Report
on
Senate Bill 10, Section 31
Eighteieth Legislature, Regular Session, 2007

A Study of Health Insurance Premium Assistance Options for Uninsured Texans

Submitted by the
Texas Department of Insurance
and
Health and Human Services Commission

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Executive Summary

For the past ten years, the State of Texas has experienced the highest uninsured rate in the nation, and is well above the national average. Although the state has enacted several programs and a variety of insurance reforms designed to increase the number of Texans with health insurance, the uninsured rate has continued to grow. In 2007, an estimated 5.9 million state citizens had no insurance throughout the entire year.[1] In response to this growing problem, the 80th Texas Legislature recognized the difficulty of purchasing affordable health insurance and directed the Texas Health and Human Services Commission (HHSC) and the Texas Department of Insurance (TDI) to conduct a joint study of small employer premium assistance programs and how such a program might be designed to provide financial assistance to small employers. The study is required to include a review of other states' programs and provide recommendations for the Legislature's consideration. The report must include suggestions regarding the following program components:

- the manner of targeting small employers;
- provisions that would discourage employers from dropping other private coverage for employees;
- a minimum premium or a percent of a minimum premium that a small employer must pay for each employee's coverage;
- eligibility requirements for enrollees for whom financial assistance is provided;
- allocation of opportunities for enrollment in the program;
- the duration of enrollment in the program and the requirements for renewal; and
- verification that small employers participating in the program use premium assistance to purchase and maintain a small employer health benefit plan.

The legislation also requires the agencies to consider coordination of a premium assistance program with any other assistance programs in the state that are either operational or under development, and to consider options for program funding, including the use of money in the Texas Health Opportunity Pool (HOP). This report is the result of the HHSC and TDI collaborative study required under S.B. 10.

While solutions for affordable health insurance may be elusive, the causes of uninsurance have been widely researched. Increasing medical costs and health insurance premiums have priced many individuals out of the market and have reduced the availability of affordable employer-based health insurance as the percentage of firms offering health benefits has significantly declined in recent years. In 2006, only 49.1 percent of Texas employers offered health insurance, compared to a national average of 55.8 percent.[2] Recent economic events and tighter financial resources are expected to further exacerbate the problem, as is already indicated by increasing enrollment in Medicaid programs nationwide.[3]

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[1] U.S. Census Bureau, Current Population Survey, 2007.

[2] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey – Insurance Component.

[3] "States See Rising Enrollment in Medicaid as Economy Falters," Kaiser Family Foundation, September 29, 2008; http://www.kff.org/newsroom/kcmu092908nr.cfm.

Texas, like other states, has struggled to develop innovative solutions for providing affordable private health insurance opportunities. The small employer insurance market in particular has been the subject of extensive reforms in an effort to enable more small business owners to offer insurance. Texas is well below the national average of small firms offering coverage, and employers report high costs as the primary reason why they do not provide insurance for their workers. Even when coverage is offered, many workers decline enrollment due to the required employee contribution. A number of states have responded to this challenge by creating premium subsidy programs that provide small employers and their workers with the financial assistance they need in order to purchase health insurance. Subsidy programs provide a cost-effective mechanism for leveraging state and federal funds with employer and employee contributions for health insurance. Reported benefits of private/public subsidy models include their ability to:

- support and strengthen the existing private insurance market;
- enable families to enroll in one health plan, increasing enrollment of eligible children as well as adults;
- improve health status of previously uninsured citizens and reduce health care disparities;
- improve the economic condition among families who previously were uninsured;
- enable employers to provide an important benefit that will allow them to attract and retain qualified workers;
- maximize non-state funding by drawing down federal funds that are used in combination with employer contributions for eligible employees;
- enable employers to meet minimum group participation requirements, extending coverage to *all* workers, not just those who qualify for subsidies;
- reduce strain on emergency facilities and local health care public assistance programs; and
- reduce cost shifting and more equitably distribute the cost of health care.

While the benefits are considerable, states also report significant challenges in establishing an effective premium subsidy program and in attracting qualified enrollees. Program designs and subsidy arrangements are unique for each state and often vary based on the target population, funding resources, and the state's private insurance market. Despite the variations, all programs cite common challenges, including:

- designing a program that meets federal requirements within the existing private insurance regulatory framework;
- educating and attracting employers and employees who are often reluctant to enroll in a program with no proven track record;
- designing a benefit plan that appeals to both employers and employees, who often have different preferences with regard to benefits covered in the plan and the protection that this plan offers;
- developing an efficient administrative program that simplifies complex qualification and oversight functions in an environment that involves both public and private entities; and
- budgeting for increasing health care costs and increasing demand for services in order to provide a program that is sustainable over a long term.

In considering the options for a premium subsidy program in Texas, HHSC and TDI looked closely at other state programs and considered the unique features of states' Medicaid/SCHIP programs as well as the varying private insurance market regulatory framework. The complexity of these vastly different programs requires that each state carefully design a program that works within the context of unique public and private market environments without creating unintended consequences. While an evaluation of other states' programs is useful, Texas ***is*** different. A subsidy program in Texas will likely have many features shared by other states, but the final product will be uniquely Texan in order to effectively operate within the existing public/private market.

As summarized in Chapter 5, this report provides several specific key recommendations that HHSC and TDI agree should be considered in the design of a Texas premium assistance program, including:

- Design a program that is affordable for the target audience.
- Provide benefit plans that appeal to both employers and employees to maximize interest and enrollment in the program.
- Require employers to contribute a percentage of the premium cost based on the cost per employee.
- Create one or more standardized benefit plans for subsidy program participants.
- To address crowd-out concerns, restrict enrollment to previously uninsured firms and employees in order to discourage employers from discontinuing other private coverage.
- Consider providing a tax credit to reward employers who already provide insurance and cannot, therefore, qualify for the premium subsidy program.
- Limit participation to one or several insurers.
- Require participating insurers to use either a pure community rating methodology or modified community rating.
- Provide two limited open enrollment periods annually, with an option to add additional enrollment periods as needed.
- Allow insurance agents to participate in the marketing of subsidy plans.
- Offer enrollment to employees and their eligible dependents.
- Provide subsidy payments directly to the insurer rather than sending payments to the employer or employee.
- Consider allowing local communities to "buy in" to the state-operated premium subsidy program.
- Consider alternative group minimum participation requirements.
- Require participating enrollees to complete a health risk assessment upon enrollment.
- Require 12-month enrollment periods and annual recertification of eligibility.

As reiterated throughout this report, designing a premium assistance program is a highly technical endeavor that involves careful consideration of many factors. Each of these factors will influence the success or failure of a program. If the state receives approval to use federal funds, many plan decisions must be consistent with federal requirements.

This report provides overviews of the private health insurance market and public coverage programs in Texas, followed by a review of other states' premium subsidy programs. The report also discusses the key components of a premium subsidy program and the advantages and disadvantages of various options and concludes with options and recommendations for legislative consideration in the development of a small business premium subsidy program.

Though development of a premium subsidy program is an ambitious project, both HHSC and TDI agree that uninsured Texans have much to gain by such an arrangement. Both TDI and HHSC are committed to assisting the Legislature and state leaders in this endeavor and any others that might be enacted to expand health coverage in Texas.

Chapter 1

Texas' Private Insurance Market

In order to design an effective insurance expansion strategy that builds on the existing private market, a clear understanding of the Texas insurance market is critical. While federal health programs like Medicaid and SCHIP are subject to national standard requirements, state insurance regulations vary considerably from state to state. An understanding of these differences and how they may impact the potential success of a subsidy program is critical. What works in one state may not be effective in another state due to important differences in the regulatory requirements that apply to small group insurance plans.

Equally important to any discussion of solutions for the uninsured is an understanding of the target population. Many states' efforts to reach the uninsured have experienced minimal success due in part to a lack of understanding of the complex demographic and economic characteristics of this population. As part of TDI's ongoing efforts to improve insurance affordability and availability, the Department has completed extensive research of the small employer insurance market and the challenges small business owners face when trying to offer insurance. A discussion of the research and key findings is included in this chapter, providing a look at some of the key factors that should be considered in the development of a successful employer subsidy program. Some of the most significant findings include:

- Employment-based insurance provides coverage to more than 12 million Texans, more than all other types of health coverage combined.
- Eighty-nine percent of large firms offer insurance, compared to only 32 percent of small firms.
- Within large firms, 4.5 million employees are eligible for coverage, but only 3.5 million are enrolled.
- Of the 1.9 million employees working in small firms, less than 800,000 are eligible for employer coverage and less than 650,000 are enrolled.
- More than 2.7 million working Texans do not have access to employer-sponsored coverage at the firm where they work.
- More than one million workers with access to coverage are not enrolled.
- The majority of small employers who do not offer coverage report that they can pay $100 or less per-employee-per-month for insurance.
- The average annual premium for small employer insurance in 2008 is estimated at $5,109, or $425 per-employee per-month.

These and other findings and the role they play in developing an effective employer/employee subsidy program are described in this chapter. Also included are an overview of the uninsured population and a discussion of the Texas insurance market and the regulatory provisions that will impact any public/private expansion options.

Texas' Uninsured Population Demographics

While most Texans receive comprehensive health insurance or health care coverage through one of a variety of available private and public health care benefit plans, one-fourth of the state's residents have no health insurance. As demonstrated in Table 1.1, the number of uninsured has slowly but consistently increased from 4.8 million in 1997 to more than 5.9 million in 2007. Last year, 25 percent of Texans reported they had no health insurance at anytime during the year, compared to a national average of 15 percent.

Table 1.1: Number and Percentage of Texas' Uninsured Population

Year	Number of Uninsured Texans	Percent of Uninsured Texans	National Uninsured Percentage
1995	4,615,000	24.5%	15.4%
1997	4,836,000	24.5%	15.6%
1999	4,664,000	23.3%	16.1%
2000	4,500,000	21.4%	16.3%
2001	4,960,000	23.5%	15.5%
2002	5,555,598	25.8%	14.0%
2003	5,527,771	24.6%	14.6%
2004	5,583,000	25.0%	15.2%
2005	5,515,677	24.2%	15.6%
2006	5,704,000	24.5%	15.7%
2007	5,962,000	25.5%	15.3%

Source: U.S. Census Bureau, Current Population Survey.

The reasons for Texas' high uninsured rate have been discussed and analyzed at length. While no single factor can be blamed, a combination of population demographics, rising health care and health insurance costs, increased demand for health care services, and related economic and workforce dynamics play an interrelated role in the problem. Compared to states with low uninsured rates, Texas has:

- lower availability of employer sponsored insurance coverage;
- lower average wages;
- higher average insurance premiums;
- a larger immigrant population;
- a high percentage of Hispanic citizens; and
- few unionized businesses.

Although the uninsured population is not limited to any one particular demographic group, certain characteristics increase the likelihood that an individual may or may not have health insurance. Following is a brief overview of Texas' uninsured population and the demographic

characteristics that should be considered in designing an effective premium subsidy program that is specifically targeted to the population for which it is intended.

- **Age:** Of the 6.0 million uninsured Texans, 4.5 million (76 percent) are adults. Young adults ages 18-24 are at greatest risk of having no health coverage; nearly half (41.7 percent) were uninsured, followed closely by adults ages 25-34 years old (39.5 percent are uninsured). Texas also has the highest uninsured rate of any state for adults over age 65, a population that has grown significantly in recent years. In 2005, an estimated 43,526 adults over 65 were uninsured. By 2007, the number had increased to 100,000. While still representing only 4.1 percent of all adults over 65, the rate has more than doubled since 2005 when only 1.8 percent was uninsured. Because older citizens are much more likely to need health care services than younger adults, this growing segment of the uninsured population is particularly worrisome due to the potential for relatively high health care costs. Texas' high rate is likely due to a higher influx of older adult immigrants who do not qualify for Medicare. Nationally, 1.9 percent of adults age 65 and older are uninsured.

