$7,007	$4,620	$5,158	$5,768	$6,482	$6,966
Small Businesses	$3,758	$4,014	$5,523	$5,347	$6,944	$4,406	$4,974	$5,668	$6,347	$6,827
Large Businesses	$4,523	$4,996	$5,525	$6,674	$7,015	$4,667	$5,198	$5,787	$6,508	$6,993

Source: Analysis of the 1999-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Table 2.12: Average Employee Contribution for Single and Family Coverage by Company Size

Size of Business	Texas					United States				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Average Employee Contribution for Single Coverage										
All Businesses	$448	$408	$473	$530	$548	$420	$450	$498	$565	$606
Small Businesses	$402	$368	$497	$427	$487	$378	$413	$452	$479	$538
Large Businesses	$465	$419	$466	$554	$561	$436	$462	$513	$591	$627
Average Employee Contribution for Family Coverage										
All Businesses	$1,798	$1,761	$1,962	$2,298	$2,568	$1,438	$1,614	$1,741	$1,987	$2,283
Small Businesses	$2,728	$2,770	$2,450	$3,453	$2,887	$1,656	$1,894	$2,035	$2,155	$2,494
Large Businesses	$1,637	$1,623	$1,899	$2,168	$2,530	$1,390	$1,555	$1,686	$1,955	$2,242

Source: Analysis of the 1999-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Tables 2.13 and 2.14 further illustrate that employers' contributions for insurance in Texas are generally comparable to the national average for both large and small businesses, with the exception of family coverage for small employers. These data continue to highlight the challenges of expanding health insurance for workers in small firms who often have trouble affording their portion of the insurance contribution. Low-income workers in particular who need family coverage are even less likely to be able to afford such coverage if they work for small employers who generally contribute less to the cost of family coverage.

Table 2.13: Average Employer Contribution Percentage per Employee for Single and Family Coverage by Company Size

Size of Business	Texas					United States				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Average Employer Contribution Percentage per Employee for Single Coverage										
All Businesses	80.8%	84.5%	83.8%	83.8%	83.9%	81.9%	83.1%	82.7%	82.3%	82.6%
Small Businesses	84.2%	87.5%	84.9%	88.1%	87.2%	84.7%	85.4%	85.1%	85.8%	85.2%
Large Businesses	79.4%	83.5%	83.4%	82.7%	83.1%	80.8%	82.2%	82.0%	81.1%	81.8%
Average Employer Contribution Percentage per Employee for Family Coverage										
All Businesses	71.0%	73.5%	73.8%	74.0%	73.2%	76.3%	76.2%	76.8%	76.5%	75.3%
Small Businesses	57.9%	59.2%	69.3%	60.8%	70.6%	72.7%	72.4%	73.6%	74.7%	73.2%
Large Businesses	73.4%	75.5%	74.4%	75.5%	73.5%	77.1%	77.0%	77.4%	76.9%	75.7%

Source: Analysis of the 1999-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Table 2.14: Average Employee Contribution Percentage for Single and Family Coverage by Company Size

Size of Business	Texas					United States				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Average Employee Contribution Percentage for Single Coverage										
All Businesses	19.2%	15.5%	16.2%	16.2%	16.1%	18.1%	16.9%	17.3%	17.7%	17.4%
Small Businesses	15.8%	12.5%	15.1%	11.9%	12.8%	15.3%	14.6%	14.9%	14.2%	14.8%
Large Businesses	20.6%	16.5%	16.6%	17.3%	16.9%	19.2%	17.8%	18.0%	18.9%	18.2%
Average Employee Contribution Percentage for Family Coverage										
All Businesses	29.0%	26.5%	26.2%	26.0%	26.8%	23.7%	23.8%	23.2%	23.5%	24.7%
Small Businesses	42.1%	40.8%	30.7%	39.2%	29.4%	27.3%	27.6%	26.4%	25.3%	26.8%
Large Businesses	26.6%	24.5%	25.6%	24.5%	26.5%	22.9%	23.0%	22.6%	23.1%	24.3%

Source: Analysis of the 1999-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Table 2.15 shows that, in Texas, a company's contribution towards employee health insurance increased as the salary of the majority of workers increased. This is true for both single and family coverage.

Table 2.15: Average Employer Contribution Percentage per Employee for Single and Family Coverage by Wage Level

Percentage of Low-wage Employees	Texas				United States			
	2000	2001	2002	2003	2000	2001	2002	2003
Average Employer Contribution Percentage per Employee for Single Coverage								
50% or More	80.7%	79.8%	83.4%	84.0%	79.3%	78.3%	78.6%	79.0%
Less Than 50%	88.1%	85.0%	84.7%	85.2%	85.2%	84.1%	83.6%	83.4%
Unknown	80.5%	83.8%	82.4%	81.4%	81.2%	82.1%	81.4%	82.3%
Average Employer Contribution Percentage per Employee for Family Coverage								
50% or More	60.3%	61.0%	62.5%	67.8%	66.8%	68.7%	68.3%	70.7%
Less Than 50%	70.4%	70.2%	71.8%	71.7%	75.6%	76.4%	75.9%	74.3%
Unknown	79.2%	79.3%	78.4%	75.8%	78.9%	78.8%	78.5%	77.3%

Source: Analysis of the 2000-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Table 2.16: Average <u>Employee</u> Contribution Percentage for Single and Family Coverage by Wage Level

Percentage of Low-wage Employees	Texas				United States			
	2000	2001	2002	2003	2000	2001	2002	2003
Average Employee Contribution Percentage for Single Coverage								
50% or More	19.3%	20.2%	16.6%	16.0%	20.7%	21.7%	21.4%	21.0%
Less Than 50%	11.9%	15.0%	15.3%	14.8%	14.8%	15.9%	16.4%	16.6%
Unknown	19.5%	16.2%	17.6%	18.6%	18.8%	17.9%	18.6%	17.7%
Average Employee Contribution Percentage for Family Coverage								
50% or More	39.7%	39.0%	37.5%	32.2%	33.2%	31.3%	31.7%	29.3%
Less Than 50%	29.6%	29.8%	28.2%	28.3%	24.4%	23.6%	24.1%	25.7%
Unknown	20.8%	20.7%	21.6%	24.2%	21.1%	21.2%	21.5%	22.7%

Source: Analysis of the 2000-2003 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Of those employers who responded to the 2004 SPG small employer survey and who offer insurance to their employees, 55 percent require no employee contribution for employee-only coverage, down from 60 percent in 2001. Ten percent of the employers require employees to contribute less than $50 each month, and 16 percent of employees pay between $50 and $100 a month. Five percent of the employers report their employees contribute more than $200 a month towards the cost of insurance.

Employee Insurance Participation Rates

The small employer survey also indicates that the vast majority of employees offered coverage do participate, as approximately 55 percent of respondents indicated that more than 90 percent of employees offered insurance had accepted. Over 25 percent of respondents, however, indicated that at least 21 percent of those employees offered coverage had declined. In ten percent of cases, companies had over 50 percent of employees declining coverage.

As demonstrated earlier in Tables 2.6 and 2.7, take-up rates for full time eligible employees are 85.5 percent for all businesses combined, 81.4 percent for small firms and 86.3 percent for large firms. Part-time employees are less likely to accept coverage; only 48.3 percent of eligible employees in small firms and 72.5 percent of eligible employees in large firms accepted coverage.

Employers' Purchasing Decisions and the Economy (2.2-2.5)

Cost is the main reason small employers reported they do not offer health insurance benefits to their employees. Sixty-five percent of the 2004 survey respondents either assume that health insurance is too expensive or have tried to purchase health insurance and found it unaffordable. Another eight percent said they wanted to offer coverage but their employees are not able to afford their share of the premium. Other reasons provided for not offering coverage are: employees already have coverage (14 percent); the employer believes they cannot get coverage because an employee has a pre-existing health condition (three percent); the majority of employees prefer higher wages over health insurance (four percent); and providing health insurance is too much of an administrative hassle (1 percent).

Small employers who did offer health insurance were also asked how likely the company was to discontinue providing health insurance within the next five years. Eighteen percent said they were almost certain or very likely to discontinue providing health insurance benefits. Another 24 percent indicated that they were somewhat likely to discontinue. If an economic downturn or an increase in premiums were to occur, it stands to reason that those employers who are "somewhat likely" to discontinue might become "very likely" to discontinue coverage.

A review of CPS data indicates that the number of Texans with private insurance, including employment-based coverage, has decreased over the past five years after a gradual increase during the late 1990s. In 1995, 61.8 percent of Texans were covered under private plans, and by 1999 the figure increased to 64.5 percent. Since 1999, that figure has gradually declined; by 2004, the percentage had dropped to 59.2 percent, compared to a national rate of 68.1 percent. At the same time, enrollment in the state's Medicaid and CHIP programs has increased. Though CPS does not provide any explanation for the drop in private coverage or the increase in public coverage, the economic downturn and increasing health insurance costs are obvious factors.

Because our primary list of options for expanding coverage focused on private rather than public programs, crowd-out was not a significant concern. Though we know that some employees have enrolled their children in either Medicaid or CHIP rather than their employment-based insurance plan, we do not know the extent to which this has occurred. During the 2005 legislative session, lawmakers were concerned with increases in the number of children enrolled in CHIP/Medicaid who live with parents employed by firms that offer insurance coverage. However, little information is available to determine why the child was not enrolled in the employer health plan. In some cases, the parent is not eligible to enroll because he/she works part-time, or has not been with the firm long enough to qualify. In other cases, the cost of the employee's required contribution for dependent coverage is likely unaffordable.

In both the 2001 and 2004 SPG small employer surveys, employers were asked, "Since CHIP was implemented in 1999, have you seen a decline in the number of employees who cover their children under the health insurance plan offered by your business?" Responses were as follows:

Table 2.17: Decline in Child Enrollment in Employer-sponsored Plans after CHIP Implementation

Employers' Response	2004	2001
I do not know if any of my employees' children are covered under Medicaid or CHIP and none have indicated that they would prefer to be covered under an employment-based health plan.	66.4%	69.4%
I do know that some employees have children who are covered under Medicaid or CHIP, but I have not had any discussions with my employees about their preference.	13.8%	11.2%
Less than 5 employees have indicated to me that they would prefer to enroll their children in an employment-based health plan rather than Medicaid or CHIP.	6.9%	4.4%
Between 5 and 10 employees have indicated to me that they would prefer to enroll their children in an employment-based health plan rather than Medicaid or CHIP.	0.9%	1.0%
More than 10 employees have indicated to me that they would prefer to enroll their children in an employment-based health plan rather than Medicaid or CHIP.	0.3%	0.3%

Employers' Interest in Purchasing Alliances, Subsidies and Tax Incentives (2.6 – 2.7)

SPG employer survey results show that the overwhelming majority of small employers surveyed support the concept of small employer health purchasing alliances. Of the employers surveyed in 2001, 95 percent supported purchasing alliances, with 77 percent strongly supporting the concept. Purchasing alliances were also popular among employers who participated in focus group discussions throughout the state. In virtually every focus group discussion, at least one employer suggested the creation of a statewide purchasing alliance as a possible solution for the uninsured with a significant agreement among other focus group participants. In response, one of the suggested policy options included in the SPG 2003 report was expansion of purchasing alliances for small employers. Though purchasing coalitions have been allowed since 1993, few were formed due to certain statutory provisions and a lack of interest on the part of insurers. During the 2003 Texas legislative session, the Texas Legislature enacted new legislation which provides broader opportunities for purchasing coalitions and cooperatives among both small and large employers. Since the new provisions took effect, employers and insurance agents across the state have been working closely to develop new group coalitions and cooperatives, and others are in the process of doing so. TDI is working with insurers/HMOs, agents and employers to facilitate development of the new alliances and is encouraged by the interest shown thus far. Two coalitions in particular have aggressively pursued this new alternative and several large carriers have agreed to issue coverage. The number of enrollees and participating carriers is expected to increase as more experience becomes available. Additional information on these groups and the technical distinctions between coalitions and cooperatives and who may join is available at the Texas Department of Insurance website, at:

http://www.tdi.state.tx.us/company/lhcoopdefintyps.html.

On the subject of tax subsidies and tax incentives, limited information is available. Fifty-two percent of small employers surveyed in 2004 support subsidies and 43 percent do not. No specific question was asked relative to tax incentives, primarily because of the limited ability of the state to provide them (i.e., Texas does not have a corporate or personal income tax). However, the survey did address the broader issue of financial incentives to small employers. In the 2001 SPG survey of small employers, 84 percent of employers surveyed supported financial incentives, with 55 percent strongly supporting the idea. In 2004, support was even higher with 87 percent supporting the concept and 61 percent expressing strong support.

Other alternatives for motivating employers to purchase coverage have been discussed, including:

- Requiring all state contractors to provide health insurance to their staff in order to receive any state contract awards;
- Discounted rates for certain fees/licenses/permits for employers that offer insurance; and
- Publishing lists of employers who do/do not offer coverage.

None of the above mentioned suggestions have been enacted.