Table 1.2: Uninsured Rates by Age – 2007

Age Range	Number Uninsured	Percent of Total Uninsured	Percent Uninsured Within Age Category
Ages 6 and Younger	570,053	9.6%	20.4%
Ages 7 – 17	864,926	14.5%	22.0%
Ages 18 – 24	960,561	16.1%	41.7%
Ages 25 – 34	1,350,623	22.7%	39.5%
Ages 35 – 44	929,402	15.6%	27.6%
Ages 45 – 64	1,186,401	19.9%	21.8%
Ages 65 +	100,039	1.7%	4.1%
Total	**5,962,004**	**100.0%**	**25.2%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

- **Race/Ethnicity:** Like other border states, the uninsured in Texas are disproportionately Hispanic. Although Hispanics represent approximately 36 percent of the state's total population, they account for nearly 60 percent of the uninsured.

Table 1.3: Uninsured Rates by Race/Ethnicity – 2007

Race/Ethnicity	Number Uninsured	Percent of Total Uninsured	Percent Uninsured Within Race/ Ethnicity Category
White	1,504,093	25.2%	14.1%
Black/African American	614,454	10.3%	22.8%
Hispanic	3,583,568	60.1%	39.0%
All Other	259,890	4.4%	22.2%
Total	**5,962,004**	**100.0%**	**25.2%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

- **Poverty Status**: Though the uninsured as a group have a wide range of incomes, a majority (almost 60 percent) live in families with incomes below 200 percent of the federal poverty level. An estimated 27 percent have incomes below 100 percent of poverty ($21,200 for a family of four in 2008). More than 1.7 million uninsured Texans live in families with incomes above $50,000.

Table 1.4: Uninsured Rates by Poverty Status – 2007

Income/Poverty Level	Number Uninsured*	Percent of Total Uninsured	Percent Uninsured Within Income Category
Under 50%	665,872	11.2%	44.7%
51% to 99%	957,046	16.1%	39.7%
100% to 149%	980,580	16.5%	38.6%
150% to 199%	841,251	14.2%	38.9%
200% to 249%	750,540	12.6%	33.7%
250% or Higher	1,749,124	29.4%	13.6%
Total	**5,944,413**	**100.0%**	**25.1%**

* Applies to the portion of the population for whom poverty status was determined.
Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

- **Citizenship:** Contrary to popular perception, a large majority of uninsured Texans are U.S. citizens. However, non-citizens are much more likely to be uninsured, with an uninsured rate of 60 percent compared to 20 percent for native citizens and 33 percent for naturalized citizens.

Table 1.5: Uninsured Rates by Citizenship – 2007

Immigration Status	Number Uninsured	Percent of Total Uninsured	Percent Uninsured Within Immigration Status Category
U.S. Citizen (Native)	4,091,625	68.6%	20.4%
U.S. Citizen (Naturalized)	355,733	6.0%	32.9%
Not a U.S. Citizen	1,514,646	25.4%	60.0%
Total	**5,962,004**	**100.0%**	**25.2%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

- **Employment Status:** Most uninsured adults (69 percent) are employed. Of the remaining uninsured, only five percent are considered unemployed (i.e., are actively looking for work). The remaining 26 percent are not in the labor force, including parents who are taking care of children, early retirees who no longer work, non-working college students, adults caring for aging parents, individuals who are disabled and unable to work, and other adults who for various reasons are not working or looking for work.

Table 1.6: Uninsured Rates for Adults by Employment Status – 2007

Employment Status	Number of Uninsured Adults	Percent of Total Uninsured	Percent Uninsured Within Employment Category
Employed	3,022,227	69.0%	27.4%
Unemployed	224,499	5.1%	49.7%
Not in Labor Force	1,133,057	25.9%	35.8%
Total	**4,379,783**	**100.0%**	**29.9%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

- **Company Size:** Workers in small firms are more likely to be uninsured than employees in firms with 100 or more employees (Table 1.7). Nearly one-third (31 percent) of uninsured adults are employed in firms of less than 10 workers; a total of 59 percent work in firms of less than 100 employees. While nearly all large firms offer insurance, it is important to note that a quarter of the uninsured adults are employed in firms with 500 or more workers. Many of these workers are not eligible because they work too few hours or are considered temporary or contract workers.

Table 1.7: Uninsured Rates for Employed Adults by Company Size – 2007

Size of Firm	Number of Uninsured Adults	Percent of Total Uninsured	Percent Uninsured Within Size Category
Not Reported	179,708	5.9%	57.3%
Less than 10	944,193	31.2%	44.5%
10-24	411,566	13.6%	44.0%
25-99	425,097	14.1%	33.3%
100-499	336,759	11.1%	25.0%
500-999	107,082	3.5%	17.5%
1,000 or more	617,822	20.4%	14.0%
Total	**3,022,227**	**100.0%**	**27.4%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

Private Insurance Market Overview

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 2006, accident and health insurers and health maintenance organizations (HMOs) reported more than $23 billion in health insurance premiums written in Texas. Although some small states have experienced a shortage of commercial carriers, Texas has not suffered reductions that other states have reported. In 2007, more than 700 insurers were licensed to offer health insurance coverage. An additional 14 HMOs also provided comprehensive coverage for more than one million Texans covered under fully insured commercial benefit plans.

Like other states, however, Texas' health insurance market is dominated by a few companies. Based on premium information provided in the annual financial statements required of all insurers, the two largest insurers collected 41 percent of total premiums paid in 2006. The top 4 insurers collected more than half (54.9 percent) of premiums, and the largest 12 wrote 70 percent. Similarly, the three largest HMOs collected 70 percent of commercial premiums. The largest five accounted for 85 percent of premiums.

Texas has also continued to maintain a healthy market for small employers. In the years immediately following the federal small employer market reforms under the Health Insurance Portability and Accountability Act (HIPAA), and subsequent state insurance reforms, a number of small employer insurers chose to leave the small employer market. 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 46 health insurers and HMOs offering health plans for small businesses.

Many of Texas' licensed insurers and HMOs also administer self-funded plans frequently offered by large employers. Self-funded plans are exempt from state regulation under the federal Employees Retirement and Income Security Act (ERISA). While most insurance plans offered by small employers are fully insured and subject to oversight by the Texas Department of

Insurance, many large firms provide self-funded plans. Administrative services provided by licensed insurers for self-funded plans are also exempt from state oversight. Based on various resources, TDI estimates that approximately 60 percent of Texans with employer sponsored coverage (7.2 million people) were covered under self-funded ERISA plans in 2006.

Employer Sponsored Insurance Availability and Participation

Although affordability is a significant concern, availability of private insurance – either group or individual – has not been a problem for most Texans. Due to revisions in the regulation of small group insurers and creation of the Texas Health Insurance Risk Pool, almost all state residents are guaranteed access to insurance. However, premium costs, employee contribution requirements, and participation requirements among small firms continue to have an impact on the ability of small groups and individuals to purchase coverage.

Of the Texans who have health insurance, slightly more than half (56.9 percent) have private coverage, compared to a national average of 67.5 percent. As the table below shows, compared to residents of other states, Texans are less likely to have access to employer-sponsored coverage since fewer employers offer insurance. While most states have experienced declining rates of employer-sponsored coverage in recent years, the decline in Texas is more pronounced. Since 2001, the percentage of Texans with employer coverage has dropped from 58.5 percent to the current rate of 50.4 percent, a 16 percent decrease in 6 years.

Table 1.8: Sources of Health Insurance

Source of Insurance	Number	Texas Percentage	National Average
Private Insurance	**13,490,000**	**56.9%**	**67.5%**
Employment Based	11,949,000	50.4%	59.3%
Individual Insurance	1,709,000	7.2%	8.9%
Government Insurance	**6,086,000**	**25.7%**	**27.8%**
Medicaid	3,015,000	12.7%	13.2%
Also has private insurance	410,000	1.7%	2.3%
Medicare	2,814,000	11.9%	13.8%
Also has private insurance	1,130,000	4.8%	7.1%
Military	1,017,000	4.3%	3.7%
Total Insured	**17,742,000**	**74.8%**	**84.7%**

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.

Note: Numbers may not add up to totals as some people have more than one type of insurance.

While the U.S. Census Bureau's Current Population Survey provides insurance data based on a survey of the general population, another resource provides extensive information on the availability and affordability of employer sponsored coverage. The federal Agency for

Healthcare Research and Quality (AHRQ) oversees the annual Medical Expenditure Panel Survey – Insurance Component (MEPS-IC). The MEPS-IC survey collects detailed information on employer-sponsored insurance, including data for both large firms (defined as 50 or more employees) and small businesses (2-49 employees). Table 1.9 summarizes information on both offer rates and participation rates for large and small businesses and clearly indicates important differences based on firm size. Some of the more significant findings are:

- Most large firms (88.9 percent) offer health insurance compared to only 32.2 percent of small firms.

- Less than half (48.8 percent) of employees in small firms work for an employer offering coverage, compared to 92.5 percent of employees in large firms.

- More than 3.5 million workers in large firms are enrolled in the health plan offered by their employer, compared to 624,822 workers in small firms.

- More than one million workers have access to coverage in a large or small firm but are not enrolled. Some of these workers may have other coverage, such as a spouse's employer-sponsored plan. However, numbers collected through the CPS survey indicate a large number of these eligible workers are uninsured and have not enrolled due to costs or other reasons.

- Although most large employers offer coverage, many workers are not eligible. More than 1.6 million workers in large firms do not qualify for their employer-sponsored plan because they work part time, are temporary or contract workers, or have not worked long enough to meet the required waiting period. Again, however, not all of these workers are uninsured.

- More than 1.1 million employees in small firms also do not have access to coverage. Most of these workers (982,366) are employed in firms that do not offer coverage. Another 152,320 workers are eligible for coverage but are not enrolled.

Table 1.9: Employer Sponsored Insurance: Offer and Participation Data

Texas Insurance Enrollment Data	Small Firms	Large Firms
1. Total number of firms	294,072	124,657
2. Total number of employees	1,918,682	6,098,561
3. Percentage of firms that offer insurance	32.2%	88.9%
4. Number of firms that do offer insurance	94,691	110,820
5. Number of firms that do not offer insurance	199,381	13,837
6. Number of employees working in firms that offer insurance	936,316	5,641,168
7. Percentage of employees working in firms that offer insurance	48.8%	92.5
8. Number of employees working in firms that do not offer insurance	982,366	457,393
9. Number of employees eligible for coverage	777,142	4,479,087
10. Number of employees who are enrolled	624,822	3,533,999
11. Percentage of all employees that have employer-sponsored coverage	33%	58%
12. Number of employees who have access to coverage but are not enrolled	152,320	944,088
13. Number of employees who do not have access to coverage	1,141,540	1,619,474

Source: Agency for Healthcare Research and Quality, 2006 Medical Expenditure Panel Survey – Insurance Component.

Small Employer Insurance Market

Texas, like other states, has enacted numerous reforms and initiatives in an effort to encourage more small business owners to offer health insurance. In 1993, the Texas Legislature adopted the Small Employer Health Insurance Availability Act. The Act was subsequently amended in 1995, and minor revisions were adopted in 1997 to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements. The final reforms as they exist today apply to all small employers with 2 to 50 employees, and include the following provisions:

- guaranteed issuance of health insurance which prohibits an insurer from refusing to insure any eligible group, regardless of the health status of employees or dependents or size of the group;
- portability and continuation of coverage options for employees who want to keep their coverage when they leave a job;
- limitations on pre-existing condition requirements;
- premium rating requirements and limitations on rate increases based on a group's experience;

- ability to establish purchasing cooperatives that allow small firms to band together for the purpose of purchasing health insurance; and
- creation of "consumer choice of benefit" plans that allow insurers to offer plans that exclude or limit certain benefits with the expectation that premium costs would be significantly lower.

Since the initial reforms took effect in 1993, the number of small employers with health insurance has more than doubled from 36,952 in 1993 to 87,510 in 2007 (Table 1.10). Prior to the reforms, only 10 percent of small employers offered health care benefits, compared to an estimated 32 percent in 2007.

Table 1.10: Small Employer Insurance Enrollment 1993-2007

Year	Number of Small Employers with Insurance	Number of Insured Lives
1993	36,952	Unavailable
1994	50,144	Unavailable
1995	63,698	Unavailable
1996	74,164	Unavailable
1997	83,437	978,966
1998	86,106	1,608,737
1999	96,710	1,446,486
2000	97,793	1,444,480
2001	84,240	1,070,483
2002	89,201	1,192,386
2003	91,281	1,162,704
2004	91,456	1,189,319
2005	86,106	1,102,135
2006	88,571	1,178,414
2007	87,510	1,135,127

Source: Texas Department of Insurance Figure 48 Small Employer Experience Report.

While the small group reforms have addressed accessibility problems and enabled more small employers to obtain coverage, small business owners continue to report two primary obstacles to obtaining coverage: costs; and minimum participation requirements.

Insurance Costs and Rating Provisions

Clearly the most difficult challenge for employers (including both small and large firms) is the increasing cost of insurance. While all employers have experienced significant premium increases in recent years, the increases are usually more difficult for small firms to absorb and discourage many employers from even attempting to obtain coverage. As Table 1.11 below indicates, average premium costs have more than doubled in the past ten years.

Table 1.11: Average Small Business Premium Costs

Year	Average Annual Premium for Single Coverage	Average Annual Premium for Family Coverage
1997	$ 2,172	$ 5,534
1998	2,270	5,575
1999	2,539	6,486
2000	2,955	6,784
2001	3,229	7,974
2002	3,580	8,800
2003	3,793	9,831
2004	4,346	10,253
2005	4,270	10,970
2006	4,463	11,310

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component 1997-2006.

Although the MEPS (Medical Expenditure Panel Survey) rate data are not available for 2007 or 2008, insurance rates in 2007 increased an average of six percent, followed by average rate increases of eight percent in 2008. Based on these additional cost increases, the average cost of single coverage in 2008 is estimated at $5,109; family insurance is estimated to cost $12,947.

While these increases are dramatic, they are even more compelling when considered in the context of how much uninsured employers are willing to spend for health insurance. In a 2004 TDI survey of employers that did not offer health insurance, the vast majority of survey respondents indicated they could afford less than half of the average cost of coverage (Table 1.12). While the average monthly cost-per-employee in 2004 was $362, only **one percent** of surveyed employers reported they would pay at least $300 a month. Only 37 percent were able to spend at least $100 a month; one-third would pay $50 or less per-employee.

Table 1.12: Monthly Premium Amounts Employers Will Pay for Insurance

Cost Per-Employee-Per-Month That Employer Can Pay	2001	2004
Less than $50	23%	17%
$50	22%	17%
$100	20%	20%
$150	9%	8%
$200	5%	6%
$250	2%	2%
$300 or More	2%	1%
Would Not Purchase at Any Cost	14%	14%

Source: Texas Department of Insurance Small Employer Surveys, 2001 and 2004.

Although average premium costs are useful for tracking increases over time and for comparing Texas' premiums with those in other states, it is important to note that many small firms will face premiums significantly higher than average rates. Prior to the enactment of state and federal small group insurance reforms, Texas had no rating restrictions or limitations within the group health insurance market. Insurers charged whatever rates they felt were appropriate. With enactment of the guarantee issue provisions, regulators were concerned that insurers could avoid the intent of the law by increasing the premiums for unattractive groups to a point where the employer simply could not afford the coverage. To address this concern, most, if not all, states also enacted varying forms of insurance rating restrictions that were designed to restrict to some extent the amount of premium that could be charged for a high risk group. Legislative options enacted by states range from requiring approval of health insurance rates to a less restrictive "rate-band" approach as enacted in Texas. These rate-band provisions establish some parameters that insurers must follow when setting rates while still allowing for wide rate variation among groups and insurers. In Texas, rates are not subject to review or approval by the Department. The rate bands also limit the extent to which rates are increased for low-risk groups in order to subsidize rates for high-risk groups that would likely been denied coverage prior to the guaranteed issue requirements.

Understanding the process by which rates are established in Texas is critical to the development of a premium subsidy program that is designed to interact with the private insurance market. This is especially true when considering certain subsidy program design elements used in another state where significantly different insurance rate regulation requirements apply. The variations of rating structures in other states have broad implications on the cost of coverage and the variability among different employer groups, and will directly impact the success or failure of a similar program design in Texas.

Texas' small group insurance rating requirements involve a series of steps. First, a premium rate is determined based on the benefit plan design and the case characteristics of a group, as follows:

- Age and Gender: Each employee is assigned a premium rate based on their age and gender. No limitations apply to rate variations based on age or gender.
- Group Size: Insurers may vary rates up to 20 percent based on a group's size. Larger groups generally receive lower rates than smaller groups.
- Industry Factor: Rates may vary by an additional 15 percent based on the employer's type of industry due to the fact that some industries exhibit higher medical claim costs than others.
- Geographic Area: Rates may be increased or decreased based on an area factor that reflects the fact that medical costs may be higher or lower in some areas of the state.

Once the group rate is calculated based on the characteristics described above, the carrier may adjust the rate by a "risk load" to reflect risk characteristics that include health status-related factors of the group or any one member of the group. The risk load may be as high as 67 percent and must be applied uniformly to all members of the group in order to comply with the federal non-discrimination provisions under HIPAA. Upon renewal of a policy, rate increases based on the risk load factor are limited to no more than 15 percent per year. Increases due to other

factors such as changes in case characteristics (including the age of employees) may be in addition to any increase due to the risk load adjustment.

These rating provisions will allow some groups to qualify for premiums that are lower than the average stated above in Table 1.11, but other groups will be charged premiums significantly higher than average. Rates for older workers can be two or three times higher than the rates for younger workers. An employer with even one older employer may be charged premium rates much higher than a competitor with younger workers. In a 2006 TDI data call that is required of the largest insurers in the state, actual annual premiums for individual employees insured under policies issued by the carrier were as high as $19,055, $20,164, $20,610, $26,894, and $62,209. While such extreme costs are not common, these rates illustrate the wide range of premium rates a small employer may be charged depending on the characteristics of the workers. Many groups will encounter rates higher than the average available to other firms.

The impact of these rating provisions on the design of a premium subsidy program is an important factor that will be discussed in more detail later in the report. However, the numbers above illustrate that the relative value of a premium subsidy will vary significantly depending on the characteristics of a firm's employees if the subsidy program is designed for use under the existing rating structure that applies to the small group market. A business with an average monthly premium cost of $350 per employee will find that a subsidy of $150 a month will have a more significant impact than in a firm where the average monthly premium cost is $500 or more per worker.

Minimum Participation Requirements

In addition to creating rating provisions for small firms in order to complement the "guaranteed access" requirement, Texas and other states also enacted "minimum participation requirements" that are designed to ensure enrollment of an adequate number of healthy individuals to offset the costs of high risk enrollees. In Texas, state law allows an insurer to require enrollment of at least 75 percent of eligible employees within a small group in order to qualify for coverage. With guaranteed access, insurers are now required to accept all individuals in a small group, regardless of health status. When the law was first enacted, insurers were appropriately concerned that such a provision would attract a disproportionate number of unhealthy people and would discourage healthy individuals from enrolling in coverage if they knew they could enroll later if they became sick, a practice referred to a "adverse selection." Over time, premiums would continue to increase to cover the claims for the relatively sick groups and healthy individuals would continue to drop coverage, perpetuating the cycle of higher premiums and decreasing numbers of healthy enrollees.

In Texas, state law allows an insurer to require enrollment of at least 75 percent of eligible employees within a small group in order to qualify for coverage. Texas law provides that a small employer insurer may require a minimum percentage of workers to enroll in an employer plan in order to receive coverage. For groups of only two employees, the law requires both workers to enroll in the plan. For all other groups, a carrier may not require more than 75 percent of eligible employees to enroll. At the time HIPAA and state insurance reforms were enacted guaranteeing issuance to small groups that previously may have been declined by most insurers, the minimum participation requirement was provided as a way for insurers to protect against the

risk of "adverse selection." By requiring at least 75 percent of eligible employees to enroll, health plans were more likely to attract a balanced mix of both sick and healthy employees. However, in Texas as well as other states, small business owners report that the 75 percent participation requirement has prevented them from offering coverage to any of their employees. This is particularly true for:

- firms with a higher percentage of low-wage workers who often cannot afford the premium contribution required to enroll in the plan;
- small businesses with a large percentage of healthy, younger workers who feel that they do not need health insurance coverage or do not want to spend the money; and
- firms located in border communities where employers report many of their workers prefer to seek health care in Mexico, where the cost of medical care is often lower than the cost of insurance.

Despite the guaranteed issuance provision, an employer who cannot meet the participation requirements is not eligible for insurance and will be declined by the insurer. Although insurers are allowed to establish participation requirements below 75 percent, TDI is not aware of any insurers that have allowed a lower participation rate. Carriers are required to apply their participation requirements to all small groups.

Small Employer Insurance Participation

Although small employer insurance regulations in Texas apply to small firms with 2 to 50 employees, the smallest firms often encounter more significant challenges when trying to provide insurance. As Table 1.13 below shows, only 25.6 percent of firms with less than 10 employees offer coverage, compared to 44.3 percent of firms with 10 to 24 employees. Among firms with 25 to 50 employees, 72 percent offer insurance. Of all uninsured workers in small firms who do not have access to insurance, 50 percent work for employers with less than 10 employees, 32 percent in firms with 10 to 24 workers, and only 18 percent in firms with 25 to 50 employees.

Table 1.13: Small Employer Insurance Offer and Participation Data

Texas Insurance Enrollment Data	Firms with Less than 10 Employees	Firms With 10 to 24 Employees	All Small Firms with 2-50 Employees
1. Total number of firms	221,194	51,858	294,072
2. Total number of employees	790,608	617,107	1,918,682
3. Percentage of firms that offer insurance	25.6%	44.3%	32.2%
4. Number of firms that do offer insurance	56,625	22,973	94,691
5. Number of firms that do not offer insurance	164,569	28,885	199,381
6. Number of employees working in firms that offer insurance	252,203	297,445	936,316
7. Percentage of employees working in firms that offer insurance	31.9%	48.2%	48.8%
8. Number of employees working in firms that do not offer insurance	538,405	319,662	982,366
9. Number of employees eligible for coverage	215,633	253,720	777,142
10. Number of employees who are enrolled	172,506	204,498	624,822
11. Percentage of all employees that have employer-sponsored coverage	22%	33%	33%
12. Number of employees who have access to coverage but are not enrolled	43,127	49,222	152,320
13. Number of employees who do not have access to coverage	574,975	363,387	1,141,540

Source: Agency for Healthcare Research and Quality, 2006 Medical Expenditure Panel Survey – Insurance Component.