Section 3: Summary of Findings - Health Care Marketplace (3.1)

Though Texas has a healthy commercial insurance market, certain population groups have problems obtaining affordable health insurance. This is particularly true for people with pre-existing health conditions and low income individuals who do not have access to employer-sponsored coverage. For those who do purchase individual insurance, the coverage may be more limited in the scope of benefits than group insurance. However, to measure the extent to which coverage is "adequate" for one particular person or a group of people is a complex task, involving numerous data elements, including, but not limited to: the premium cost of the insurance; the individual's income level and personal expenses that impact the affordability of coverage; additional deductible and coinsurance costs and any other out-of-pocket costs associated with the insurance; the types of benefits provided and whether they meet the personal health needs of the individual; and accessibility of providers. Due to the complexity of measuring these variables, Texas did not attempt to collect specific data on the adequacy of existing insurance through SPG survey activities or focus group sessions. However, the issue of adequacy of coverage was discussed in general at every Working Group meeting, at both stakeholder conferences, and during most focus group sessions. Focus group participants in particular expressed frustration with the lack of affordable coverage for individuals with pre-existing health conditions and found it ironic that sick people who need coverage the most are also the group most likely to be refused coverage at any cost. While many focus group participants were aware of the availability of coverage for individuals with pre-existing conditions through the Texas Health Insurance Risk Pool, they also found the premiums to be unaffordable and felt their experience was fairly typical of many uninsured Texans.

Working Group members were somewhat less likely to agree on whether the existing marketplace offers adequate coverage for different income levels. Several members suggested that insurance plans are not only adequate, but have become excessively generous. They believe that much of the increase in health insurance costs is due to overly generous benefit plans that encourage unnecessary care and discourage consumers from using insurance wisely. Their suggestion for addressing insurance affordability concerns is to return to more traditional catastrophic benefit plans that provide reduced benefits and more significant cost-sharing requirements. In exchange for the reduction in coverage, these Working Group members believe insurance costs will significantly decrease, and more uninsured individuals and businesses will be able to afford coverage.

At the same time, other Working Group members argue that, while it is true most group policies in Texas are comprehensive and provide adequate, even generous, coverage for most people, there are clearly areas where they feel the coverage is lacking. This is particularly true in the individual insurance market. While Texas has a relatively healthy individual market compared to many other states, the cost of individual coverage is often unaffordable for much of Texas' uninsured population. Individual policies generally provide lower benefits compared to group plans, require higher out-of-pocket expenses, do not provide maternity coverage, and often exclude coverage that individuals with pre-existing health problems are likely to need. Several members of the Working Group and numerous focus group participants also expressed particular concern over the lack of coverage for mental health treatment and prescription drugs in both group and individual plans.

There is no doubt that Texans - both in the individual market and the group market - have a wide range of insurance choices. While there has been some consolidation in recent years, the health insurance market still remains highly competitive. Employers continue to have many policies and carriers from which to choose, and most continue to purchase policies with very generous, comprehensive benefit packages. However, a growing number of businesses, particularly small firms, are beginning to choose more restrictive plans and are shifting more costs to employees. While some employees can afford the higher costs, others cannot. The extent to which these trends affect the "adequacy" of coverage or the extent to which persons of different income levels may be affected by increases in costs is very difficult to determine.

When the Texas Legislature considered small employer group reforms in 1993 and 1995, lengthy discussion took place regarding the specific benefits that should be included in "standard" benefit plans. In 1993, the Legislature established certain specific benefit requirements for three standard health benefit plans in the small employer market. The law required TDI to adopt rules establishing the actual benefits that must be included. After considerable public and industry participation and discussion about adequacy of coverage, TDI adopted three benefit plans that provided varying levels of coverage and, in theory, offered employers a range of choices. However, these three plans were not at all popular, and the Legislature therefore eliminated this requirement in 1995 and replaced it with a provision that required insurers to offer standard basic and catastrophic benefit plans.

Again, TDI worked for months with providers, consumers and insurance industry representatives to establish new benefit levels for the two plans. Though initially there was widespread support for the final "basic" and "catastrophic" benefit plans, very few plans were sold. In an effort to determine why so few employers purchased the plans, employers, insurance agents and insurance carriers/HMOs were surveyed. Agents indicated employers did not want the plans, and said the reduction in rates was not significant enough to entice employers to purchase the plans. Carriers indicated that it was difficult to promote the plans since they varied significantly from their "standard" plans, and that employers preferred plans with full benefits over the "bare bones" basic and catastrophic plans. Employers reported they did not know the plans existed, despite the fact that state law required the plans be offered as an option to any employer purchasing coverage. Regardless of the reason, the standard plans did not attract large numbers of small employers, and in 2003, the Texas Legislature amended the law to discontinue the requirement that carriers offer basic and catastrophic benefit plans. Instead, carriers must now offer small employers a "Consumer Choice Plan" (CCP) which allows carriers and HMOs the flexibility to reduce or remove certain mandated benefits. The plans also allow for higher limits on coinsurance and deductible provisions. The plans are *required* to be offered to small employers, but may also be sold to large employers and individuals if a carrier chooses to do so. However, insurers and HMOs must continue to also offer benefit plans that include all mandated benefits, and must inform the employer/purchaser of the option to choose between the two types of plans.

While Texas, like other states, requires insurers to include certain "mandated benefits" in health insurance plans, carriers have a great deal of flexibility in customizing benefit plans to meet the specific requests and needs of their clients. In the past, the Texas Department of Insurance did attempt to collect information on the extent to which certain benefits were included in group

policies. The data reported by insurers and HMOs was inconsistent and yielded information of limited value, however, due to the complexity of comparing actual benefit levels. For example, the survey asked insurers to report the percentage of insureds covered under policies that provided certain benefits including: inpatient hospital, physician inpatient and outpatient coverage, home health care, prescription drug benefits, vision care, maternity coverage, family planning benefit, organ transplants, and other common benefits. However, without providing corresponding data on maximum benefit levels and cost-sharing requirements for each of the benefits provided, the data gives an incomplete picture of the extent to which people have adequate coverage. Although TDI attempted to design a more complex reporting format that would provide some of that critical information, the Department and industry representatives were unable to develop a survey instrument that would accurately reflect the many variables selected by employers. Without that information, it is impossible to reach any meaningful conclusions about the relative *adequacy* of coverage available other than to say that a wide array of products are available, and many benefit plans offer comprehensive benefits that should be adequate for most people.

Benefit Variations Among Groups (3.2)

Texas law requires insurers to include specific benefits and policy provisions in group and individual health plans, and all policy forms must be approved by the Texas Department of Insurance for sale in Texas. In a benefit comparison of fully-insured small and large employer health plans completed by TDI in March of 2000, the Department determined that most types of group plans provide many of the same benefits. Virtually all group plans (including the small employer basic and catastrophic plans, the HMO standard small employer plan, "typical" small employer indemnity and HMO plans, and "typical" large employer indemnity and HMO plans) included a wide range of coverage including physician or other health care practitioner services, hospitalization coverage, miscellaneous hospital services and supplies, anesthesia coverage, assistant surgery fees, outpatient services for emergency care, durable medical equipment, radiation therapy, inhalation therapy, chemotherapy, x-ray and laboratory services, maternity benefits, complications of pregnancy, physical therapy, occupational and speech-language therapy, home health care services, mammography screening, and numerous other benefits.

Despite the fact that most plans include very similar coverage, insurers generally have resisted efforts to standardize benefit plans. The small employer standard basic and catastrophic benefit plans were extremely unpopular, and insurers have indicated to TDI, the Legislature, and in public Working Group sessions that they prefer to market their unique company plans rather than sell standardized plans required by state laws. Insurers and agents indicate that they need the flexibility provided under non-standard plans, because these plans allow benefits to be adjusted as necessary or as requested by their clients.

Many of the provisions required of group plans also apply to individual plans, so to a large extent, both types of plans have many of the same benefits. However, individual plans often include higher deductible and coinsurance requirements and may exclude some of the benefits commonly provided in group plans. For example, benefits for maternity coverage and prescription drugs are not standard benefits for individual plans, but are provided in most group plans. However, one of the most significant differences in benefits provided under individual

and group plans is that individual policies often exclude coverage of pre-existing health problems that are generally covered under group plans. Numerous focus group participants indicated that they had attempted to purchase individual health insurance products, but they were denied coverage for existing health problems. The inability to find a policy that would cover these pre-existing conditions led several participants to decide against purchasing individual coverage.

As part of a review of mandated benefits for the Texas Department of Insurance, the actuarial firm Milliman and Robertson (now Milliman USA) conducted a survey to determine the extent to which self-insured plans covered mandated benefits required in fully-insured plans. Milliman's study revealed that 89% or more of surveyed companies reported full coverage for 10 of the 13 mandated benefits reviewed.[viii] Though no information was provided on other benefits, there is no data that suggests self-insured plans in Texas provide benefits that differ significantly from those provided under fully-insured plans.

Self-Insured Firms (3.3)

The Texas Department of Insurance estimates that approximately 5 million Texans are covered by self-funded plans. This represents about 40 percent of all Texans with private coverage, including both group and individual insurance. The most common concern raised with regard to self-funded plans in Texas is the fact that these plans are not subject to state premium tax requirements. As such, fully-insured plans are at a disadvantage since they must include premium tax payments in the premiums charged to their fully-insured clients. Insurers claim they are therefore unable to compete on a level playing field with self-funded plans, and they are concerned they may be losing business because of this inequity created under ERISA (Employees Retirement Income Security Act). In addition, because self-insured plans are not subject to assessments by the Texas Health Insurance Risk Pool, these costs are shifted entirely to fully-insured plans and the employers and employees who purchase them. Insurers have expressed growing concern with this inequity. In 2005, the Texas Legislature considered but did not pass a proposal for revising the assessment methodology that would have included self-funded groups by basing the assessment on the number of insured lives rather than premium volume. Future legislation on this issue is likely.

State Government Health Insurance Expenditures (3.4)

The State of Texas (including federal and state funds for public programs) is the largest single payer of health care services in the state and, as such, has a significant impact on the provision of health care services. The 2006-2007 General Appropriations Act adopted by the 79th Texas Legislature allocates a total of $25.4 billion for health-care services provided by the state in fiscal year 2006, and $26.0 billion in FY 2007. The two year budget of $51.43 billion is more than 20 percent higher than the FY 2004-2005 biennium, for which the state budget included $40.12 billion for health care-related spending. The budget includes funds for state and school employee health insurance programs, medical care of inmates in the Texas state correctional facilities, Medicaid, CHIP, and all other health and human services health care programs.

Safety-Net Provider Concerns (3.7)

Because so many Texans rely on safety-net providers for their health care needs, one of the primary objectives throughout the grant process was to do nothing that would negatively impact existing programs or hinder the work of safety net providers. This issue became particularly apparent while discussing the CHIP buy-in options. Several public health representatives pointed out that providers have already expressed extensive concerns over reimbursement rates and administrative burdens under CHIP and Medicaid, and any attempts to expand those programs must be coordinated with providers. At the same time, safety net providers are overburdened and cannot continue to adequately serve the uninsured without some assistance. If the uninsured population continues to grow, the safety net system will be further stressed. This is particularly true with regard to the mental health providers. Several inpatient treatment centers have closed within the past few years and the remaining treatment facilities report long waiting lists for patients. These issues must be considered and addressed if any expansion of insurance programs is to be effective.

Review of Other States' Programs (3.9)

SPG staff devoted an extensive amount of time to researching the experiences of other states' health care and health insurance programs. This information was presented in Working Group sessions, included in packets of information provided to Working Group members, discussed in committee and subcommittee meetings, and was posted on the SPG website. While this comparison provided some useful background and discussion material, many barriers were also identified that made other states' programs either impractical or unlikely for Texas.

(Note: Universal coverage was not an option considered as part of the SPG research activities.
No data is available on items 3.5, 3.6, or 3.8.)

Section 4: Options for Expanding Coverage

One of the primary objectives of the SPG project was to obtain information on the needs of Texas' uninsured population that could be used to develop specific proposals for expanding coverage. During the initial planning stages and throughout the research and policy phases, it was clear that no single approach would be effective in significantly reducing the uninsured. The challenge, therefore, was to identify a variety of options that could achieve widespread support and to provide reasonable alternatives for the state leaders, policymakers and legislators who will ultimately decide which options to implement.

Throughout the course of this project, SPG staff and Working Group members remained keenly aware of the diverse interests and needs of uninsured individuals and political subdivisions across the state and the importance of developing realistic options in a changing political environment. To add to the challenge, Texas, like other states, experienced significant economic changes during the course of the SPG study. Even before the tragic events of September 11th, the Texas economy showed signs of slowing down, raising concerns among some Working Group members that options for expanding health insurance would likely need to be limited to those that do not require additional state funds. In addition, successful outreach efforts for the state's Children's Health Insurance Program resulted in a significant increase in enrollment of children in both Medicaid and CHIP, leading to higher costs and increased demand for services under both programs. These factors, coupled with increasing budget concerns after September 11th, had a significant impact on the policy options that were realistically available for expanding health insurance. Although much of the initial discussion focused on options that would not require additional state funding, the primary focus of the work completed since October 2001 was limited almost entirely to private/public partnerships and other options that require little if any state funds.

As indicated in the SPG grant application materials, one of the primary goals of the SPG program is to provide states an opportunity to collect data and information previously not available that could be used to develop options for expanding health insurance. The research activities, surveys and focus group sessions conducted under the Texas study were specifically designed to fill in gaps of information that are important in developing insurance expansion ideas specifically designed for Texas. However, the initial 12-month time period presented significant challenges that were difficult to overcome. During this relatively short time period, states were required to develop survey instruments, contract with vendors, field surveys, analyze survey results, and issue a detailed report on all research findings. These time constraints clearly impacted the effective use of the survey data in developing policy options, providing opportunities for public review, and developing a consensus for support of specific expansion ideas.

However, recognizing that we could not wait for finalized data to begin discussions about insurance expansion options due to time constraints, the SPG staff and Working Group members began researching other states' programs and developing background information on a wide range of options early in the process with the understanding that the viability of the options might be affected by the survey results. Initially, any and all ideas for expanding coverage were open for discussion. Working Group members were provided a notebook with extensive

information on all options prior to the first meeting at which they were discussed, and materials were placed on the SPG web-site for others to review. In addition, public meetings were held to present and discuss information on more than 20 different policy options that included a wide range of ideas. These included: creation of a state-supported purchasing alliance for small businesses; Medicaid and CHIP expansions to include low-income parents; restructuring of Medicaid benefits to expand coverage to additional people; establishment of a CHIP "buy-in" program; opening enrollment in the state employees' insurance plan to small businesses and/or individuals; creation of small employer tax incentives; mandating insurance coverage for businesses and individuals under contract with the state; providing subsidies for enrollment in the Texas Health Insurance Risk Pool; low-wage worker subsidies for small businesses; development of an insurance education and information program for small businesses; development of a two-tiered premium system for the Texas Health Insurance Risk Pool to encourage enrollment of healthy family members; and revising the small group standard insurance policies to increase interest and affordability. (Note: an employer buy-in program under SCHIP was not considered by this group since the 77th Legislature directed that such a program be implemented by the state Health and Human Services Commission. Texas already has an employer buy-in program under the state Medicaid program.)

After discussing all policy options at two lengthy meetings, Working Group members were asked to indicate their level of interest in each option by rating them individually on a scale of one to five. Several members stipulated that they did not want their votes to be interpreted as support for or opposition to any particular option; rather, the votes were simply an indication of whether or not the discussion for an option should continue. The results of the Working Group survey appear on page 76.

During the remaining months of the project, attention was focused on three general areas that received the most support and appeared to be most logical based on the preliminary survey results: small employer insurance reforms; CHIP buy-in options; and education/information activities for individuals and small businesses. The actuarial firm Milliman USA served as consultant on the project and assisted in the development and analysis of specific options under each of the three categories. In January 2002, a statewide conference was held in Austin to present the project survey results and discuss the various options that had been developed, with presentations by the survey contractors and actuarial consultants from Milliman USA. The conference was widely advertised across the state and more than 200 people attended the two-day event. General feedback from conference attendees was very positive and encouraging, with many people expressing a desire to become more involved with this project. However, it was clear from discussions within the break-out sessions on the second day of the conference that attendees wanted additional work to be completed on the options presented before they could reach any consensus on how Texas should proceed. Most participants agreed that it was premature to reach any conclusions about what specific steps Texas should take at that time, particularly given the economic uncertainty and budget concerns for the next biennium.

During the following 18 months, the SPG staff continued working with stakeholders to refine and focus on specific options. Though the Working Group officially ended, several key members and legislative staff continued working with SPG staff. Additional research was completed under the Supplemental State Planning Grant, and several options were implemented.

Others were more fully developed and defined so that implementation may be seriously considered. The following is a brief overview of the policy options that received extensive evaluation and widespread support, and an update on implementation activities.

Small Employer Insurance Market Reforms

The majority of people with health insurance in Texas and throughout the United States obtain coverage as a benefit provided by their employer. In 2004, an estimated 53.2 percent of Texans were insured under employment-based plans. However, many working Texans are employed at firms that do not offer insurance, and many of these businesses are small firms with 50 or fewer employees. Small business employees and their families are about twice as likely to be uninsured as workers employed by large firms, and firms with 25 or fewer workers are even less likely to offer coverage than those with 25 to 50 employees. In 2003, approximately 41 percent of employees working in firms with less than 25 employees were uninsured. These workers represent 47 percent of the state's uninsured employees.

Numerous studies have examined the reasons why small employers do not offer health insurance. Factors most often cited include: unaffordable premium costs; the presence of pre-existing health conditions which make the group uninsurable; a high number of low-income workers; high employee turnover; and lack of interest among employees. While some of these problems are inherent in the nature of a small business, Congress partially addressed these issues in the Health Insurance Portability and Accountability Act (HIPAA) enacted in 1996. The Texas Legislature also adopted insurance reforms for small employers in 1993 and 1995. Both the federal and state laws apply to small firms with 2-50 employees. Among other things, the more significant provisions included were:

- Guarantee issue requirements for all groups, regardless of the health status of the group applicants;
- Rating restrictions that limit the extent to which insurers can increase rates for small firms;
- Authority to establish purchasing cooperatives that allow small firms to band together for the purpose of purchasing health insurance; and
- Creation of standard benefit plans that provide reduced benefits with the expectation that premium costs would be significantly lower.

While these reforms have helped increase the number of small firms that offer health insurance, many small employers continue to find that the cost of health insurance is unaffordable. Insurance enrollment information filed with the Texas Department of Insurance (TDI) indicates that 91,456 small employers provided health insurance benefits for their employees in the year 2004. Though this number is up significantly from 36,952 in 1993, it still represents only 26 percent of all small firms in Texas. Most small employers continue to not offer health insurance.

To better understand the reasons why small firms in Texas do not offer coverage, the TDI State Planning Grant program surveyed small employers in 2001 and 2004. The survey requested information on why employers do not provide insurance and what type of changes they would like to see implemented to make insurance more affordable and attractive to small business

owners. This information, along with suggestions provided by focus group participants and ideas from other states, directed the development of several options designed to address the low number of small employers with health insurance, which are summarized below.

1) **Improve the effectiveness of the two small employer standard benefit plans**

The basic and catastrophic benefit plans introduced in 1996 were extremely unpopular. Although these plans were intended by the Legislature to provide employers with a lower cost, limited benefit plan, rate information collected by TDI suggests that the plans are not significantly less expensive than the traditional comprehensive plans sold by carriers. Insurers report that employers are not interested in the plans, but information collected in the SPG survey of small employers indicates that 80 percent are not even aware the plans exist. Employers who participated in the focus group sessions also were not familiar with the plans. At the same time, numerous employers specifically suggested that the state should adopt a standard benefit plan to make it easier for small employers to shop for and compare insurance policies. As such, it is not clear whether the policies were truly undesirable, or if other factors were to blame for their failure. Some agents indicated that companies discouraged them from selling the standard plans, while others reported that they were unable to even obtain quotes when requests are submitted to the carriers. Other anecdotal information suggested that agents received lower commissions when selling the plans and, therefore, had no incentive to actively market them to their clients.

Regardless of the reasons, virtually all stakeholders agreed that the basic and catastrophic plans needed to be reconsidered. In 2003, the Texas Legislature agreed and responded by abolishing the two standard plans and authorizing insurers/HMOs to offer new Consumer Choice plans (CCP) that exclude or reduce coverage for certain mandated benefit requirements. The list of mandates which are subject to reduction or elimination was determined by the Legislature after considerable debate and varies somewhat for small group, large group, and individual products. Some of the benefits which may be excluded/reduced include treatment for acquired brain injury; coverage for AIDS, HIV or related illnesses; chemical dependency treatment, or telemedicine/telehealth services. In addition, carriers may also charge higher deductible and coinsurance requirements than are allowed under traditional plans. Insurers/HMOs are required to continue offering full coverage plans with all the mandated benefits, and must obtain written notice from a purchaser that verifies he/she is aware that they are buying a CCP that excludes some benefits.

Data collected in calendar year 2004 shows that 17,445 Texans were covered under the new Consumer Choice plans, including 4,283 people who were previously uninsured. Those numbers are expected to increase significantly in 2005 since many carriers/HMOs did not offer CCPs until this year. Cost savings reported by carriers vary widely. Most savings are attributed to increases in consumer coinsurance requirements rather than changes in mandated benefit coverages. Generally, carriers reported less than three percent savings due to mandated benefit exclusions/reductions.

Target Population: Small employers

Financing Source and Mechanism: Small employers and employees pay the full cost of the insurance

Logistical Requirements: The Texas Legislature has enacted legislation implementing changes in the standard small employer plans. TDI subsequently adopted necessary rules, and plans were available to consumers beginning January 1, 2004.

2) <u>Revise rating requirements for small employer health plans</u>

Insurers have generally strongly opposed any attempt to reduce their ability to underwrite and rate small groups based on the anticipated risk of each individual group member. While the definition of a large group varies from company to company, most groups with more than 50 people are sufficiently large to not be subject to the individual underwriting that smaller groups face. While the actual rating formulas and underwriting criteria used by insurers are closely guarded trade secrets, most carriers develop rate calculations based on several standard factors, including the applicant's age, gender, health status, the location of the group, and type of industry. Based on these different characteristics, insurers determine how much risk a particular applicant represents and calculate a rate accordingly. As a result, any one of these characteristics may result in a significant increase or decrease in a particular person's rate, even when they are part of a group. For example, in general, the older a person is, the higher the insurance rate that person must pay. Therefore, a 24 year old healthy male will pay considerably lower premiums than an equally healthy 50 year old male. Because of the ability to rate group members as individuals, insurance costs for small firms vary significantly based on the characteristics of the group members. As such, it is possible that a business with only eight employees may pay significantly higher insurance costs than a firm with 15 employees if the smaller business has employees who are older and/or less healthy than the employees at the larger firm.

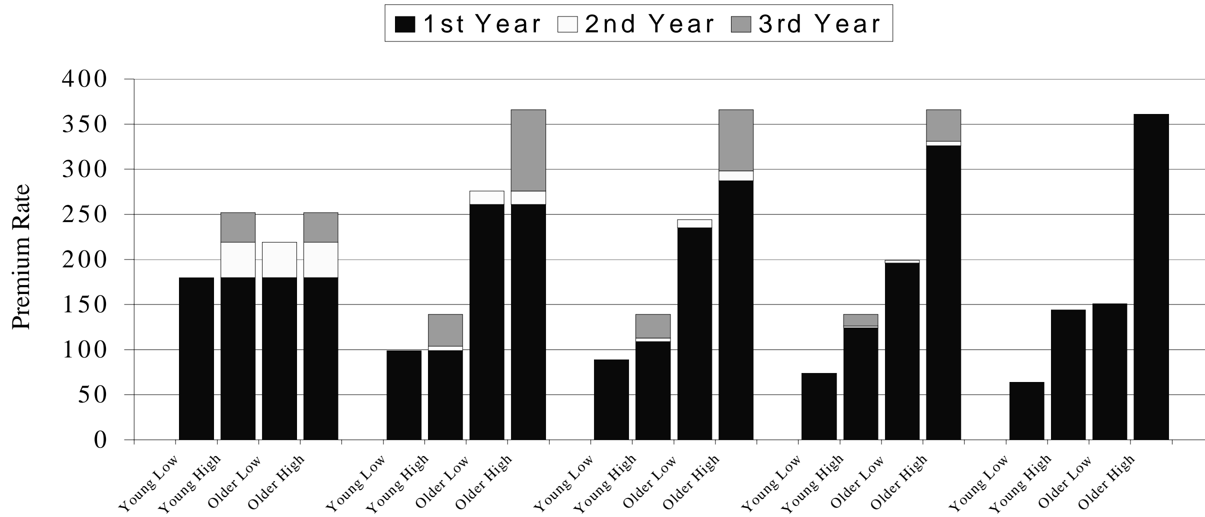
These disparities have led many states, including Texas, to enact rate reforms designed to limit wide rate differences within the small employer market. New York implemented a true "community rating" system that basically requires all insured people to pay the same rate, regardless of age, sex, health status, location, etc. Community rating generally lowers rates for high-risk individuals, while increasing rates for young, healthy applicants who are considered low-risk. For example, a 25-year-old healthy male pays the same premium as a 50-year-old unhealthy male. By spreading the risk equally across all people, the objective is to provide lower rates overall for more people so more people will purchase insurance. While this concept is appealing in theory, true community rating may not produce the desired affect. Because younger, healthy people will immediately experience significant rate increases, some will drop coverage rather than pay the higher rates required to subsidize the older, less healthy people. Over time, as additional young, healthy people fall out of the system, rates will continue to increase, causing still more people drop coverage. This creates an "adverse selection spiral" that ultimately results in such high rates that no one can afford the cost of health insurance.

Most states have implemented less extensive rating reforms with varying degrees of success. Texas law allows small employer carriers to adjust premium rates based on age, gender, area, industry and group size. Rates can also be adjusted plus or minus 25 percent on the basis of health status. When all the various factors are considered, the rate difference between groups

within the same class can be no more than 67 percent higher or lower. While this has lowered rates for some groups that previously were not subject to any limitations, some employers would like to see the rate bands limited even more. There is also some support for further restricting or even eliminating the ability to use health status factors in calculating rates.

Milliman USA examined the potential impact of four rating options. These options included community rating, modified community rating (which does not allow rating for health status), an allowed rate band of +/-10 percent, and the current allowed rate band of +/-25 percent. For each rating option, Milliman examined four different consumer groups: 1) young low risk; 2) young high risk; 3) older low risk; and 4) older high risk. To isolate the impact of the rating options, Milliman assumed that the expected cost of each group stayed the same for all three rating years (i.e. no medical trend). Assuming the groups that pay the greatest subsidy are the most likely to lapse, Milliman assumed that the young low risk group lapsed at the end of year one and the older low risk group lapsed at the end of year two. The community rated and modified community rated plans provided combined two-year rate increases of 40 percent. As discussed earlier, this can create what is referred to as an “adverse selection spiral” (i.e. as the community rates increase, the healthier risks continue to leave the “community” and over time the average rate gravitates to the highest expected cost groups). The increase under the rate band plans was 28 percent for the +/-10 percent rate band and 12 percent for the +/-25 percent rate band. Under the community rated plan, the young, low risk consumer group appears to subsidize the older, high risk consumer groups because the young, low risk group pays significantly more than their expected cost while the old, high risk group pays less than their expected cost.