Texas Department of Insurance Small Employer Insurance Study

In 2001, Texas was fortunate to be selected as one of the early federal State Planning Grant (SPG) recipients, receiving $1.3 million to begin an ambitious study of the uninsured population. The work was continued under supplemental grants received in 2003 and 2005. Working with a diverse and proactive group of stakeholders who served on the SPG Oversight and Implementation Working Group, TDI staff completed a variety of qualitative and quantitative research activities, focusing primarily on the small employer insurance market. The study included multiple focus groups, surveys, and regional health fairs attended by small business owners and their employees, which allowed TDI to collect detailed information on the challenges small firms face, as well as make recommendations for changes that small employers would

support in an effort to provide more affordable health insurance options. During the third phase of the research project, the research data was used to develop a specific insurance program for small employers under the Insure Houston pilot project. Much of the SPG information is relevant to development of a premium subsidy program, particularly as it relates to affordability and benefit plan design. Following is a brief overview of the study findings that may be of value in considering options for a small employer subsidy.

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.
- Focus group participants often suggested that Texas should create a system of universal health care.

To follow up on issues raised in the original focus groups and to collect more comprehensive data from communities with high Hispanic populations, a second series of focus groups were held in 2005 in seven Texas cities: Houston; El Paso; Dallas; Amarillo; Laredo; Harlingen; and Corpus Christi. Cities on the Texas/Mexico border 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 questions 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.

Survey of Households above 200 Percent of Federal Poverty Level

Under contract with TDI through the SPG program, the Texas A&M University Survey Research Laboratory (SRL) conducted a telephone survey of uninsured households above 200 percent of federal poverty level (FPL). Individuals above 200 percent of FPL were selected due to the fact that most studies conclude that families below 200 percent of FPL require some type of subsidy or substantial premium assistance from employers or other entities. At the time the survey was conducted, more than 1.8 million uninsured Texans resided in families with incomes above 200 percent 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.

Small Employer Surveys – 2004 and 2001

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.

More than 13,000 completed surveys were received in 2001, 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 the 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.

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 had 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, for a response rate of over 21 percent, well above the typical response rate for surveys of this nature.

Some of the more significant findings of the 2004 survey are as follows:

- 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.
- Eighty-one percent of employers 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.
- Sixty-nine percent of employers said it is more important for government to focus on improving access to affordable health insurance than improving access to affordable health care, while 26 percent said that improving access to affordable health care is more important.
- 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.

A total of 51.7 percent of companies indicated that they did not currently offer health insurance in 2004, while only 45.9 percent did not offer coverage in 2001. Almost 85 percent of respondents said they had not provided health insurance coverage within the past five years, while only 41 percent had attempted to purchase health insurance during the same timeframe. Table 1.14 provides a detailed comparison of the percentage of companies that offered insurance or attempted to purchase it within the past three years.

Table 1.14: History of Offering Insurance and Attempts to Purchase Insurance

Offered or Attempted to Purchase Insurance	2004 Percentage of Respondents	2001 Percentage of Respondents	Percent Change
Employers who offered insurance within past five years	15.5%	15.1%	2.9%
Employers who have not offered insurance within past five years	83.7%	84.5%	(1.0%)
Employers that attempted to purchase insurance within past five years	40.9%	40.7%	0.6%
Employers that did not attempt to purchase insurance within past five years	58.0%	58.4%	(0.7%)

A large majority of employers not offering insurance (73 percent in 2004 and 77 percent in 2001) indicated that employees were interested in the benefit, with approximately 31 percent showing a strong level of interest. Yet, despite the significant interest among employees, few employers expect to offer insurance within the next three years. Only 1.6 percent of the surveyed firms in 2004 and 3.7 percent in 2001 stated they definitely **will** offer insurance, while 79 percent in 2004 and 75 percent in 2001 indicated that they either definitely or probably **will not** offer coverage.

Table 1.15: Likelihood of Offering Insurance Within the Next Three Years

	2004 Percentage of Respondents	2001 Percentage of Respondents	Percent Change
Company will definitely not offer health insurance in next three years	24.8%	25.2%	(1.6%)
Company probably will not offer health insurance in next three years	53.9%	49.3%	9.4%
Company probably will offer health insurance in next three years	18.2%	20.4%	(11.0%)
Company definitely will offer health insurance in next three years	1.6%	3.7%	(56.6%)

When asked to indicate the primary reason for not offering insurance, employers reported that cost is clearly the most significant factor. Sixty-five percent of the employers in 2004 and 62 percent of employers in 2001 indicated that they either tried to purchase coverage but found it too expensive, or they have not attempted to purchase coverage because they know it is unaffordable. Another seven percent of employers in 2001, and eight percent in 2004 were willing to offer the benefit, but have determined that the majority of their employees are unable to afford their share of the premium. Approximately four percent of the employers in both years report they were unable to obtain insurance because one or more employees have a pre-existing condition that makes the group uninsurable. It should be noted that under state insurance reforms enacted in 1993 and 1995, no small employer group may be denied coverage due to the health status of the applicants. The question does not, however, provide information that would allow us to determine whether the employer was actually wrongly denied coverage when they attempted to purchase insurance or if they simply believe they are ineligible for insurance. A detailed breakdown of responses is provided in Table 1.16.

Table 1.16: Primary Reason for Not Offering Insurance

Reason Insurance is not Offered	2004 Percentage of Respondents	2001 Percentage of Respondents	Percent Change
We have not tried to purchase insurance because we know it is too expensive.	26.9%	26.8%	0.4%
We tried to purchase insurance, but it was too expensive.	38.4%	35.6%	8.1%
The majority of employees do not want insurance because they already have coverage.	13.6%	15.1%	(10.2%)
We could not obtain insurance because one or more of our employees has a pre-existing health condition.	3.3%	4.0%	(16.3%)
The majority of employees do not want health insurance because they do not think it is necessary.	1.2%	0.9%	29.6%
The majority of employees prefer higher wages to health insurance.	4.2%	4.7%	(10.6%)
We are willing to offer coverage but the majority of employees are not able to afford their share of the premium.	7.9%	7.1%	11.6%
Providing health insurance is too much of an administrative hassle.	1.4%	1.5%	(8.5%)

To examine employers' perceptions regarding the cost of insurance and determine the amount of money they are able to pay for coverage, employers were asked how much the firm would be able to pay for each employee's coverage, most employers (69 percent in 2004 and 79 percent in 2001) report that they could pay no more than $100 a month. Forty-eight percent of companies in 2004 and 59 percent in 2001 actually responded that they could pay no more than $50 per employee per month. **This information is of particular importance as it confirms the fact that most small firms cannot afford premiums for even a relatively inexpensive benefit plan.** A detailed breakdown of the maximum employer contribution responses is provided below.

Table 1.17: Employers' Ability to Pay for Insurance

Maximum Premium Contribution Employer Can Afford Per-Employee-Per-Month	2004 Percentage of Respondents	2001 Percentage of Respondents	Percent Change
The company would not purchase insurance at any cost.	14.4%	13.7%	4.9%
Less than $50 per-employee-per-month.	17.2%	23.4%	(26.3%)
$50 per-employee-per-month.	16.7%	22.1%	(24.1%)
$100 per-employee-per-month.	20.3%	19.5%	4.3%
$150 per-employee-per-month.	7.8%	8.0%	(2.9%)
$200 per-employee-per-month.	6.1%	4.6%	33.5%
$250 per-employee-per-month.	2.2%	1.7%	26.4%
$300 or more per-employee-per-month.	1.3%	1.7%	(24.3%)

Several questions were included in the survey to determine the types of health care benefits that employers would most prefer if they were purchasing health insurance. When asked to choose between a basic benefit plan with annual benefit levels of $10,000, $20,000, or $50,000, or a catastrophic policy with limits of $100,000, $250,000, $500,000, or no limit, employers were surprisingly evenly divided in their choices. Nearly 46 percent chose a basic benefit plan and 48 percent chose a catastrophic plan in 2004, while these numbers were 48 percent for basic and 43 percent for catastrophic, respectively, in 2004. There was no consensus on policy limits, however, as illustrated in Table 1.18 below. The disparity of the distribution highlights the difficulty of designing a benefit plan that appeals to a large number of employers with diverse preferences and expectations.

Table 1.18: Employers' Preference for Basic or Catastrophic Plans With Annual Limits

Type of Benefit Plan	2004 Percentage of Respondents	2001 Percentage of Respondents
Preventive care, coverage for routine illnesses and minor injuries with a $10,000 annual limit per person each year	15.3%	14.3%
Preventive care, coverage for routine illnesses and minor injuries with a $20,000 annual limit per person each year	12.7%	12.5%
Preventive care, coverage for routine illnesses and minor injuries with a $50,000 annual limit per person each year	17.8%	21.1%
Catastrophic coverage that would not cover routine illnesses with a $100,000 annual limit per person each year	10.8%	12.4%
Catastrophic coverage that would not cover routine illnesses with a $250,000 annual limit per person each year	10.6%	N/A
Catastrophic coverage that would not cover routine illnesses with a $500,000 annual limit per person each year	11.0%	14.4%
Catastrophic coverage that would not cover routine illnesses with no annual limit	15.4%	16.6%

Note: Catastrophic coverage with a $250,000 maximum was not included as an answer choice on the 2001 survey.

When asked about the importance of specific benefits, employers' responses varied considerably as illustrated in Table 1.19. A majority of respondents expressed strong support for primary care only when an individual is sick (77 percent in 2004 and 72 percent in 2001), primary care when sick and for well-care (68 percent in 2004 and 67 percent in 2001), specialist care (74 percent in 2004 and 73 percent in 2001), in-patient hospital care (87 percent in 2004 and 85 percent in 2001), laboratory services (71 percent in both 2004 and 2001), prescription drugs (71 percent in both 2004 and 2001), radiological care (75 percent in 2004 and 73 percent in 2001), preventive screenings such as mammograms (65 percent in 2004 and 66 percent in 2001), and well-child care (53 percent in 2004 and 51 percent in 2001). Employers indicated the least amount of support for maternity care, mental health services, alcohol or drug abuse treatment, chiropractic care, vision benefits, and dental benefits.

Table 1.19: 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 = Not Reported

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%

Source: Final Results of the 2001 and 2004 Texas Small Employer Survey, Texas State Planning Grant.

Note: Questions related to surgical treatment for obesity and diet programs to treat obesity were not included in the 2001 survey.

All employers were asked to indicate their level of support for nine possible health insurance expansion options in both the 2001 survey and the 2004 survey. As shown in Table 1.20, the surveyed employers overwhelmingly support having the ability to purchase insurance through a large existing health insurance plan (91 percent); providing a financial incentive for small employers who offer health insurance (87 percent); allowing children not eligible for CHIP to "buy-in" to the program (79 percent); and or expanding the CHIP program to include more children (70 percent). Options receiving the least amount of support are expanding Medicaid to include low-income parents of children already enrolled in Medicaid (54 percent); providing a government subsidy to lower-income employees to help them pay their share of the cost of health insurance (52 percent); and expanding the state's Medicaid program to include the low-income parents of children who are already enrolled in Medicaid (45 percent).