Chart 4.1: Impact of Various Rating Requirements - Years 2 and 3 Rate Increases



	Community Rated	Modified Community Rated	+/- 10% Rate Band	+/- 25% Rate Band	Expected Cost
2nd Year Rate Increase	21%	6%	4%	2%	0%
3rd Year Rate Increase	15%	33%	23%	10%	0%
Combined 2-Yr. Rate Inc.	40%	40%	28%	12%	0%

In the SPG carrier survey conducted by Milliman USA, the largest group carriers supported less restrictive rate bands as a way of reducing overall rates. Though they agree that some small employers will pay higher rates, the carriers feel that many employers will experience lower rates, thus enabling some uninsured firms to purchase coverage. Carriers are opposed to any efforts to further restrict rate bands or underwriting requirements.

Target Population: Small employer groups

Funding Source and Mechanism: Small employer premium payments

Logistical Requirements: Legislation would be required to revise the current rating provisions and restrictions.

3) Create a small employer purchasing alliance

As part of the small employer health insurance reforms enacted in 1993 and 1995, Texas law authorized the creation of public and private small employer purchasing alliances. The Legislature also directed the state to establish a statewide purchasing alliance, which was created as the Texas Insurance Purchasing Alliance (TIPA). While TIPA experienced significant

success in the beginning, after five years the alliance dissolved due to a number of complex problems.

Despite the failure of TIPA, purchasing alliances remain an extremely popular option among employers and individuals who believe an alliance will provide significant cost savings. Small employers participating in focus group sessions throughout Texas have repeatedly expressed their desire to participate in a purchasing alliance. Ninety-five percent of the small employers who participated in the SPG small employer survey indicated they want a purchasing alliance, with 77 percent expressing strong support. However, most surveyed employers – 72 percent – also were unaware of the fact that Texas law already allows for the creation of private purchasing alliances. However, the original legislation was subject to varying interpretations and some confusion on the part of insurers and employers. As recently as 2003, only one fully-insured alliance existed in Texas, with approximately 2,700 total participants. Despite high interest among employers, insurers have generally shown little interest in working to establish private alliances. Carriers interviewed by Milliman USA as part of this study in 2002 were not interested in participating in any purchasing alliance, and they did not believe an alliance will produce the cost savings small employers expect.

In 2003, the Texas Legislature addressed some of the questions and concerns about the laws allowing purchasing alliances and clarified language to enable more employers to participate. They also authorized the formation of "coalitions" which are available only to small employers. While there are important distinctions between "cooperatives" and "coalitions" under Texas law, both allow multiple employers to join together to purchase insurance. As of August 2005, 14 cooperatives and coalitions were registered with TDI. Though some carriers have been reluctant to provide coverage to these groups, participation appears to be increasing as more actuarial experience becomes available and agents become more informed on how the process works.

Although employers expressed interest in large statewide or regional alliances similar to TIPA, such a program remains unlikely at this time. If in the future such an entity is again considered, the SPG analysis of TIPA and other state's alliances identified several key factors that should be addressed to maximize success:

- Involve agents and brokers from the beginning to assure effective marketing of the alliance;
- Limit the number of carriers allowed to participate in the alliance;
- Limit the number of health plan choices offered to a reasonable level that will allow for adequate enrollment and maximum administrative cost savings;
- Negotiate competitive rates with carriers;
- Implement strategies to reduce the risk of excessive adverse selection compared to the regular commercial market; and
- Invest in a strong marketing and advertising program in the initial phase of the program to assure employers are aware of the availability of the alliance.

Target Population: Small employers

Funding source and mechanism: No state money is necessary for a private alliance, which insurers or employers can establish under current law. If a statewide alliance is initiated similar to TIPA, the Legislature could fund initial start-up costs. However, private insurer funds could also be used to cover start-up costs. Once the alliance is in place, costs would be covered by premiums paid by small employers.

Logistical requirements: Legislation would be needed for the state to establish a statewide alliance.

Insurance Education and Information for Small Businesses and Individuals

Among the most common issues raised by focus group participants in 2001 and again in 2005 is the difficulty of purchasing insurance and a general lack of information available to assist them in understanding the choices available to them. Uninsured individuals and small business owners specifically requested that the state provide more consumer oriented information to help shop for health care coverage, and employers in particular wanted a rate guide to serve as a resource for comparing prices. To address these concerns, several options were developed to respond to these very specific requests for assistance. Following is a brief discussion of each option and an update on implementation status.

1) <u>Publish a small employer rate guide</u>

Both individuals and small employers complain about the inability to compare health insurance premium rates due to the huge variation in benefits and plan designs. Participants in focus group sessions expressed overwhelming need for a rate guide that would allow them to compare insurance prices. Several specifically referred to the Medicare supplement rate guide published by TDI and suggested that the state publish a similar guide for both individual and small group insurance. Employers stated they find it difficult and intimidating to shop for insurance, and would like to have a "non-biased" resource that would allow them to get at least a rough estimate of how costs compare among different carriers. While some employers stated they were pleased with their personal agent and felt the agent worked hard to get them the best deal, the general feeling among focus group participants is that most agents are trying to sell them the most expensive plan in order to maximize commissions. Without some means of comparison, employers have no way to evaluate or compare premium prices and have no choice but to rely on what the agent tells them. Employers also pointed out that the time they have to spend shopping for insurance is much more limited than a large company with a human resource department, and anything that can be done to make the process more simplified would be welcomed.

Small employers also complained that applying with several different companies for the purpose of comparing prices is not practical since agents/insurers will not provide a "final" price quote until the employer has submitted detailed health applications for every individual employee and dependents. The agent provides a basic rate quote based on a few group characteristics, but the final quote is not available until after the underwriting department has reviewed the application of each group member. Numerous employers felt that some agents deliberately underestimate the initial premium quote when they know the final quote will be significantly higher based on what

the employer has told them about the group. However, in order to get the final premium rate, the employer is required to pay at least one month's estimated premium at the time the application is submitted. Employers explain that they cannot afford to go through this process with more than one company at a time, thus making it difficult if not impossible to obtain price estimates from several different companies. Once they have gone through the lengthy and time-consuming process with one company, many employers do not have the time to re-start the process and are reluctant to terminate the coverage they already have, leaving them and their employees uninsured again while they continue to shop around.

While developing a rate guide poses some challenges because of the lack of uniformity among policies, several states have successfully developed guides using hypothetical individual and group applicants. Based on a review of those guides and using recommendations developed by Milliman USA, TDI developed a Texas small employer rate guide in the fall of 2002. The rate guide provides basic rate estimates for typical HMO, PPO and indemnity plans offered by small employer carriers, and includes cost estimates for the new Consumer Choice Plans. Insurers are provided guidelines for rate submissions using age, sex and geographic rating factors. Employers using the guide are provided instructions on how to use the rate quotes, and the limitations of these standard estimates. The information stresses that these are estimated rates, and employers' final rates will vary from the sample rates quoted in the rate guide. However, the guide allows employers to compare rates using standard factors, and provides employers a general idea of how much insurance costs and how rates can vary among different carriers. The small employer rate guide is updated regularly, and is available on the TDI website as follows: http://www.tdi.state.tx.us/consumer/serg01.html.

Target Population: Small employers with 2 to 50 employees

Funding Source and Mechanism: The production and publication costs of developing the rate guide and maintaining the web database are paid by TDI. Consumers who do not have access to the internet will be provided printed copies of the data upon request.

Logistical Requirements: TDI developed a format and process for collecting and reporting the rate information. Information is provided on the TDI website and will be updated on a regular basis.

2) Conduct local community "health insurance fairs" in cities throughout Texas

Small employers in particular wanted an opportunity to meet with representatives from the Texas Department of Insurance to discuss questions about their insurance or to get advice about how to shop for coverage. While TDI does provide consumer assistance through a toll-free telephone line and provides brochures by mail and through the agency's web-site, employers want something more personal that provides an opportunity to interact with TDI technical staff who can answer questions and discuss in detail the many questions employers have about health insurance.

During the fall of 2002 and summer of 2005, the SPG staff had an opportunity to host small business health insurance fairs as requested by employers. In conjunction with a separate SPG initiative to examine certain aspects of the local small employer health insurance market, SPG staff organized nine health insurance fairs in areas across the state. Though the health fairs' primary purpose was to provide a forum for small employers to meet with TDI staff and obtain information on health insurance options, they also were used to facilitate personal visits with local agents and insurance company representatives to discuss expansion and reform options for small employers, and local market concerns that impact employers' ability to obtain coverage. In addition to SPG and TDI staff, representatives from the local chambers of commerce, state CHIP program and the U. S. Department of Labor and the Small Business Administration also attended to provide information to employers. All health insurance carriers and HMOs that are licensed to offer small employer coverage were invited to attend to provide information packets and answer questions on insurance products for small employers.

Although the fairs required a great deal of planning and time, they were undoubtedly a significant success. Employers, agents and company representatives expressed overwhelming support for the insurance fairs. Many employers commented to SPG staff that they had been struggling to get information on health insurance options, and the fair provided them the chance to easily obtain the information they needed in one setting, without contacting several different carriers or agents. In most locations, agents and insurance carriers indicated they would like to work with TDI to organize and fund such fairs on an annual basis. The fairs provided an excellent opportunity for the state to collaborate with the business community and insurance industry, while providing a significant service for local employers.

The fairs also provided SPG staff with important information that was used to facilitate development of the agent survey. Conversations with agents provided a unique perspective on the local insurance market that frequently differed from information provided by insurance carriers. The opportunity to meet with agents was critical in identifying items of concern that were subsequently addressed in the agent survey.

Target Population: Small employers, with the possibility of expanding to individual consumers in the future

Funding Source and Mechanism: Depending on how the program is operated, the costs could be funded largely by fees paid by insurers and agents to participate in each fair. However, some state revenue would likely be required for staff costs, and to cover some expenses associated with the program.

Logistical Requirements: Although Legislation may not be required, the department needs legislative authorization to hold such fairs, and to spend state money for that purpose. Other state agencies participating in the events would need appropriations to cover the costs of staff who attend the fairs.

3) <u>Provide information to help consumers shop for coverage</u>

In addition to cost information, consumers expressed a desire for a comprehensive "shopping" guide that would walk them through the complex process of shopping for coverage. After talking to focus group participants in detail about what features they most needed, TDI staff developed a new website devoted exclusively to helping uninsured Texans find health insurance or, in some cases, options for low cost or free health care services. The website takes the consumer through a series of questions designed to help them determine what type of coverage they need, and whether they may be eligible for various types of public coverage. The site is reviewed regularly and updated frequently to add new information. Direct links to fully insured private insurance products are provided as well as information and links to a large number of public and private programs. The website can be accessed from the TDI homepage, or at www.TexasHealthOptions.com. Both English and Spanish versions are available.

CHIP Buy-In Options to Expand Coverage to Parents

Texas currently has more than 850,000 uninsured adults age 19 or older with incomes between 0 and 100 percent of federal poverty level, and nearly one million uninsured adults between 100 and 200 percent FPL. Most of these adults are employed or live in a household with an employed adult, but for a variety of reasons they do not have health insurance. They also do not usually qualify for Medicaid or any other public program, and their low income seriously limits affordable options. As such, identifying options to assist this population is particularly difficult.

Early in the SPG review process, a majority of stakeholders and working group members supported expanding insurance coverage to low-income adults through a CHIP "buy-in" program. Through administrative efficiencies and the purchasing power generated from pooling with subsidized programs, CHIP buy-in programs have the potential to provide coverage to thousands of adults who cannot afford coverage in the commercial market. However, the success of a buy-in program and the extent to which it increases affordability depends largely on how the program is designed.

To qualify for federal funding for a CHIP buy-in program, states must comply with extensive federal requirements. If approved, the programs provide substantial subsidies to expand coverage to adults, but the state must still provide the required matching rate. These funding and administrative requirements present significant challenges for many states, but the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative offered by the Centers for Medicare and Medicaid Services (CMS) provides more leeway to states in designing programs. To avoid entirely the federal requirements and restrictions, states also have the option of implementing "full-cost" buy-ins that receive no federal funds but also do not require federal approval, or they may subsidize the plans with state-only funds. The advantage to such a program is states have complete control over the benefit plans, premium and co-pay requirements, eligibility provisions and other plan elements. The obvious disadvantage is the state does not receive the generous federal contribution.

The Texas SPG Working Group discussed the benefits and disadvantages of both a full-cost buy-in and a subsidized buy-in using both state and federal funds, as well as a state-only subsidized program. The buy-in option was also presented at the state conference and was the subject of

three separate break-out sessions. While there was a great deal of interesting discussion and debate about how such a program could be implemented in Texas, there were also a number of concerns raised. For example, numerous participants pointed out that the state has encountered some difficulties negotiating rates with current providers in order keep them in the program. If the program were expanded to include adults (full-cost or subsidized), the state may have problems finding enough providers to serve the added population without significant reimbursement rate increases. Several people also commented that CHIP is already growing at such a rapid pace that it is premature to consider adding adults. Others felt that Texas should focus more on locating and enrolling uninsured children who are eligible for but not enrolled in CHIP before we consider expanding the program to adults.
The most difficult problem identified, however, was how to fund the state's contribution required for a state/federal subsidized buy-in. While there were many who strongly advocate maximizing our ability to use federal money, the fiscal outlook at that time was not conducive to expanding coverage in any way that required additional state funds. Despite high interest, budget deficits in the subsequent legislative sessions precluded any consideration of a CHIP expansion proposal.

The possibility of a CHIP buy-in remains an option for which there is still considerable interest in the future under more favorable economic conditions. It should be noted that 94 percent of the non-poor uninsured participating in the SPG household survey indicated that CHIP should be expanded to include more children and certain low-income parents. Small employers also supported expanding CHIP with 78 percent favoring a plan that would allow children to buy-in to the program by paying a premium. Fifty-six supported a plan to expand coverage to parents of children enrolled in CHIP, and 71 percent favored a plan to expand the program to include children above 200 percent FPL.

During the 2001 Texas legislative session, the Legislature directed that a study be conducted to determine the feasibility of expanding CHIP to include adults. The SPG staff coordinated efforts with the Health and Human Services Commission to develop the necessary information. Under SPG contract, the actuarial firm Milliman USA developed extensive data and program design alternatives. The detailed information is included in the report to the Legislature, "Family Buy-In Option for the Children's Health Insurance Program", November 1, 2002, which is available at http://www.hhsc.state.tx.us/chip/reports/02-11_HB835_CHIP.html.

Implementation Activities (4.17)

The 78th and 79th Texas Legislatures considered a number of proposed bills that would make changes to the benefit plans available to small employers. Legislation was enacted to expand options for the creation of both small and large employer health insurance purchasing cooperatives. Several bills were enacted to address concerns expressed by agents regarding carrier activities that may discourage agents from writing certain small groups. The Legislature also created the new Consumer Choice Benefit Plans that allow insurers to offer flexible insurance plans that exclude or reduce coverage for certain mandated benefits. No legislative action was expected or enacted to expand the CHIP program to include either additional children or certain low-income adults. As discussed earlier, TDI has already developed the small employer rate guide and created a new website that assists Texans looking for health insurance

or health care coverage. The Department also organized and sponsored small employer health insurance fairs in 2002 and in 2005.

While the most significant challenge to this entire process has been financing and the lack of funding for any state expansion effort, other barriers also remain. Shopping for insurance continues to require a great deal of time and effort as reported by most employers, but simplifying the process will likely draw resistance from most carriers. Standardized benefit plans and application forms have both been discussed as alternatives that employers desire but carriers oppose. Rate regulation in any form also is generally opposed by carriers, but can be an effective way of controlling costs for many employers. At the same time, the regulations that lower costs for some high-risk employers may also increase costs for some low-risk employers. The challenge of creating a program that is both fair to employers and insurers is significant, and all options must be carefully evaluated to avoid unintended consequences.

TDI recently was notified that HRSA approved Texas' request for a Pilot Project Planning Grant. The new grant will allow the state to develop a unique small employer health insurance program for uninsured workers in the greater Houston metropolitan area. The project will use data collected in SPG surveys and focus groups and local health care utilization data to design a benefit plan that reflects the health care needs of small employers and their workers. Insurers, actuaries, providers, small employer business representatives, employees, and local community leaders have agreed to participate. A variety of financing options for low income workers will be considered and programs developed in other states will be evaluated for features that may be applicable to this program. Local and state legislative leaders and policy makers will play a key role. Once developed the plan eventually will be implemented statewide if successful in Houston. The planning phase will be completed in August, 2006.

Policy Options Not Selected (4.18)

Policy options not selected by the Working Group included: restructuring Medicaid and CHIP benefits, using savings to expand coverage to other populations; an expansion of Medicaid managed care; expand Medicaid and CHIP in those counties that volunteer to leverage local funds currently used in the County Indigent Health Care Program to draw down more federal money; expand small employer market to include "groups of one;" create a standardized individual insurance policy; require insurance policies sold to employers to include part-time workers; allow small groups to obtain insurance through the Texas state employee insurance plan; provide low-wage worker subsidies for insurance premium payments; require insurance for all companies contracting with the state.

Several primary factors contributed to the decision not to pursue these options. Restructuring Medicaid and CHIP and the option to expand the programs in counties that agreed to leverage funds presented significant administrative and political challenges. Texas recently completed a significant reorganization of the Medicaid program, and most people agreed that this is not the best time for attempting additional changes within that program. There also was concern that a restructuring of Medicaid/CHIP benefits would meet significant resistance from providers and consumer advocates due to fears that important benefits could be eliminated or reduced.

Providers also have expressed objection to an expansion of Medicaid managed care due to concerns that reimbursement rates will not be adequate.

The options to expand the small employer market to groups of one, the creation of a standardized individual insurance policy, and the requirement that policies cover part-time workers were not supported by the insurance industry and were not strongly supported by any particular stakeholder group. Politically, they would have presented significant challenges. The remaining options also were not strongly supported by the Working Group due to the administrative complexities that would be involved, the potential for significant costs to the state, and the political resistance they likely would have encountered.

Public Program Enrollment Efforts (4.19)

Prior to the economic downturn and budget deficits faced by the Texas Legislature in 2003, the state engaged in an extensive outreach effort to enroll individuals eligible for but not enrolled in either CHIP or Medicaid. The TexCare Partnership program developed an extremely popular advertising and outreach program that works with local communities to reach families that may be eligible for enrollment. The campaign includes television and radio advertising, posters, brochures distributed through public schools, as well as local outreach efforts through churches, county health departments, shopping centers, physician offices, and other public locations. The state also worked with members of the Texas CHIP Coalition to coordinate outreach with a large number of stakeholder groups interested in promoting the program. The outreach campaign received high praise for its success as was evidenced by the steady increased enrollment in CHIP. Enrollment and renewal rates continued to outpace projections with more than 530,000 children enrolled in 2003.

However, while the state is proud of its success in CHIP enrollment, the increase in enrollment coupled with increased medical costs resulted in significantly increased costs to the state at a time the state faced a budget shortfall of $9 billion for the FY 2004-05 biennium. In response the state reduced its advertising campaign for the CHIP program. Though the state has begun a more aggressive outreach effort in recent months as the budget situation has improved, the enrollment efforts remain scaled-back relative to the initial days of enrollment.

Texas SPG Policy Options:

Levels of Interest by Working Group Members, October 2001

(Options Sorted by TOTAL SCORE)

Policy Option Description	Level of Interest *						Total Score	Avg. Score
	1	2	3	4	5	N/A		
Inform Public of Recent Insurance Reforms	1	0	0	1	19	0	100	4.76
Minimize Language Barriers in CHIP/Medicaid	2	0	1	6	13	0	94	4.27
Group/Individual Health Insurance Rate Guide	1	0	2	5	13	1	92	4.38
Small Employer Purchasing Alliances	0	1	2	7	11	1	91	4.33
Create Standardized Insurance Plan for Individual Policies, With Rating Guide	1	2	4	5	10	0	87	3.95
Small Employer Incentives	1	0	3	4	12	2	86	4.30
Coordinate Medicaid/CHIP Enrollment to Maximize Enrollment in Both Plans	2	0	1	4	12	3	81	4.26
Incentives to Encourage State Contractors to Provide Health Insurance	2	4	5	5	6	0	75	3.41
Health Insurance Risk Pool Premium Reduction	2	1	4	3	9	3	73	3.84
Small Employer Market Expansion to Include Self-employed Businesses	3	2	6	4	6	1	71	3.38
Medicaid and CHIP Expansion in Counties Volunteering to Leverage CIHCP Funds	3	0	1	6	8	4	70	3.89
Risk Pool Sliding Scale Premium Subsidies	2	0	4	4	8	4	70	3.89
Reduction in Health Insurance Risk Pool Premiums for Dependents	2	1	4	7	5	3	69	3.63
Allow Families to Buy-in to CHIP Program	3	2	4	6	5	2	68	3.40
Low-wage Worker Subsidy	3	2	3	4	7	3	67	3.53
Restructure CHIP and Medicaid Benefits, Use Savings to Expand Coverage	4	1	6	3	6	2	66	3.30
Texas State Employee Insurance Plan Buy-in	4	5	6	2	5	0	65	2.95
Medicaid Managed Care Expansion	3	3	0	5	7	4	64	3.56
Mandatory Insurance Requirement for State Contractors	10	4	2	1	4	1	48	2.29
Require Coverage of Part-time/Temporary Workers	8	3	4	2	2	3	44	2.32

* Working Group members ranked their level of support on a scale of 1 to 5, with 1 meaning “no interest” and 5 meaning “strongly interested.” The numbers in columns 1-5 reflect the number of individuals who registered votes for each score. Votes were classified as “N/A” when a Working Group member elected not to vote on a particular policy option.

Section 5 - Consensus Building Strategy *(5.1-5.4)*

When designing the original grant implementation plan, Texas developed a comprehensive list of stakeholders who are actively involved in areas related to insurance and health care expansion efforts. Each of those individuals and interest groups was contacted and invited to serve as a member of the Oversight and Implementation Working Group. Everyone contacted agreed to participate, and subsequently provided letters of support which were included with the grant application. The Working Group included the Governor, Lt. Governor and Speaker of the House of Representatives; members from both the House and Senate; the director of the Legislative Budget Board; executives from the largest state agencies involved in the provision of health care in the state (such as the Texas Department of Health, Health and Human Services Commission, the state Medicaid program, the state CHIP program, as well as others); consumer advocacy group members; physician and hospital representatives; insurance industry representatives; and employer representatives.

After the initial organizational meeting, the Working Group members as well as other interested parties received regular updates and information packets. Four Working Group meetings were held prior to the statewide conference on January 31 - February 1, 2002. All meetings were very well attended with an average attendance rate of more than 80 percent.

Because the involvement and support of the entire Legislature is critical to the success of this project, the SPG staff communicated regularly with all members of the Legislature, not just those members who serve on the Working Group. Regular mailings and informational packets were distributed and several legislators became active participants in the SPG activities.

While the Working Group members as individuals worked extremely well together, the ability to make decisions was hampered by the limited amount of time provided under the project. As has been described earlier in this report, 12 months was not enough time for staff to prepare the level of detail on policy options that would enable this diverse group to reach consensus on which options the state should pursue. We would not, however, suggest any changes in the Working Group structure.

To involve citizens across the state, a press release was sent to hundreds of newspapers and periodicals throughout the state announcing the grant program and inviting interested parties to either contact TDI for information or follow the project through our web-site. Throughout the SPG study, all Working Group meetings were officially posted and publicized through the Texas Secretary of State's Office as open meetings, and notices were provided to all individuals who had attended previous meetings. Meeting information was posted on the SPG web-site, and e-mail notices were sent to anyone who requested to be informed. The SPG web-site also requested comments and feedback, and a process was implemented to assure that a response or acknowledgement was sent to all commenters. All surveys mailed also included information on how respondents could participate in the project.

Input was also obtained through focus group sessions held with small employers and uninsured Texans in 20 different cities across the state. Focus group sessions were publicized through a

variety of means, including newspaper stories and advertisements, posters, mailings, and contacts with local providers of health services for the uninsured. Two separate surveys also were used to obtain significant input from small employers and uninsured individuals. Agent and insurance carrier input was obtained through two separate surveys, telephone interviews and meetings with representatives of the two groups.

Finally, a statewide conference was held on January 31 - February 1 that was widely advertised across the state. More than 200 people attended the conference, which provided detailed information on the SPG research, focus group and survey results, and the policy options under review. Nine breakout sessions were held to discuss the different options and obtain feedback from attendees. Under the Supplemental State Planning Grant, a stakeholder consortium was held in May 2004, and more than 100 people attended the event.

Because Texas is an extremely large and geographically diverse state covering more than 250,000 square miles, distance precluded many interested people from actively participating in this project. As such, the SPG staff relied greatly on the project web-site and information distributed by Working Group members to build awareness across the state and to provide timely information as the work progressed. Local press releases were issued periodically to provide information on focus groups, insurance fairs, and other activities or accomplishments under the SPG project. E-mail notices and updates were sent on a regular basis to interested stakeholders. The director also made a number of speeches and presentations to groups across the state and to various legislative committees.

The activities of the SPG project have been widely embraced by state leaders and policymakers as an excellent opportunity for Texas to obtain some valuable and badly needed information that is critical to understanding the uninsured population. Though numerous attempts have been made in recent years to study this problem and develop solutions, most of those studies had little data to use in guiding the decision-making process. This grant provided the chance to obtain meaningful data from the uninsured population and from employers who desperately want to provide insurance.

While the policy environment is very receptive to recommendations for expanding insurance coverage, the reality of the economic limitations faced by the state indicate that any expansion of public programs is unlikely at this time or in the near future. However, several options that do not require large sources of revenue from the state have already been implemented and others are still under consideration.

Section 6: Lessons Learned and Recommendations to States

Texas-specific data was critical in the design and development of policy options. While national CPS data was useful for demographic information, detailed data obtained through the household survey and the employer survey significantly affected the discussion process and directed the development of policy options that are under consideration. Conference attendees in particular were extremely pleased to see the survey information, and they voiced their plans to take the data back to their communities and local collaborative groups to use in their planning process. The qualitative data obtained through the focus groups was extremely critical to the process and provided some of the most useful insight into what employers want and the problems they faced in shopping for insurance. Several of the most popular policy options would never have been considered without the qualitative research.

Perhaps more importantly, however, is how meaningful data can change pre-conceived notions and perceptions about the uninsured. Several Working Group members and conference attendees specifically stated that their personal attitudes towards the uninsured were changed as a result of the empirical evidence provided by the surveys. The data was particularly relevant to the discussions of the importance of affordability and the significance of considering income limitations when designing realistic expansion options. The importance of the data collected under the SPG program and its ability to affect attitudes and perceptions emphasizes the need for a long-term strategy to collect and analyze information on the uninsured in Texas.