Table 1.20: Level of Support for Health Insurance Expansion Options

A = Strongly Support; B = Generally Support; C = Generally Oppose; D = Strongly Oppose; NR = No Response

Description of Policy Option	Survey Year	A	B	C	D	NR
Allowing small businesses to purchase insurance through a large existing health insurance plan, such as the Texas state employees' health plan or the health plan for federal government employees	2001 2004	64% 64%	25% 27%	4% 3%	3% 2%	4% 4%
Reducing the mandated benefits insurers must include in their policies (such as coverage of immunizations, mammograms, chiropractic care, chemical/drug abuse, etc.) as long as insurers are also required to reduce their premium costs	2001 2004	26% 32%	31% 35%	21% 17%	17% 12%	6% 5%
Providing a financial incentive to encourage small employers to provide health insurance for their employees	2001 2004	54% 61%	30% 26%	7% 6%	4% 3%	5% 5%
Allowing children who are not eligible for the state's CHIP program to "buy-in" to the program by paying the required premium	2001 2004	34% 32%	43% 47%	10% 10%	5% 5%	8% 7%
Expanding the state's CHIP program to include the parents of children who are already enrolled in CHIP	2001 2004	23% 21%	33% 33%	21% 25%	13% 14%	10% 7%
Expanding the state's CHIP program to include more children	2001 2004	31% 30%	38% 40%	14% 15%	7% 8%	10% 8%
Providing a government subsidy to lower-income employees to help them pay their share of the cost of health insurance	2001 2004	21% 22%	29% 30%	24% 24%	19% 19%	7% 5%
Expanding the state's Medicaid program to include the low-income parents of children who are already enrolled in Medicaid	2001 2004	15% 15%	29% 30%	28% 29%	19% 20%	9% 6%
Expanding the state's Medicaid program to include more children	2001 2004	21% 21%	34% 36%	22% 22%	14% 14%	10% 7%

Finally, all companies were asked in 2004 to indicate whether the most important goal for government should be to improve access to low-cost health care for those who do not currently have insurance or to focus on options for improving access to affordable health insurance. An overwhelming majority (69 percent) stated that the government's most important objective should be improving access to affordable health insurance.

Legislative and Regulatory Initiatives to Assist Small Employers

Texas has implemented several ambitious programs in an effort to improve insurance options for small employers. Some programs experienced more widespread support and remain in place today. Others were discontinued or replaced with new options for a variety of reasons. Following is a brief summary of the most significant programs.

Texas Insurance Purchasing Alliance (TIPA) – Created by the Legislature in 1993 as a non-profit corporation, TIPA provided one of the first forms of "pooling" arrangements that allowed small employers to join together to purchase coverage from an assortment of insurance carriers/HMOs. The Alliance served as administrator and provided employers and employees the opportunity to choose from a variety of insurance plan options, a choice that normally was available only to large employers. By purchasing coverage under TIPA, each employee had access to several different benefit plans. Insurance premiums, theoretically, were reduced by achieving lower administrative costs through the services provided by TIPA. At its peak, 20 insurers participated, covering 1,000 employers and 13,000 lives (about 1 percent of the potential group market at the time). Approximately 50 percent of enrolled businesses were previously uninsured. However, significant premium reductions were never achieved and, over time, premiums of TIPA plans became less competitive due to a number of factors. The program disintegrated when enrollment did not live up to expectations; carriers began withdrawing in 1995 and the Alliance officially closed in July 1999.

Texas Health Reinsurance System (THRS) – Created by legislation as a non-profit entity, the Reinsurance System operates under an independent board appointed by the Commissioner but is subject to oversight by TDI. THRS provides reinsurance coverage for small group insurers and HMOs that elect to participate in the System. Large carriers and HMOs that can demonstrate financial capacity to adequately cover risk are not required to participate in the System. Carriers may submit individual enrollees or entire groups for reinsurance coverage. Reinsurance pays claims above $5,000, with the primary insurer paying 10 percent of claim costs between $5,000 and $50,000. After $50,000, reinsurance assumes 100 percent of an individual's remaining claims in that year. Net losses are funded through assessments on the System participants. Participation in TRS has been historically low due to the fact that large companies prefer to obtain and manage their own reinsurance. As of August 31, 2008, 6 insurers reinsured a total of 24 lives in THRS.

Consumer Choice Plans (CCP) – Consumer Choice plans were authorized by the 78th Legislature and were first offered in 2004. The plans may exclude or reduce coverage for certain mandated benefits as determined by statute, which should result in lower premium costs and provide a more affordable option for employers and individuals. Small employer carriers/HMOs must offer at least one Consumer Choice plan; individual and large group carriers may offer the plans, but are not required to do so.

Though enrollment was slow during the initial year, the number of insureds covered under Consumer Choice plans has more than tripled since plans were first offered in 2004. However, while the plans were intended to attract uninsured groups into the market, most enrollees were previously insured and switched to a consumer choice plan from another plan. In 2007, three percent of the plan enrollees were previously uninsured. Small employer benefit plans have attracted the highest enrollment with 141,078 insureds. Although these are not previously

uninsured individuals for the most part, some small employers may have otherwise chosen to drop coverage entirely if the Consumer Choice option was not available. Most small employers, however, have continued with the full-coverage benefit plans that include all mandated benefit requirements. Approximately 15 percent of small employers with insurance offered a consumer choice plan in 2007. The enrollment (including employees and dependents) represents 12 percent of total lives covered under all small employer plans.

Health Cooperatives/Purchasing Coalitions – Texas law allows small employers and, in some cases large employers, to create health group purchasing cooperatives or coalitions for the purpose of joining together to purchase health insurance. The larger group size attained by combining a number of firms together theoretically improves the group's purchasing power, enabling them to negotiate for lower insurance rates. Insurance carriers/HMOs are required to issue coverage to small group coalitions and cooperatives with no more than 50 employees. These plans can potentially reduce costs by 20 to 30 percent for some employers, primarily through lower administrative costs.

Standardized Small Employer Benefit Plans – In 1993 the Texas Legislature required all small employer carriers to offer three standardized benefit plans that were designed to be less expensive than traditional benefit plans. The plans were not popular with insurers/HMOs, and in 1995, the 74th Legislature made several revisions and required that only two standard plans be offered. However, insurers, HMOs, and agents resisted marketing of these plans and few employers were even aware these standardized plans existed. After years of very limited enrollment, the 78th Legislature in 2003 repealed the standard plan requirement and replaced the plans with Consumer Choice plans.

State Planning Grant Uninsured Study: Harris County Pilot Project Development – The final stage of the SPG program provided grants to selected states to design (but not implement) a pilot program that would provide coverage to a large segment of the uninsured. As a recipient of one of the pilot project planning grants, TDI worked with the city of Houston to design an affordable insurance program for small business owners and their workers. The Houston/Harris county area was selected for the pilot because of the high number of small businesses, an estimated uninsured population of 1.3 million residents, and a highly motivated business community that was actively seeking solutions for their uninsured workers.

Using data collected through surveys and focus groups conducted by TDI under the SPG program as described earlier in this report, TDI staff worked with stakeholders that included the Greater Houston Partnership, insurers, providers, employers, and employee representatives to develop a unique, affordable small employer insurance program. Essential elements for program success were identified and included:

- an average cost of no more than $150 per employee per month;
- inclusion of preventive and primary care benefits as well as protection from catastrophic injuries and illnesses;

- a simplified enrollment and rating process that would minimize the amount of time and effort required of employers and employees to enroll and allow employers to determine prior to application the true cost of coverage; and
- a benefit plan design that appeals to both employers and employees to encourage higher employee participation.

Working with consulting actuaries, two benefit plans were designed for testing (see Appendix A). One plan focuses on primary and preventive care with limited out-of-pocket costs and a low annual deductible, but includes length-of-stay limits for hospital care and service limits for out-patient care. The second plan includes a higher deductible and limited coverage for primary and preventive care, but provides more extensive coverage for catastrophic medical events.

To simplify the application process for employers, agents, and carriers, the two benefit plans were priced using a modified community rating process, which is a distinct and significant departure from the rating methodology currently used in the small group market in Texas. A simple rate chart would enable employers and agents to immediately calculate the group rate for their workers without going through a lengthy, time-consuming underwriting process. Rates vary only according to the age and gender of the group participants, with a standard rate for all children. Employers interested in enrolling in the plan could quickly estimate the cost of coverage for their group without submitting lengthy paperwork for underwriting review.

After completing the initial plan design, TDI staff conducted 25 focus groups with employers and employees throughout the Houston area. The prototype benefit plans were presented in detail to focus group participants, who then provided comments and suggestions for improving the benefit plan design. Based on the focus group comments, the consulting actuaries made slight modifications to the plan designs and provided final price estimates for the revised plans.

Focus group response to the benefit plan proposal was overwhelmingly positive. Even without the minor modifications, **88 percent of the participants indicated they would purchase the plans if the program were implemented as presented**. Key factors that were critical to their approval of the program included:

- simplified enrollment process;
- ability to immediately determine the true cost of coverage;
- availability of two benefit plans to meet the widely diverse medical needs and financial situations of employees; and
- affordability of the benefit plan.

In December, 2006, TDI hosted an industry conference to present the study findings and pilot proposal and to discuss implementation of the program. The Harris County Healthcare Alliance subsequently issued a Request for Proposals (RFP) in February to solicit an insurance carrier for the benefit plan. The Alliance planned to create a healthcare cooperative that would administer the program for small businesses in the Houston area. However, after discussions with three carriers, the Alliance was unable to reach agreement on the terms of a health care program that would implement the program objectives using the benefit plan designs while meeting the affordability requirements.

According to the Alliance, insurers were unwilling to comply with the modified community rating requirement due to concerns of adverse selection in a program that was unable to restrict or limit enrollment.

Chapter 2

Public Coverage in Texas

Public programs play an important role in providing access to health care services to uninsured individuals who otherwise likely would lack access to most of these services. A recent study done by the Kaiser Commission on Medicaid and the Uninsured showed that between 2004 and 2006, when the economy was still improving, the overall national uninsured rate increased from 16.9 to 17.9 percent. This increase in the number of the uninsured was explained by a decline in the rate of employer coverage while there was little change in public coverage. Later, between 2006 and 2007, employer coverage rates stabilized as public coverage increased, which led to an additional 1.5 million individuals obtaining coverage.[7] This study shows the critical role that public coverage plays in decreasing the number of uninsured.

Texas residents who do not have private health insurance can access health care services through a number of publicly funded programs, provided they meet the eligibility criteria set for each program. These programs include Medicaid, the Children's Health Insurance Program (CHIP), County Indigent Health Care programs, hospital-developed programs and hospital districts, and other state-funded programs managed by the Department of State Health Services, among others. When the number of individuals unable to access private health insurance increases, additional pressure is placed on publicly funded programs, as uninsured individuals are likely to seek access to health care services through these programs. As a result, funding for these programs represents a significant financial commitment by the state.

Overall, health and human services rank second only to public education as the largest expenditure of the Texas state budget.[8] In the 2008-09 biennium, state health and human services programs account for almost 32 percent of the total state budget ($168.8 billion).[9]

Medicaid

Medicaid is a jointly funded federal-state health care program that was designed to assist low-income families in providing health care for themselves and their children. In Texas, the Medicaid program was established in 1967 and is now administered by the Health and Human Services Commission (HHSC). Medicaid is an entitlement program, which means that the federal government does not, and a state cannot, limit the number of eligible people who can enroll, and Medicaid must pay for any medically necessary services covered under the program. In March 2008, approximately 2.9 million Texans,[10] about one in eight state residents, relied on Medicaid for health insurance or long-term services and supports.

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[7] Kaiser Commission on Medicaid and the Uninsured, The Decline in the Uninsured in 2007: Why Did It Happen and Can It Last?, p. 2.

[8] Legislative Budget Board, "Fiscal Size- Up: 2008-09 Biennium http://www.lbb.state.tx.us/Fiscal_Size-up/Fiscal%20Size-up%202008-09.pdf, p.9, figure 17.

[9] Legislative Budget Board, "Fiscal Size- Up: 2008-09 Biennium http://www.lbb.state.tx.us/Fiscal_Size-up/Fiscal%20Size-up%202008-09.pdf, p.2, figures 2 and 3.

[10] http://www.hhsc.state.tx.us/research/MedicaidEnrollment/meByMonthCompletedCount.html.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, the elderly, and people with disabilities. The federal poverty level (FPL) is a poverty threshold set by the U.S. government, which is used to determine program eligibility. Table 2.1 shows FPL by family size for 2006 through 2008.

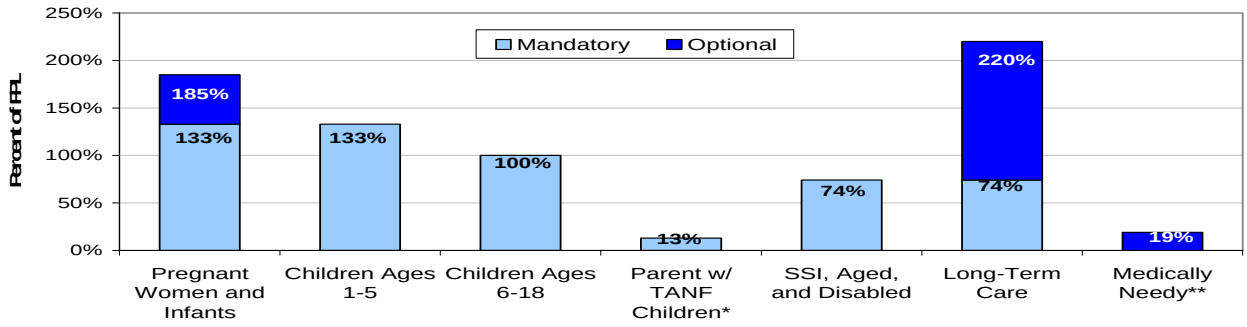
Table 2.1: Federal Poverty Guidelines, 2006-2008
(For the 48 Contiguous States)

Size of Family Unit	Annual Income		
	2006	2007	2008
1	$ 9,800	$10,210	$10,400
2	$13,200	$13,690	$14,000
3	$16,600	$17,170	$17,600
4	$20,000	$20,650	$21,200
5	$23,400	$24,130	$24,800
6	$26,800	$27,610	$28,400
7	$30,200	$31,090	$32,000
8	$33,600	$34,570	$35,600
For each additional person, add	$ 3,400	$ 3,480	$ 3,600

Source: U.S. Department of Health and Human Services, HHS Poverty Guidelines, http://aspe.hhs.gov/poverty/figures-fed-reg.shtml.

Allowable income for individuals varies based on the income parameters set by the program. Figure 2.1 shows current Medicaid income eligibility levels in the most common Medicaid eligibility categories. The federal government requires states participating in Medicaid to provide certain benefits to all mandatory populations at the required level, though states can choose to cover individuals with higher incomes as optional populations.

Figure 2.1: Texas Medicaid Income Eligibility Levels for Selected Programs, June 2008



* In SFY 2008, for a parent with TANF children, the maximum monthly income eligibility limit is $188, which is the equivalent of 13% of FPL for a family of three.
** For medically needy pregnant women and children, the maximum monthly income limit in SFY 2008 is $275, which is the equivalent of 19% of FPL for a family of three.

Source: Texas Medicaid in Perspective.

Texas Medicaid covers a limited number of optional groups. The state extends Medicaid eligibility to pregnant women and infants up to 185 percent of FPL – somewhat higher than the federal eligibility requirement for this group of 133 percent. Another optional group in Texas is known as the "medically needy" group, which includes children and pregnant women whose income limit exceeds Medicaid eligibility level but who do not have required resources to cover their medical expenses.[11] These individuals are allowed to subtract the cost of their medical bills from income and, if their remaining income meets Medicaid income limits, they become Medicaid eligible. Texas also covers as optional those individuals in need of long-term care services whose incomes fall between 74 percent and 220 percent of FPL.

Medicaid offers a comprehensive benefit package that includes coverage for physician, inpatient, outpatient, pharmacy, lab, and x-ray services. It also covers long-term services and supports for aged and disabled clients.

Medicaid Costs

Overall, Medicaid costs continue to increase. Texas Medicaid expenditures doubled in 10 years from $8.5 billion to $16.9 billion in federal fiscal year 2007 (excluding Disproportionate Share Hospital (DSH) and Upper Payment Limit). In federal fiscal year 2008, Medicaid expenditures were estimated at $19 billion, including $7.5 billion in state funds and $11.5 billion in federal funds. The federal share of the program is determined annually based on average state per capita income compared to the U.S. average. The federal government funds approximately 61 percent of the cost of the Medicaid program in Texas.[12] The state share is funded with general revenue funds appropriated by the Texas Legislature.

[11] Texas Medicaid in Perspective, Chapter 1, pages 1-2 – 1-3.
[12] Texas Medicaid in Perspective, 6th edition.

Medicaid enrollees, for the most part, access health care services in a managed care environment similar to those with private insurance. Services are delivered through managed care organizations (MCOs) or through a primary-care case-management model. Individuals enrolled in the regular Medicaid program do not have cost-sharing obligations. The federal government strictly limits states' ability to impose cost-sharing obligations for low-income Medicaid enrollees.

Medicaid and Private Insurance

Comparing the costs and benefits of Medicaid with those of the private insurance market is difficult. The Medicaid population includes the elderly and people who have disabilities and chronic illnesses – groups which typically do not have comprehensive health insurance. Moreover, Medicaid pays for long-term services and supports, such as nursing facilities and personal attendant care, which are not typically covered by private health insurance. It also pays for comprehensive services to children that exceed those offered by most private insurance plans. Given the unique concentration of medically high-risk persons enrolled in the Texas Medicaid program, no commercial insurance pool would resemble the Medicaid population. Table 2.2 provides a high-level comparison of Medicaid benefits and those a typical private employer-sponsored health insurance package might offer.

Table 2.2: Comparison of Medicaid Benefits and a Typical Private Employer-Sponsored Health Insurance Benefit Package

	Medical (Inpatient Hospital, Acute Care)	Dental	Long-Term Services and Supports	Prescription Drugs	Lifetime Maximum Benefit	Deductible
Medicaid: Children	Yes	Yes	Yes	Yes (Unlimited)	None	None
Medicaid: Adults	Yes	No	Yes	Yes (Three per Month)*	None	None
Typical Employee Benefit Package (Individual Adult or Child)	Yes	Yes (Separate Optional Coverage with Additional Contribution)	No	Yes (Usually Requires a Co-pay)	$1,000,000 (or More for a Majority of Individuals)	$0-$1,700 (Varies by Plan Type)

* Some exceptions apply. For example, nursing facility residents, home and community-based waiver clients, and STAR, ICM, and STAR+PLUS adult enrollees receive unlimited prescription benefits.

Source: The Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefit 2007 Annual Survey and Texas Medicaid in Perspective.

When the costs of providing coverage for a similar group of individuals (e.g., non-disabled adults) are compared, Medicaid's average costs tend to be lower than in private plans, mostly because of the lower reimbursement levels to providers. In 2008, the average cost of health care services (including prescription drug benefits) for low-income, non-disabled Medicaid adults is estimated to be $312 a month.

Medicaid can also be used as a vehicle for increasing access to private health insurance. In 1994, Texas implemented the Health Insurance Premium Payment (HIPP) program, in which Medicaid recipients with access to private insurance can enroll in employer-sponsored insurance (ESI). In order to qualify for HIPP, an employee must either be Medicaid eligible or have a family member who is qualified for Medicaid. The state reimburses enrollees for their (and their family members') share of the ESI when it is determined that the cost of insurance premiums and administration is less than the cost of projected Medicaid expenditures for the Medicaid enrolled individuals. The state also pays for the co-payments, deductibles, and other cost sharing for these enrollees, as well as Medicaid-covered services that are not part of the ESI benefit. HIPP enrollees who are not eligible for Medicaid are required to pay all cost-sharing obligations, including the deductible and co-payments as required by the ESI plan.

In fiscal year 2006, HIPP covered 29,312 individuals, including 12,012 Medicaid eligible enrollees and their family members.[13] The 80th Legislature, Regular Session, 2007, required HHSC to improve HIPP referrals and increase enrollment in the program.[14] The agency is currently working on implementing program improvements; however, recent studies have shown that many employers have increased cost-sharing obligations for their employees, which could impact the cost-effectiveness test.[15]

Supplemental Medicaid Funding

The Medicaid program also funds a significant amount of uncompensated care in Texas through two supplemental payment programs: the Disproportionate Share Hospital (DSH) program and the Upper Payment Limit (UPL) program. The $1.5 billion DSH program is specifically intended to provide funds to qualifying hospitals to help offset costs generated by providing care to Medicaid, low-income and indigent patients. The UPL program, now at an estimated $2 billion per year, funds qualifying hospitals for the difference between their regular Medicaid reimbursements and what they would have been paid using Medicare payment principles. These funds can be used by hospitals to help offset uncompensated care costs and represent a significant amount of funding related to costs generated by the uninsured.

Medicaid Buy-In

The Medicaid Buy-In program, authorized by the 79th Texas Legislature in 2005, covers working Texans who have Social Security defined disabilities and earn less than 250 percent of the federal poverty level. The program is referred to as a "buy-in" because individuals that participate in the program pay varying monthly premiums based upon their income. Individuals in the Medicaid Buy-In program have access to the same Medicaid services available to adult Medicaid recipients, which include office visits, hospital stays, x-rays, vision services, hearing services, and prescriptions. Qualified individuals may also be eligible for attendant services and day activity health services.

In October of 2008, 48 individuals were enrolled in this program. The agency is seeking to expand participation in this program through the Legislative Appropriations Request.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) provides health insurance to uninsured children and teens who are not eligible for or enrolled in Medicaid and whose income is at or below 200 percent of the FPL. The CHIP benefit package includes coverage for primary and preventive care, inpatient and outpatient hospitalization, pharmacy, lab, x-ray, rehabilitation, mental health, vision, and dental services. Overall, CHIP coverage is similar to what individuals receive in large private insurance plans.

[13] Texas Medicaid in Perspective, Chapter 2, pp. 2-8.
[14] GAA, http://www.lbb.state.tx.us/Bill_80/8_FSU/80-8_FSU_1007_Art1_thru_Art2.pdf rider 42.
[15] http://www.kff.org/newsroom/ehbs092408.cfm.

Like Medicaid, CHIP is also funded jointly by the federal and Texas governments, with the federal government contributing about 72 percent of total program costs in 2008. Total health care costs of the program, including prescription drug benefits, are estimated to be $604.8 million for fiscal year 2008.

In 2008, 389,062 children accessed health insurance through CHIP. More than half of all enrolled children (54 percent) are in families with incomes between 101 percent and 150 percent of FPL.

Some families in CHIP pay an annual enrollment fee to cover all children in the family. This amount is based on family income and ranges between $0 and $50. CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. As with the enrollment fee, co-payment amounts vary depending on family income. For example, families with lower incomes pay $3 for a doctor visit, while individuals in a higher income family will pay $10 for a similar visit. The amount that a family is required to contribute to the cost of health care services is capped based on the family's annual income. The family contribution is capped at 1.25 percent of family income for families with income at or below 150 percent of FPL and 2.5 percent for families with income between 151 and 200 percent of FPL.

Children enrolled in CHIP receive their services through managed care organizations. The average monthly cost of providing health services (including the prescription drug benefit) in 2008 is about $125 per child.