Data Collection Strategies (6.2-6.4)

The Texas project conducted all the original data collection activities that were proposed. In addition, a telephone interview/survey of carriers and a survey of agents were also added to the original plan, and were completed during the 12 month extension period under the grant. Under the additional supplemental grant, Texas completed the 2004 small employer survey and three surveys related to student health insurance coverage.

The focus group sessions with the uninsured and small employers and the statewide survey of small employers clearly provided the most useful information. While the focus groups were costly, they also presented some of the most compelling experiences and provided qualitative information that simply could not be gathered through a survey. The focus groups also provided an excellent opportunity for local communities to become involved in a way that would not have otherwise been possible. Local legislators were also appreciative of the efforts to include their constituents in this process.

The small employer survey was equally important in shaping policy options for small businesses, and emphasized the need for extensive change in order to see significant results. The premium cost data in particular gave new meaning to the concept of an “affordable” health plan and enabled working group members to put costs into perspective. As the cost of health insurance for employees averages $3,000 or more a year for employee-only coverage, it was crucial to know that more than half the surveyed employers could pay $1200 or less. Only three percent of the small employers indicated they could afford $3,000 a year. These numbers brought both a

stark reality and focus to the discussion as we evaluated options for providing affordable coverage during a time of massive state budget cuts and a slow economy.

Though it is hard to measure which specific strategies had the most effect on improving response rates, this issue was given serious attention for all data collection activities. For the employer survey, the decision to pay for return postage and the use of a custom-designed answer sheet that greatly simplified the response process were likely two of the most important factors. We also gave strong consideration to privacy concerns and, though we did ask employers to provide zip codes, we did not request any other information (i.e., name or respondent, business name, address, phone number) that might discourage employers from responding. We also provided very specific information about how the data would be used, and promised employers that the complete survey results would be compiled into a report they could obtain from the SPG web-site.

To increase focus group participation, we also recognized the importance of offering a financial incentive. While state regulations prohibited the Department of Insurance from paying focus group participants directly, the contractor that conducted the sessions did not have this limitation. As such, all focus group attendees received a $25 money order and were provided breakfast, lunch, or dinner depending on the time of day their session was held. While the money did not seem to be a primary motivator for small employers, it probably paid a significant factor in recruiting individual participants.

Additional Data Collection Needs (6.5)

Texas would benefit greatly from additional data to address differences in attitudes towards insurance options and preferences among the Hispanic and non-Hispanic populations. Information obtained from some focus group participants and the household survey suggest that different approaches may be needed to attract Hispanics to participate in both the public and private health insurance programs now available. However, resources are not available to conduct this research.

Key stakeholders also expressed a strong desire for regional data on the cost of caring for the uninsured, how those expenses are paid, the services that are provided, and the extent to which the costs are subsidized by the insured. Employers and insurers in particular expressed concern that the cost of caring for the uninsured is shifted to the insured through higher medical costs, which result in higher insurance premiums. But no data exists to measure or even roughly estimate the extent to which that might be occurring.

A third area for potential research activity is large employers. While uninsured individuals are much more likely to work for small firms than large firms, nearly one million uninsured Texans work at large firms. Though many of these individuals may be seasonal or contract workers, little is known about their income, why they are uninsured, or the firms' policies towards part-time or temporary workers. This information would be useful to determine how to best assist this population of uninsured workers. Again, however, due to lack of funding, the State does not plan to conduct this research.

Lessons Learned (6.6-6.7)

Because the focus of the SPG project was on collecting data and developing policy options for expanding insurance coverage, the project did not specifically consider changes to the structure or coordination of healthcare programs. Last year, the Texas Legislature restructured the entire Health and Human Services system, including significant operational changes in the oversight and coordination of the state's Medicaid and CHIP programs in order to improve services and streamline administrative functions of all health-care related activities. The state also adopted a simplified joint application form that is used for both CHIP and Medicaid. Both the Governor and the Legislature have demonstrated a commitment to maximizing the efficiency of these operations in Texas to provide the highest quality of care for all program participants. While there are numerous areas at the local community level where the coordination efforts of health care programs could benefit from improved collaboration and structural changes, those topics were beyond the scope of this project.

One of the most beneficial aspects of the SPG activities has been the opportunity to bring many stakeholders together to address the problems of the uninsured. While both the insurance industry and employers have strong feelings about what should and should not be done, both groups expressed a willingness to consider the problem with an open mind. The exchange of information between the two groups and other stakeholders who participated in the process was both educational and encouraging. However, the stakeholders who participated in this process may not be representative of other employers and insurers across the state. One of the questions that remains unanswered is how others who were not involved in this process and who do not have the benefit of the survey and research data will respond to the options under consideration.

Recommendations to Other States (6.8)

- Begin the data collection activities as early as possible. Do not underestimate the amount of time that is required to complete large survey activities and allow plenty of time to complete your analysis so the data can be used to influence policy options.

- Use the experiences of other states to help you in your project. Talk to states about their experiences with surveys and focus groups to assist you in planning your own research activities. Learn from their mistakes and successes.

- Involve legislators to the greatest extent possible. Provide them with regular updates, invite them to your meetings, send them copies of your research reports, and encourage them to keep up with the activities of your group. They will appreciate your efforts to keep them informed and will generally be more aware of the uninsured issue and the challenges of expanding coverage.

- Focus group activities require extensive amounts of time and effort that are difficult to anticipate. If possible, work with a contractor to assist in your efforts.

- Include both insurance carriers and insurance agents in any discussion or research related to the private insurance industry. While the two work together, they often have different,

and sometimes conflicting, ideas about changes they would support or oppose. Agents are also critical to many expansion efforts and offer a different perspective than the carriers.

Project Challenges (6.9)

Although George W. Bush was governor at the time Texas submitted its SPG application in July 2000, strong support for the project has continued under the administration of Governor Rick Perry. While the political environment obviously experienced some changes under the direction of a new leader, those changes were not significant to the scope of this study.

Changes in the economic environment have certainly had an impact on this project. Although the project focused considerable attention on expanding coverage through the private market from the beginning, the economic downturn and projections of budget shortfalls required an even greater focus on options that do not involve large outlays of state funds. The realities of the current budget limitations have certainly impacted the discussion of options and discouraged consideration of some options that might have generated more interest under a different economic environment.

Due primarily to the time constraints of the initial 12-month study period, the changes in economic conditions, and the difficulty of executing so many survey activities within a short time frame, the SPG team realized that obtaining consensus within the time provided was unlikely. While the goal of reaching consensus was never dismissed, the expectations were adjusted to develop a list of options for consideration rather than a final list for adoption. We determined that we could jeopardize the progress made thus far by trying to impose a vote of consensus, and ultimately decided that an acknowledgement of the accomplishments to date and a continued move towards consensus was a more reasonable goal.

Next Steps

The Texas Department of Insurance recently received a new Pilot Project Planning Grant to continue work begun under the SPG program. The new grant will allow Texas to develop a small employer program for Houston-area uninsured workers, using the data and information obtained from SPG research activities. While working on the new planning activities, grant staff and other Working Group members will continue working with stakeholders and legislators throughout the state to further consider and refine the options developed during the SPG process. Several presentations are scheduled in the next few months to discuss activities under the Grant, which will allow further discussion of these initiatives and an opportunity to involve more stakeholders in this ongoing process.

Section 7: Recommendations to the Federal Government

Over the course of this study, several issues related to federal government restrictions or practices were discussed that, if addressed, could assist states in their efforts to expand insurance coverage. Though not developed in any great detail, following is a brief listing of suggestions for consideration:

- Depending on the how the CHIP buy-in option is structured, a Federal waiver may be required if a state-federal subsidized plan is selected. However, we do not know at this time of any specific changes in federal law that would be required for any of the options under consideration.

- On several occasions during the course of the initial grant study, the SPG staff and Working Group noted that a lack of data discouraged an in-depth review of some options. This was particularly true with private market reforms. While the Medical Expenditure Panel Survey (MEPS) data did provide some useful information, the data would be more useful if provided in a more timely manner. In addition, restrictions on the ability of states to access the data due to privacy concerns severely limit the extent to which detailed reports can be created. However, we note that the Federal government has since reviewed the process by which MEPS data is provided to states and is working to provide more timely data.

- In addition, while a one-time survey is useful and provided very valuable information for Texas, most surveys need to be repeated in order to be of any long-term use. This is particularly true in view of the recent economic shifts. The Federal government should consider providing funds for states to repeat survey activities initiated under this process, with the goal of establishing a long-term funding process specifically for the purpose of state-level surveys.

The availability of timely, comprehensive data is critical for states when considering policy options and developing budget projections for proposed expansion activities. The lack of such information can seriously impede the progress of some activities, as legislators are reluctant to fund any program without accurate cost projections. Development of any survey activities that would provide timely demographic data on the uninsured would be particularly useful. While CPS data is helpful, it does not always provide an accurate picture at the level of detail states need for budget analysis.

Another area of research that would be useful is a comprehensive study of the effects of ERISA on the regulated insurance market (particularly the small employer market) and the impact of lost revenue to states due to the inability to collect premium taxes on self-funded ERISA insurance plans. Insurers are particularly concerned with their inability to compete with self-funded plans and commonly raise this argument when testifying against legislation that imposes any additional benefit requirements on fully-insured plans. Self-funded plans are also exempt under ERISA from paying assessments to fund state high-risk pools. As a result those costs are born solely by the employers and employees who purchase coverage in the fully-insured commercial market.

Finally, creation of a joint federal/state clearinghouse for data information and research related to the uninsured would be very useful. Over the course of this study, the SPG staff became aware of several important resources that were previously not identified. While the internet has vastly improved the capabilities of conducting research on the uninsured, a one-point resource for coordinating such information would be extremely beneficial.

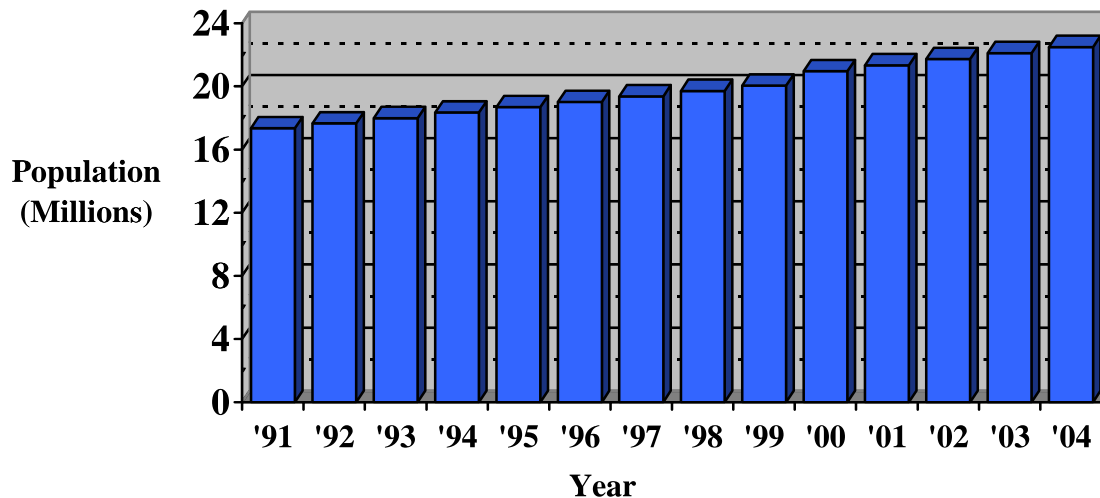
Appendix I: Baseline Information

Population

Table A1: Texas Statewide Population and Population Growth Rate Estimates: 1991-2003

Year	Population	Growth Rate
1991	17,339,904	-
1992	17,650,479	1.79%
1993	17,996,764	1.96%
1994	18,338,319	1.90%
1995	18,679,706	1.86%
1996	19,006,240	1.75%
1997	19,355,427	1.84%
1998	19,712,389	1.84%
1999	20,044,141	1.68%
2000	20,949,136	4.52%
2001	21,334,855	1.84%
2002	21,723,220	1.82%
2003	22,103,374	1.75%
2004	22,490,022	1.75%

Chart A1: Texas Statewide Population Growth: 1991-2003



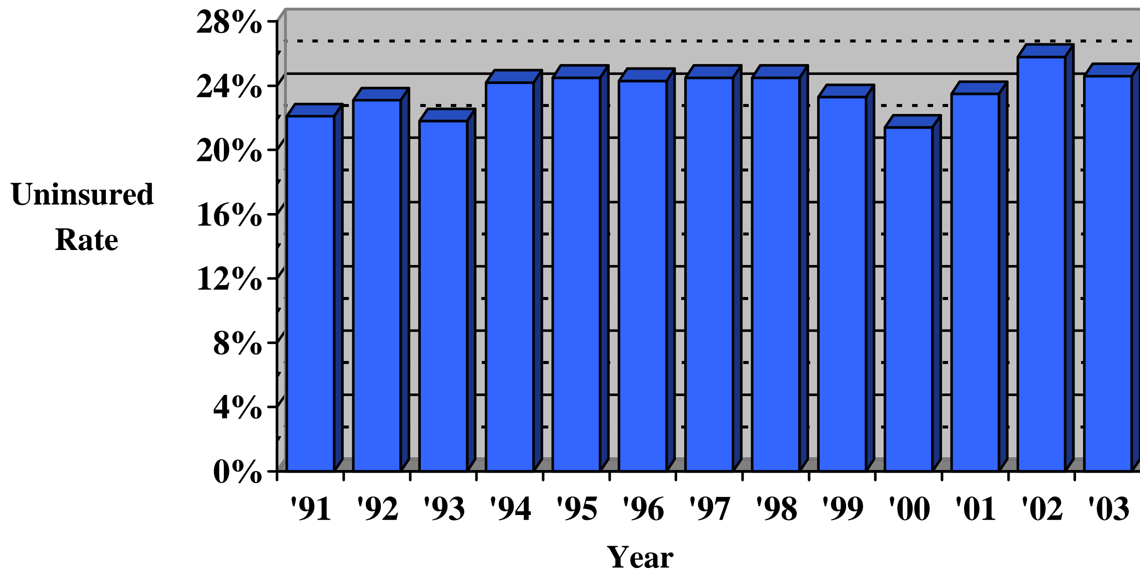
SOURCES: 1) State Population Estimates: Annual Time Series, July 1, 1990 to July 1, 1999. Table ST-99-3. US Census Bureau, Release Date: December 29, 1999.
2) Annual Estimates of the Population for the United States and States, and for Puerto Rico: April 1, 2000 to July 1, 2004 (NST-EST2004-01), Population Division, U.S. Census Bureau

Number and Percentage of Uninsured

Table A2: Number and Percentage of Texans Without Health Insurance: 1991-2003

Year	Uninsured Rate	Number Uninsured
1991	22.1%	3,755,000
1992	23.1%	4,144,000
1993	21.8%	3,981,000
1994	24.2%	4,580,000
1995	24.5%	4,615,000
1996	24.3%	4,680 000
1997	24.5%	4,836,000
1998	24.5%	4,880,000
1999	23.3%	4,664,000
2000	21.4%	4,500,000
2001	23.5%	4,960,000
2002	25.8%	4,556,000
2003	24.6%	5,374,000

Chart A2: Percentage of Texans without Health Insurance: 1991-2003



Source: United States Census Bureau, Current Population Survey.