Texas also sought federal approval to allow families to use their CHIP premiums as a contribution to employer-sponsored insurance (ESI) for CHIP children. Under the program titled CHIP Premium Assistance, or CHIP PA, Texas sought flexibility for families to help pay for their ESI coverage, including children's coverage, with the CHIP premiums. This option would offer CHIP families a program similar to the Medicaid HIPP program, which also makes premiums available for ESI under certain conditions. The federal government did not approve this request by Texas, and HHSC plans to pursue a CHIP PA program through an amendment to the reform waiver, after its approval.

CHIP Perinatal Program

The 79th Legislature, Regular Session, 2005, authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The program began enrollment in January 2007, to provide prenatal care for the unborn children of low-income women who do not qualify for Medicaid. Once born, the child receives traditional CHIP benefits for the duration of the coverage period. In 2008, the program provided health coverage to almost 54,000 clients with an average monthly cost of $516.

Additional State Funding for Health Care Services

In addition to the Medicaid and CHIP programs, the state funds a number of programs to help address the health care needs of low-income individuals without insurance or persons with special medical conditions.

The Department of State Health Services coordinates several programs that assist uninsured individuals in accessing primary and preventive care services, and mental health services for children and adults. Specialized services are available for children with special health-care needs, individuals with end-stage renal disease (through the Kidney Health Care program), and individuals who have epilepsy or hemophilia. The state has also made funding available for hospitals to partially reimburse costs of providing care to uninsured and under-insured individuals in need of services as a result of traumatic accidents.

The Department of Assistive and Rehabilitative Services provides reimbursement for comprehensive rehabilitation services for individuals with spinal cord and/or traumatic brain injuries.

In addition to the state-funded programs, there are local programs in place that provide access to health care. Texas counties are constitutionally required to provide health care services to their uninsured low-income residents. Counties that do not have hospital districts or public hospitals meet their constitutional obligations through County Indigent Health Care Programs that provide services for individuals with income at or below 21 percent of the FPL. Counties can choose to provide services to individuals with higher income depending on the availability of funding. Many counties that have public hospitals or hospital districts provide access to health care for individuals with income higher than 21 percent of FPL. Most of these local programs serve individuals with incomes below 150 percent of FPL.

Each year the state provides financial support to counties that spend more than 8 percent of their tax revenue for the County Indigent Health Care program. The state has also designated a portion of the tobacco settlement funds to compensate for some of the unreimbursed health care costs at the county, city and hospital district levels.

Multi-Share Programs

During the last several years, a number of states and local communities have developed programs to provide health-care coverage to uninsured individuals who work for small businesses using a blend of employer, employee, and public funds.

Having multiple payers finance the premium makes the coverage more affordable, and therefore, more attractive to businesses and employees. Multi-share programs can offer a comprehensive benefit at a price that is often lower than what is available in the traditional small employer market. Multi-share programs, as designed in Texas, are not insurance programs but rather coverage of health care services.

HHSC, as required by S.B. 10, and TDI, as directed by Rider 18 of the General Appropriations Act, together provided $1,660,000 in grants to entities that are working to develop multi-share programs: Galveston; Central Texas; Houston; Dallas; El Paso; and the Brazos Valley. HHSC's grants totaled $1 million and TDI provided $660,000.

By assisting communities in the development of the programs, the state facilitates establishment of local infrastructures that will:

- Assist small businesses in accessing affordable health coverage.
- Improve access to care for the employees of the small businesses and their families.
- Reduce the likelihood that these individuals and their families will need to rely on public programs.

Currently, only Galveston's 3-Share program is operational. The program, which started in July 2008, has currently enrolled 500 individuals, and plans to make health care services accessible to 5,000 individuals over a five-year period. Other communities that are working to establish the infrastructure for multi-share programs include Harris County, Central Texas (Travis, Williamson and Hays counties), Dallas County, and El Paso County. The 3-Share programs project that they will cover up to 50,000 individuals.

State Initiatives Under Development

Even though Texas has a number of programs for uninsured individuals, its 26 percent uninsured rate still leads the nation. To address the continuing growth of the uninsured and related costs, S.B. 10 also included a provision that required HHSC to establish the Health Opportunity Pool (HOP), a portion of which could be used for reducing the number of people without access to health coverage. Under Section 531.507 of S.B. 10, HHSC is required to develop a premium assistance program to provide subsidies for low-income uninsured individuals.

In April of 2008, HHSC submitted a Medicaid and health care reform waiver proposal to the Centers for Medicare and Medicaid Services (CMS) requesting new federal funds as well as the authority to use certain existing federal funds to provide subsidies to uninsured individuals at or below 200 percent of FPL (depending on available funding). Individuals with access to qualifying employer sponsored insurance (ESI) would be able to use subsidies to purchase the coverage through their employers.

Implementation of the waiver is contingent upon CMS approval of the state's proposal. At the time of submission of this report, negotiations are ongoing. HHSC expects that, if the waiver is approved, the subsidy program for low-income uninsured individuals would begin in late 2009.

Healthy Texas Small Employer Assistance Program

S.B. 10 also requires TDI to make recommendations for the creation of a "Healthy Texas" program to offer health insurance coverage to small employers (those with 2-50 employees) and their employees. The Department has been working with various stakeholders throughout the past year and will be publishing the results of the TDI study in a separate report for the Legislature's consideration. While some of the final details of the program are still under development, the Healthy Texas program would create a statewide reinsurance fund that reduces premium costs for small employers by assuming the financial risk of health care claims above a certain level. The program, as proposed, would be available to eligible small employers who currently do not offer insurance.

If enacted by the Legislature, the reinsurance program could also be used to provide insurance for low income individuals who qualify for coverage under the proposed HOP. Though the program details will be determined based in part on benefit requirements of CMS and may require dual benefit plans for small employers and low income individuals, the reinsurance concept and program infrastructure could be designed to accommodate both types of enrollees. The program also would meet the state's goal of expanding access to private coverage while creating a unique partnership between the public and private insurance programs.

Once finalized, the Healthy Texas report will be published on the TDI website at www.tdi.state.tx.us. The report will be located under the heading "Publications and Reports."

Chapter 3

Premium Assistance Programs In Other States

At least a dozen states have enacted some type of premium subsidy program to assist qualified individuals obtain coverage. Premium assistance programs generally use federal and state Medicaid and/or SCHIP funds to assist low income workers and families to purchase coverage. States use both employer programs and individual health plans to provide coverage, as well as public programs. In addition to extending health care to previously uninsured individuals, several of the more recent subsidy programs are designed to encourage enrollees to move from public coverage into private market plans. Other programs create a unique benefit plan specifically for the subsidy.

This study reviews premium assistance programs in several states including Arizona, Arkansas, Maine, Massachusetts, Michigan, Montana, New Mexico, New York, Oklahoma, and Oregon. While this list is by no means comprehensive, the selection of states was chosen to provide an overview of the wide range of approaches states have used in designing a premium assistance program.

While programs in other states provide valuable insight and direction on opportunities that Texas may want to explore, every program is uniquely designed to complement each state's public programs and private insurance market. Distinct differences in states' Medicaid and SCHIP programs will determine what specific approach is best suited for a particular state. If subsidy programs are coordinated with private benefit plans, the varying insurance regulatory provisions and market conditions of each state are equally important. A program that functions well in one state may not work in Texas without significant changes in both the public and private market sectors. The summaries provided below are intended to provide a general overview of the various options that other states have enacted, but do not provide the level of detail necessary to adequately evaluate the appropriateness of such an approach in Texas.

Public Coverage in Selected States

Coverage of individuals through premium assistance programs cannot be considered in isolation. Existing public programs should be reviewed in conjunction with the review of the states' subsidy programs. If a state already provides Medicaid coverage to optional populations with higher income levels, then this state would have fewer low income individuals without access to health coverage.

For example, based on the Kaiser Foundation 2005 data, Medicaid enrollment, as shown in Table 3.1, represented 17 percent of the total population in Texas. All states selected for the review of their premium assistance programs, except for Oregon and Montana, covered a higher percentage of the state's total population through their Medicaid programs during the same year. In addition, these states also provide broader coverage for optional Medicaid populations, such as parents of children enrolled in public programs.

Table 3.1: Public Coverage Statistics and the Uninsurance Rate

State	Medicaid Enrollment as a Percent of Total Population (2005)	Income Eligibility for Non-Working Parents Applying for Medicaid (2008)	Income Eligibility for Working Parents Applying for Medicaid (2008)	State's Uninsurance Rate[25]*
Texas	17%	13%	28%	24.4%
Arizona	24%	200%	200%	19.6%
Arkansas	27%	200%	200%	17.5%
Maine	20%	200%	206%	9.5%
Massachusetts	19%	133%	133%	8.3%
Michigan	18%	38%	61%	10.8%
Montana	12%	33%	60%	16.1%
New Mexico	28%	200%	409%	21.9%
New York	26%	150%	150%	13.4%
Oklahoma	20%	200%	200%	18.2%
Oregon	15%	100%	100%	16.8%

* Percent of People Without Health Insurance Coverage by State Using Two- and Three-Year Averages: 2004-2005 and 2006-2007.

The Medicaid program is also used as a vehicle for covering uninsured individuals through innovative programs that are different than traditional Medicaid.

Based on the authority granted in Section 1115 of the Social Security Act, the Secretary of Health and Human Services has broad authority to authorize demonstration projects that are in line with the objectives of the Medicaid statute. In these demonstration projects, also known as Medicaid waivers, states expand eligibility to individuals not qualified under eligibility rules in the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.[26] Since 2001, 1115 demonstration projects also include Health Insurance Flexibility and Accountability (HIFA) waivers to extend health coverage to people who are uninsured without increasing federal Medicaid funding.[27]

These waivers allow states to provide coverage to individuals who otherwise would not be able to qualify for Medicaid, including adults without dependent children.
The majority of the states referenced in this report finance their premium assistance programs through Medicaid or SCHIP programs. Only two states designed their programs without any federal financing. The Deficit Reduction Act (DRA) of 2005 had an impact on the federal funding available to states to finance new coverage initiatives. Section 6102 of the DRA prohibited the use of SCHIP funds for the coverage of non-pregnant childless adults, which

[25] U.S. Census Bureau, Income Poverty and Health insurance coverage in the United States: 2007 (p.25).
[26] http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp.
[27] http://www.familiesusa.org/issues/medicaid/other/waivers/waiver-faqs.html#7 (Q.4).

many states had previously done. This provision applied to the demonstration projects approved after enactment of the DRA and did not apply to any existing waivers or waiver amendments.[28]

Below is a description of each of the referenced state's premium assistance program(s). Appendix B also contains tables summarizing each state's target population, employer eligibility, employee eligibility, funding, premiums/subsidies, enrollment, underwriting, delivery system, and benefit.

Arizona – The state of Arizona has two premium assistance programs, which are different in their organizational structure, relation to public coverage programs, and funding.

The Healthcare Group of Arizona (HCG) is a self-funded, state-sponsored public-private partnership that contracts with insurers to provide lower-cost health benefit plans to self-employed individuals, businesses with 50 or fewer employees, and governmental subdivisions (cities, counties, etc.). Since July 2005, HCG does not subsidize employer or employee premiums; rather it attains lower costs by protecting carriers through aggregate stop-loss reinsurance, which is financed through member premiums. While HCG encourages employers to contribute to their employees' monthly premiums, it does not require them to do so. Effective September 19, 2007, through July 31, 2008, the Arizona State Legislature has placed an enrollment freeze on all HCG plans.

HCG contracts with three managed care organizations to provide an HMO product, though the program determines the form and design of each plan. In 2006, benefit packages were expanded and a statewide preferred point of service (PPOS) product was created. The benefit packages are designed to appeal to varying employee income levels and employer health care budgets. The HMO product has three levels of plans: Classic Healthstyles is the most comprehensive and, therefore, most expensive option; Secure Advantage Healthstyles was designed for those seeking coverage for only routine and preventative care; and Active Healthstyles is similar in design to Secure Advantage, though with lower premiums and higher co-payments. The PPOS has two levels of benefits: Consumer Choice Diamond; and Topaz. As of December 2006, HCG plans covered 24,562 lives, of which approximately 90 percent were enrolled under the various HMO plans.