Average Age of Population

The average age of the Texas population was not available, but the median age in 2000 was 32.3 years according to the U.S. Census Bureau.

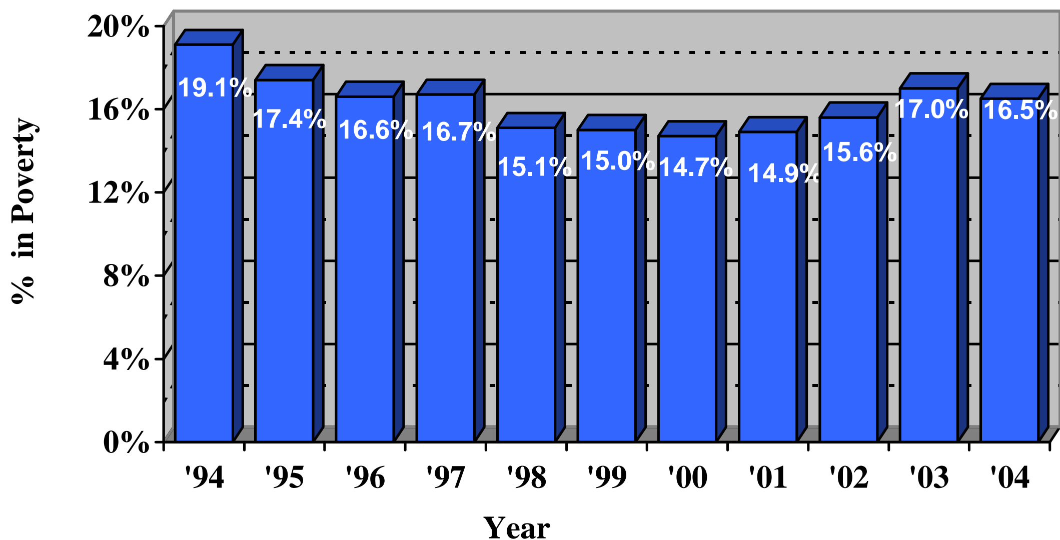
Percent of Population Living in Poverty

Table A3: Texas Uninsurance Rates by Poverty Range

Income/Poverty Level	Number Insured	Number Uninsured	Percent Uninsured within Income Category	Percent of Total Uninsured
Under 50%	777,751	619,243	11.6%	44.3%
51% to 99%	1,476,802	831,628	15.5%	36.0%
100% to 149%	1,578,418	971,920	18.1%	38.1%
150% to 199%	1,532,249	844,229	15.8%	35.5%
200% to 249%	1,374,521	585,382	10.9%	29.9%
250% or Higher	9,729,320	1,505,906	28.1%	13.4%
Total	**16,469,062**	**5,358,308**	**100.0%**	**24.5%**

Source: 2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

Chart A3: Texas Poverty Rates: 1994-2003



Source: United States Census Bureau, Current Population Survey.

Primary Industries and Number and Percent of Employers Offering Coverage

Table A4: Texas State Employment Estimates by Industry (2003-2004)

Industry	July 2004 Estimate	July 2003 Estimate	Percent Change
Natural Resources & Mining	149,800	147,900	1.28%
Construction	558,000	553,600	0.79%
Durable Goods Manufacturing	555,100	559,900	-0.86%
Non-durable Goods Manufacturing	334,900	337,000	-0.62%
Wholesale Trade	466,100	458,700	1.61%
Retail Trade	1,090,200	1,073,500	1.56%
Trans., Warehouse & Utilities	388,200	380,600	2.00%
Information	232,400	235,900	-1.48%
Financial Activities	592,900	589,500	0.58%
Professional and Business Services	1,063,900	1,040,700	2.23%
Educational and Health Services	1,145,200	1,112,100	2.98%
Leisure and Hospitality	894,000	875,600	2.10%
Other Services	365,500	361,700	1.05%
Government	1,563,100	1,562,700	0.03%
Total Nonagricultural	**9,399,300**	**9,289,400**	**1.18%**

Source: Texas Labor Market Review, Texas Workforce Commission, August 2004

Table A5: Employer-Based Health Insurance Enrollees by Industry Sector

Industry Sector	Number Insured	Number Uninsured	% Uninsured Within Industry	% of Total Uninsured
Private Households	32,443	52,592	61.85%	2.5%
Construction	386,245	365,284	48.61%	17.5%
Personal Services, Excluding Households	164,241	94,300	36.47%	4.5%
Entertainment and Recreation Services	66,633	37,141	35.79%	1.8%
Agriculture	169,613	85,044	33.40%	4.1%
Wholesale and Retail Trade	1,362,708	552,955	28.86%	26.5%
Business, Auto, and Repair Services	507,699	187,829	27.01%	9.0%
Social Services	177,989	60,820	25.47%	2.9%
Transportation	333,838	86,350	20.55%	4.1%
Hospitals and Medical Services	594,752	146,301	19.74%	7.0%
Manufacturing	1,029,517	189,037	15.51%	9.1%
Other Professional Services	396,863	49,658	11.12%	2.4%
Finance, Insurance, and Real Estate	564,293	64,469	10.25%	3.1%
Educational Services	754,544	71,695	8.68%	3.4%
Communications	173,891	12,486	6.70%	0.6%
Public Administration	360,391	24,796	6.44%	1.2%
Mining	159,000	5,527	3.36%	0.3%
Utilities and Sanitary Services	73,773	1,471	1.95%	0.1%
Forestry and Fisheries	4,730	Not Available	Not Available	Not Available
Total	7,313,163	2,087,755	22.21%	100.0%

Source: Analysis of 2001 Current Population Survey, Texas Health and Human Services Commission, Research and Forecasting Department.

Table A6: Companies Offering Employer-based Health Insurance by Industry Sector – Small Employers Only

Industry	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Industry	Percent of Total Not Offering Ins.
Agriculture, forestry, fishing	53	82	60.7%	3.7%
Construction	185	256	58.0%	11.4%
Food service	25	130	83.9%	5.8%
Manufacturing	153	119	43.8%	5.3%
Retail	184	346	65.3%	15.4%
Services	945	912	49.1%	40.7%
Wholesale	114	67	37.0%	3.0%
Other	372	311	45.5%	13.9%
No Response	22	20	47.6%	0.9%
Total	**2,053**	**2,243**	**52.2%**	**100.0%**

Source: Final Results of the 2004 Texas Small Employer Survey, Texas State Planning Grant

Table A7: MEPS Data for All Private Sector Employees (2003)

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Firms	425,925 100.00%	312,000 73.25%	113,925 26.75%	6,285,662 100.00%	4,727,002 75.20%	1,558,660 24.80%
Firms Offering Insurance	207,425 48.70%	97,968 31.40%	109,482 96.10%	3,532,542 56.20%	2,042,065 43.20%	1,486,962 95.40%
Total Number of Employees in All Firms	7,838,737 100.00%	1,948,995 24.86%	5,889,741 75.14%	110,876,535 100.00%	31,382,001 28.30%	79,494,534 71.70%
Employees in Firms Offering Insurance	6,694,281 85.40%	933,569 47.90%	5,760,167 97.80%	96,240,832 86.80%	19,331,313 61.60%	76,950,709 96.80%
Employees Eligible for Insurance in Firms Offering Insurance	5,167,985 77.20%	778,596 83.40%	4,389,247 76.20%	75,549,053 78.50%	15,175,080 78.50%	60,406,306 78.50%
Employees Eligible for Insurance that are Enrolled in Insurance in Firms Offering Insurance	4,258,420 82.40%	624,434 80.20%	3,625,518 82.60%	60,665,890 80.30%	11,730,337 77.30%	48,929,108 81.00%
Percent of Total Employees in All Firms Eligible for Insurance	65.93%	39.95%	74.52%	68.14%	48.36%	75.99%
Percent of Total Employees in All Firms Enrolled in Insurance	54.33%	32.04%	61.56%	54.71%	37.38%	61.55%

Source: TDI Analysis of the 2003 Medical Expenditure Panel Survey

Table A8: MEPS Data for All Private-Sector Employees (2003)

Firm Size (Number of Employees)	Percent of Employees Not Covered	Percent of Employees Covered
Less than 10	80.2%	19.8%
10-24	76.4%	23.6%
25-99	71.8%	28.2%
100-999	63.4%	36.6%
1000 or more	59.8%	40.2%
Less than 50	78.6%	21.4%
50 or more	61.1%	38.9%
Total	65.4%	34.6%

Source: TDI Analysis of the 2002 Medical Expenditure Panel Survey,

Table A9: MEPS Data for Full-time Private Sector Employees (2003)

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Full-time Employees in All Firms	6,231,680 100.00%	1,530,683 24.56%	4,700,998 75.44%	87,657,095 100.00%	22,981,101 26.22%	64,675,994 73.78%
Full-time Employees in Firms Offering Insurance	5,402,867 86.70%	806,670 52.70%	4,592,875 97.70%	78,716,071 89.80%	15,719,073 68.40%	62,994,418 97.40%
Full-time Employees Eligible for Insurance in Firms Offering Insurance	4,867,983 90.10%	755,850 93.70%	4,110,623 89.50%	69,899,871 88.80%	14,382,952 91.50%	55,498,082 88.10%
Full-time Employees Eligible for Insurance that are Enrolled in Insurance in Firms Offering Insurance	4,142,653 85.10%	617,529 81.70%	3,522,804 85.70%	57,946,993 82.90%	11,348,149 78.90%	46,562,891 83.90%
Percent of Total Full-time Employees Eligible for Insurance	78.12%	49.38%	87.44%	79.74%	62.59%	85.81%
Percent of Total Full-time Employees Enrolled in Insurance	66.48%	40.34%	74.94%	66.11%	49.38%	71.99%

Source: TDI Analysis of the 20002 Medical Expenditure Panel Survey.

Table A10: MEPS Data for Part-time Private Sector Employees (2003)

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Part-time Employees in All Firms	1,607,057 100.00%	418,313 26.03%	1,188,744 73.97%	23,219,440 100.00%	8,400,901 36.18%	14,818,540 63.82%
Part-time Employees in Firms Offering Insurance	1,292,074 80.40%	126,749 30.30%	1,164,969 98.00%	17,530,677 75.50%	3,620,788 43.10%	13,914,609 93.90%
Part-time Employees Eligible for Insurance in Firms Offering Insurance	302,345 23.40%	22,181 17.50%	279,593 24.00%	5,627,347 32.10%	792,953 21.90%	4,828,369 34.70%
Part-time Employees Eligible for Insurance that are Enrolled in Insurance in Firms Offering Insurance	119,124 39.40%	6,721 30.30%	112,117 40.10%	4,518,760 80.30%	612,952 77.30%	3,910,979 81.00%
Percent of Total Part-time Employees Eligible for Insurance	18.81%	5.30%	23.52%	24.24%	9.44%	32.58%
Percent of Total Part-time Employees Enrolled in Insurance	7.41%	1.61%	9.43%	19.46%	7.30%	26.39%

Source: TDI Analysis of the 20002 Medical Expenditure Panel Survey.

Eligibility for Existing Coverage Programs

Chart A4: Texas Medicaid Eligibility Requirements

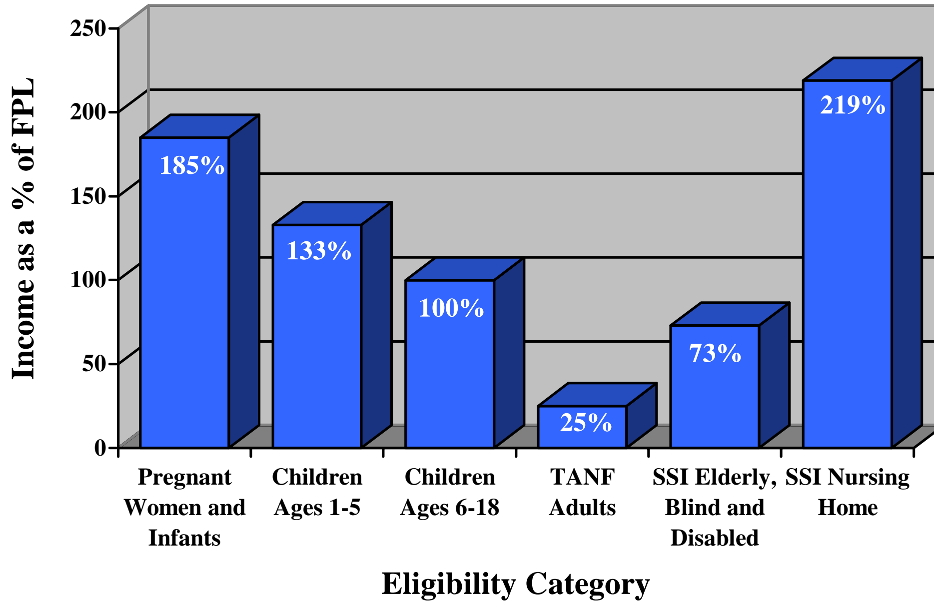


Chart A5: FPL Guidelines for TexCare Medicaid and TexCare CHIP (2003)

= TexCare Medicaid   =TexCare CHIP

AGE	100% FPL $18,850	133% FPL $25,071	150% FPL $28,275	185% FPL $34,873	200% FPL $37,700
0-1					
1-5					
6-18					

NOTES: 1) Income amounts reflect 2003 federal poverty guidelines for a family of four.
2) Children may be added or excluded, however, based on income deductions and asset tests.

Additional Baseline Current Population Survey Data

The data appearing in Tables A11-A23 was extracted from a document entitled "Demographic Profile of Uninsured Texans in 2003," which was released by the Research and Forecasting Department of the Texas Health and Human Services Commission. The original source of this information was the March 2004 Current Population Survey (CPS) from the U.S. Census Bureau.

Table A11: Texas Uninsured by Gender

Gender	Percent Uninsured	Percent Insured
Male	24.9%	75.1%
Female	24.2%	75.8%

Table A12: Texas Uninsured by Race / Ethnicity

Race / Ethnicity	Percent Uninsured	Percent Insured
Anglo	14.3%	85.7%
Black / African American	22.7%	77.3%
Hispanic	38.6%	61.4%
All Other	19.3%	80.7%

Table A13: Texas Uninsured by Age

Age Group	Percent Uninsured	Percent Insured
Ages 6 and Younger	16.9%	83.1%
Ages 7 - 17	22.1%	77.9%
Ages 18 - 24	40.4%	59.6%
Ages 25 - 34	39.2%	60.8%
Ages 35 - 44	28.3%	71.7%
Ages 45 - 64	20.5%	79.5%
Ages 65 +	2.0%	98.0%

Table A14: Texas Uninsured by Percent of Poverty Category

Percent of Poverty Category	Percent Uninsured	Percent Insured
Under 50%	44.3%	55.7%
51% to 99%	36.0%	64.0%
100% to 149%	38.1%	61.9%
150% to 199%	35.5%	64.5%
200% to 249%	29.9%	70.1%
250% or Higher	13.4%	86.6%

Table A15: Texas Uninsured by U.S. Citizen Status

U.S. Citizen Status	Percent Uninsured	Percent Insured
U.S. Citizen (Native)	19.7%	80.3%
U.S. Citizen (Naturalized)	27.5%	72.5%
Not a U.S. Citizen	60.3%	39.7%

Table A16: Texas Uninsured by Area of Residence

Area of Residence	Percent Uninsured	Percent Insured
In Metropolitan Area	25.6%	74.4%
Outside Metropolitan Area	19.1%	80.9%

Table A17: Texas Uninsured by Educational Attainment

(Persons 18 and older)

Educational Attainment	Percent Uninsured	Percent Insured
Less than High School	43.4%	56.6%
High School	28.9%	71.1%
Some College or Associate Degree	22.9%	77.1%
College or Higher	10.7%	89.3%

Table A18: Texas Uninsured by Labor Force Status

(Non-retired persons 18 and older)

Labor Force Status	Percent Uninsured	Percent Insured
Employed	26.6%	73.4%
Unemployed	47.6%	52.4%
Not in Labor Force	35.6%	64.4%

Table A19: Texas Uninsured Workers by Company Size
(Number of employees company-wide)

Uninsured Workers By Company Size	Percent Uninsured	Percent Insured
Fewer than 10 Employees	40.7%	59.3%
10 through 24 Employees	42.1%	57.9%
25 through 99 Employees	28.7%	71.3%
100 through 499 Employees	20.5%	79.5%
500 through 999 Employees	19.8%	80.2%
1,000 or More Employees	15.5%	84.5%

Table A20: Texas Uninsured By Marital Status
(Persons 18 and older)

Marital Status	Percent Uninsured	Percent Insured
Married	22.6%	77.4%
Widowed	10.3%	89.7%
Divorced or Separated	28.5%	71.5%
Single, Never Married	38.8%	61.2%

Table A21: Texas Uninsured by Presence of Parent(s) at Home
(Dependent / Related children under 18 only)

Presence of Parent(s) at Home	Percent Uninsured	Percent Insured
Both Parents Present	17.6%	82.4%
Only Mother Present	21.6%	78.4%
Only Father Present	20.7%	79.3%
Neither Parent Present	38.3%	61.7%

Table A22: Texas Uninsured Dependent / Related Children under Age 18 by Percent of Poverty Category

Dependent / Related Children Under Age 18 by Percent of Poverty Category	Percent Uninsured	Percent Insured
Under 50%	25.4%	74.6%
51% to 99%	24.5%	75.5%
100% to 149%	27.4%	72.6%
150% to 199%	30.0%	70.0%
200% to 249%	19.5%	80.5%
250% or Higher	10.1%	89.9%

Table A23: Texas Uninsured Children under Age 19 by Percent of Poverty Category

All Children Under Age 19 by Percent of Poverty Category	Percent Uninsured	Percent Insured
Under 50%	27.6%	72.4%
51% to 99%	25.6%	74.4%
100% to 149%	28.2%	71.8%
150% to 199%	30.5%	69.5%
200% to 249%	19.6%	80.4%
250% or Higher	10.1%	89.9%

Table A24: Texas Counties with the Ten Largest Uninsured Populations

County Name	Percent Uninsured by County	Percent of Statewide Total
Harris	25.5%	17.2%
Dallas	23.7%	10.6%
Bexar	26.6%	7.4%
Tarrant	22.0%	6.9%
El Paso	31.4%	4.9%
Hidalgo	33.4%	3.7%
Travis	23.6%	3.1%
Cameron	32.3%	2.2%
Denton	20.4%	1.7%
Nueces	26.4%	1.7%
All Other	22.5%	40.5%

Source: Texas Health and Human Services Commission, 2000

Additional Baseline Employer Data

The data appearing in Tables A25-A30 originated from the "Final Results of the 2004 Texas Small Employer Survey," which was conducted by the Texas State Planning Grant.

Table A25: Average Number of Employees per Company by Employee Type and Health Insurance Status for Small Employers with 2-50 Employees

Employee Type	Average Number of Employees	
	Companies Offering Insurance Coverage	Companies NOT Offering Insurance Coverage
Total Employees	12.6	8.2
Full-Time Employees	10.8	6.2
Part-Time Employees	1.8	2.0
Contract Employees	0.7	0.6

Table A26: Percent of Small Employers Offering and Not Offering Employer-based Health Insurance by Industry Sector

Industry	Percent of Companies Not Offering Insurance	Percent of Companies Offering Insurance
Agriculture, forestry, fishing	60.7%	39.3%
Construction	57.6%	42.4%
Food Service	83.8%	16.2%
Manufacturing	43.3%	56.7%
Retail	65.5%	34.5%
Services	49.1%	51.0%
Wholesale	37.6%	62.4%
Other	45.7%	54.3%
Total	**55.4%**	**44.6%**

Table A27: Average Annual Salary of Small Businesses Employees: Small Employers with 2-50 Employees

Average Employee Salary	Percent of Companies Not Offering Insurance	Percent of Companies Offering Insurance
Less than $10,000	87.5%	12.5%
$10,001-$15,000	87.9%	12.1%
$15,001-$20,000	69.6%	30.4%
$20,001-$25,000	54.0%	46.0%
$25,001-$50,000	37.7%	62.3%
$50,001-$75,000	26.2%	73.8%
More than $75,000	34.9%	65.2%
No Response	65.5%	34.5%
Total	**52.3%**	**47.7%**

Table A.28: Predominant Wage Type of Employees: Small Employers with 2-50 Employees

Predominant Employee Wage Type	Percent of Companies Not Offering Insurance	Percent of Companies Offering Insurance
Minimum Wage	91.3%	8.7%
Hourly, more than minimum wage but less than $10 per hour	73.0%	27.0%
Hourly, between $10 - $15 per hour	51.2%	48.8%
Hourly, between $15 - $20 per hour	37.9%	62.1%
Hourly, more than $20 per hour	42.9%	57.1%
Salaried	35.1%	64.9%
Independent contractors	69.6%	30.4%
Hourly plus tips	93.1%	6.9%
No Response	47.3%	52.7%
Total	**52.2%**	**47.8%**

Table A.29: Monthly Employee Contribution for Employee-only Employer-based Insurance: Small Employers with 2-50 Employees

Amount of Monthly Employee Contribution	Number of Responses	Percent of Responses
$0	1,135	56.8%
Less than $50 a month	196	9.8%
$50 - $75 a month	164	8.2%
$76 - $100 a month	167	8.4%
$101 - $125 a month	81	4.1%
$126 - $150 a month	73	3.7%
$151 - $200 a month	81	4.1%
More than $200 a month	102	5.1%
Total	**1,999**	**100.0%**

Table A.30: Monthly Employee Contribution as a Percent of Total Premium for Employee-only Employer-based Insurance: Small Employers with 2-50 Employees

Monthly Employee Contribution as a Percent of Total Premium	Number of Responses	Percent of Responses
0%	1134	56.7%
5%	65	3.3%
10%	69	3.5%
15%	39	2.0%
20%	93	4.7%
25%	177	8.9%
30%	54	2.7%
More than 30%	369	18.5%
Total	**2,000**	**100.0%**

Appendix II: Contact Information

All reports for the Texas State Planning Grant, surveys and focus group activities as well as other materials presented at the SPG conferences are available at the following web-site:

http://www.tdi.state.tx.us/company/spg.html

The report "Texas Health Insurance Risk Pool Expansion Options" is available at

http://www.tdi.state.tx.us/reports/pdf/grthirp04.pdf

For printed copies of these or other SPG materials, please call 512-322-4100.

Appendix III: SPG Summary of Policy Options

Option Considered	Target Population	Estimated Number of People Served	Status of Approval	Status of Implementation	If Implemented, Number of People Served
Revise the small employer benefit plans to increase participation	Small employers and their staff	18,000	Legislation enacted by the Texas Legislature Rules adopted by TDI; plans implemented 1-1-2004	Implementation completed 1-1-2004	18,000 in calendar year 2004; reported Dec. 2004
Organize insurance information events to provide current information on insurance options for small employers	Small business owners	Cumulative: 2,500	Completed in 2003 and 2005	Completed	1,200 in FY 2005; as of August 31, 2005
Creation of purchasing alliances and cooperatives	Small and Large Employers	Unknown	Legislation enacted in 2003. Rules adopted by TDI; implementation effective 1-1-04	Completed	Unknown; estimated between 5,000 - 10,000 in FY 2005 as of 8-31-05
CHIP Buy-In program for parents of children enrolled in Medicaid or CHIP	Low-income parents of children enrolled in CHIP / Medicaid	Not applicable	On – Hold; requires legislation	On-Hold until Legislature takes future action	Not applicable

Endnotes

[i] "2003 Demographic Profile of Texas Uninsured Population Based on March 2004 CPS," Research and Forecasting Department, Texas Health and Human Services Commission.

[ii] "2003 Texas Insurance Population Characteristics," Texas Department of Insurance. March 2005.

[iii] The Texas CHIP administrator, Birch & Davis, has heard from families who, when told they were Medicaid eligible, asked to be placed in CHIP instead because of the "welfare" stigma associated with Medicaid.

[iv] The Center for Public Policy Priorities and Orchard Communications, Inc. released a study in September 2000 entitled "Every Child Equal: What Texas Parents Want from Children's Medicaid." The findings are concluded from focus groups conducted throughout the state, and include evidence of the aforementioned obstacles to obtaining Medicaid.

[v] "Surveys of Selected Texas Healthy Kids Populations. Section 3: Survey of Families who have Terminated Insurance Coverage," Prepared for the Texas Healthy Kids Corporation by The Center for Health Policy Studies, The University of Texas – Houston School of Public Health. June 21, 2000.

[vi] 2003 Medical Expenditure Panel Survey – Insurance Component, Agency for Healthcare Research and Quality

[vii] Current Population Survey 2001, Analysis Provided by Texas Health and Human Services Commission, Research and Forecasting Department. October 2001.

[viii] "Cost Impact Study of Mandated Benefits in Texas – Report 2", Milliman and Robertson, Inc. September 2000, pg. 11