To be eligible, employers must be either sole proprietorships or have 50 or fewer employees and have not offered health coverage for at least 6 months prior to enrolling. Additionally, the business must achieve and maintain an employee enrollment rate of at least 80 percent if it has 6 or more employees or 100 percent if it has fewer than 6. Employees may be waived from participation, however, if they already have health coverage.

All full-time employees (at least 20 hours per week) of participating businesses and their dependents are eligible to enroll. Eligibility is not based on annual income or wages earned, though as stated above, either 80 or 100 percent of employees must participate for an employer to be eligible.

[28] http://www.cms.hhs.gov/LegislativeUpdate/downloads/DRA0307.pdf.

All of the plans are offered on a guaranteed issue/renewable basis, just as in the commercial small group market. Unlike the commercial market, though, HCG plans are community rated; as such, premiums are determined by medical loss trend factors and a specific group's age makeup, gender composition, and geographic location – but not health status. Premiums in the private small group market are regulated through the use of rate bands, in which premiums may vary by up to 60 percent from the index rate based on health factors. During the renewal period, carriers may rate premiums due to general trend and up to an additional 15 percent for claims history, health status, and contract duration. In addition, Arizona has a unique regulation in that they require all insurance carriers offering products to medium and large employers to also offer to small employers. In turn, these companies may claim an exemption from the 2 percent tax on premiums derived from their small employer business, though some companies choose not to claim the exemption due to the consequent increased administrative cost.

In addition to the HCG program, Arizona has a second program that assists low-income uninsured individuals. This program was implemented as an Arizona Health Care Cost Containment System (AHCCCS) Section 1115 demonstration project. In 2001, the state received CMS approval to use unspent SCHIP funds to provide coverage to the following two populations:

(1) Individuals with adjusted net family income above 100 percent FPL and at or below 200 percent FPL who are parents of children enrolled in the Arizona Medicaid or SCHIP programs, but who themselves are not eligible for either program. The state estimated that in this group 21,250 individuals would be eligible for coverage.

(2) Adults over age 18 without dependent children (this group is also knows as childless adults) and with adjusted net family income at or below 100 percent of FPL. The state estimated that 27,000 individuals would be eligible for coverage under these parameters.

CMS requires the state to provide coverage for parents with SCHIP funds (priority one group), and use the remaining CHIP funds for childless adults (second priority group). If federal CHIP funds available to the state were exhausted, Arizona received the authority to use Title XIX Medicaid funds approved for the coverage of this group as part of the Medicaid Section 1115 eligibility expansion. Current waiver documents show that in federal fiscal year 2008, the state estimated serving approximately 11,000 parents with estimated costs of $37.9 million.

The state share of the program's funding comes from regular sources of funds used for the Medicaid program. Virtually all Medicaid state-match funds are received as appropriations from the Legislature or from initiatives enacted by Arizona voters. Sources of state-match include the General Revenue Fund, Tobacco Settlement Funds, Tobacco Tax Funds, and county funds.

Services to eligible individuals are provided by ten private or county-owned health plans, which are selected through a comprehensive bidding process. The program covers inpatient and outpatient hospital services, emergency room care, physician services, outpatient health services, lab, x-ray, pharmacy, behavioral health services, and several other services. The estimated monthly cost of covering an individual through the waiver program in federal fiscal year 2008 is $286.96, an increase of almost $20 from the average cost in federal fiscal year 2007, $266.10.

Parents of CHIP and Medicaid enrolled children have no deductibles and co-payments (except for a $1 co-payment for non-emergent visits to the emergency room) but have enrollment fees of $15 and have premium contributions, which vary from $15 to $25 a month, depending on the individual's income.

Childless adults have higher cost-sharing obligations, which include cost sharing for prescription drugs ($4 for generics and $10 for brand medications), $30 for non-emergent ER visits, and $5 for physician visits.

In 2006, Arizona received approval to renew its program for uninsured individuals through 2011. Under the waiver renewal, Arizona was also required to implement a subsidy program for individuals with access to ESI. CMS required that in Arizona's subsidized employer sponsored health care coverage programs (including HCG), all employers be required to contribute at least 50 percent toward the cost of the premium for the employee coverage and at least 30 percent toward the cost of dependent coverage.

Arkansas – Arkansas' ARHealthNetworks is a "safety net" benefit program that makes healthcare coverage available to uninsured low-wage employees of small businesses. A state-federal partnership (a HIFA waiver was approved in March 2006), the program presents a cost-effective insurance alternative to employers who have between 2 and 500 full-time employees (30+ hours per week), and subsidizes premiums for employees earning 200 percent or less of the FPL. As of July 2007, 178 businesses had enrolled accounting for a total of 665 lives.

ARHealthNetworks, similar to the waiver approved in Arizona, is funded with unspent federal Title XXI (SCHIP) funds for parents of children enrolled in SCHIP and Medicaid Title XIX for adults without dependent children. The goal of the program, as submitted to the federal government, was to provide a safety net benefit to approximately 50,000 individuals over 5 years. Arkansas' share for the program funding comes from the tobacco settlement funds.

Individuals with income above 200 percent of FPL are not subsidized, but can buy in the plan. The plan is only available to working Arkansans through qualified employers and is not available as an individual plan.

Employers wishing to enroll in ARHealthNetworks must not have offered group insurance in the previous 12 months and must have at least 1 employee who qualifies to receive premium subsidies. Additionally, all full-time employees must either participate in ARHealthNetworks (regardless of income) or have documented coverage under an outside group or individual health plan. Employers must commit for a period of 12 months and renew every 12 months (if they so choose). Participating employers are required to achieve 100 percent employee health insurance coverage, regardless of income. This requirement might have contributed to the low program enrollment, since it is challenging to achieve such a high participation rate for each employer.

All employees of enrolled businesses working at least 30 hours per week and their spouses will be offered coverage, though they will only be eligible for subsidized premiums if their annual family income is equal to or less than 200 percent FPL. Coverage for those not eligible for subsidies is offered at a basic premium rate based on gender and age. ARHealthNetworks does

not use any medical factor for purposes of underwriting. Premiums are paid by the employer, employee, or are shared. As of July 2007, monthly premiums ranged from $13 for a subsidized employee to $500 for an unsubsidized one, with an average employee premium of $25 per month.

ARHealthNetworks offers a single limited benefit health plan designed to cover the most basic health needs, and contracts with NovaSys Health to use its network of providers and facilities. Members must use NovaSys Health's network for benefits to be paid. The plan includes coverage for six physician visits per year (includes clinic visits, MD/DO), seven inpatient hospital days per year, two outpatient hospital services per year (surgery, radiology, ER visits), and two prescription drugs per month (using a tiered formulary). Members are required to share costs through an annual deductible, coinsurance, and co-payments. The annual deductible is $100 for individuals, which does not apply to office visits or prescription drugs; after the deductible is met, enrollees must pay 15 percent coinsurance. The plan also features an annual $1,000 maximum limit on out-of-pocket expenses and a $100,000 annual maximum benefit limit.

Whereas ARHealthNetworks does not use health status as a rating factor, carriers in the private small group market can use health to underwrite premiums within specified rate bands. Arkansas regulations state that carriers may not impose premiums either 25 percent higher or lower than the index rate based on health factors. This regulation applies to small groups of 2 to 25 people; there are no limits placed on premiums for groups of 26 or more. As in Arizona, carriers may rate premiums due to general trend and up to an additional 15 percent for claims history, health status, and contract duration during the renewal period.

Maine – The Dirigo Health Agency was created in mid-2003 to help expand coverage for low- and middle-income individuals. The eventual long-term goal was to establish universal coverage in Maine within six years. The Dirigo Health program concentrated on two coverage initiatives:(1) DirigoChoice, a subsidized health insurance program; and (2) an increase in the eligibility level in the state Medicaid program for parents of children enrolled in Medicaid.

DirigoChoice, which was established in 2005, is a voluntary program for low-income employees of small businesses (2 to 50 full-time employees), sole proprietors, and individuals. DirigoChoice provides benefits through two health plans – distinguished only by deductible amount – currently being administered by Harvard Pilgrim Health Care.

Before September 1, 2007, discounts on premiums and reductions in deductibles and out-of-pocket costs were available on a sliding scale for enrollees earning 300 percent or less FPL; however, an enrollment freeze has been placed on all new subsidized members due to a lack of funding. Effective January 1, 2008, Harvard Pilgrim Health Care assumed responsibility from Anthem BCBS for administering the DigiroChoice health plans. Through June 2007, the number of DirigoChoice members enrolled was 14,697 – small business accounted for 24 percent of membership, with sole proprietors and individuals comprising 27 and 49 percent, respectively. The number of previously uninsured DirigoChoice members (defined as uninsured at some point in the 12-month period prior to enrolling) through March 2007 was 36 percent. According to a

July 5, 2007, report in the *Ellsworth American*, the "vast majority" of DirigoChoice enrollees receive premium subsidies, which can reach as high as 80 percent of the monthly cost.

Under the existing plan, participating employers were required to extend coverage to an employee's family, but were limited to a contribution of 60 percent of the employee-only cost. All employers are eligible to enroll in DirigoChoice regardless of whether they have previously provided employer-sponsored insurance, though they must have at least 75 percent of eligible employees choose to enroll. Various incentives are available to employers and employees upon enrolling in the program, including: a $1,500 cash reward to employers who had not previously offered insurance; $25 cash to an enrollee upon the selection of a primary care physician; and an additional $75 for meeting with that physician to complete a health risk assessment.

Even though subsidies for low-income individuals were available to reduce the overall burden on employers and employees, costs still represented a barrier for some small businesses. Based on the Commonwealth Fund's study that included a survey of small businesses, in September of 2006, very small firms with two or three employees still found the product offered through DirigoChoice unaffordable.[29] The average monthly premium in the program in 2006 for single employees was $336.[30]

According to the Commonwealth Fund's study, funding for DirigoChoice subsidies was identified through an innovative approach called the "savings offset payment." This approach calculated savings to health care providers from lower uncompensated costs and other cost-savings initiatives through assessments on health insurance claims.[31]

Both plans in the program are HSA-qualified and are offered on a guaranteed issue/guaranteed renewable basis. Benefits included in both DirigoChoice plans include physician and specialist visits, preventive services (covered at 100 percent), inpatient and outpatient hospital care, routine diagnostic tests, and occupational and physical therapy. Individual deductibles range – dependent upon any amount of reduction – from $250 to $1,000 for Plan 1, and $500 to $1,750 for Plan 2 (multiply these numbers by 2 for family amounts). Annual out-of-pocket limits for individuals range from $800 to $4,000 and $1,600 to $5,600.

Premiums are established using a modified community rating system based on age, location, and industry type; this rating system is also in force in the private insurance market (for all group sizes). Rate variation may not be more than 20 percent above or below the community rate (set by each insurer) for all of these factors combined. Gender, health status, claims experience, and policy duration may not be used to determine rates. Maine also regulates the private market by reviewing premium rates for all individual and small group plans, allowing only limited premium increases in the small group market, and by requiring that at least 78 cents of every premium dollar increase must be spent on medical claims. In negotiating with Anthem, the Dirigo Health Agency established an experience modification program to share risks with the insurer, which acts as a reserve by providing funding should costs exceed agreed-upon targets.

[29] http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=605785.
[30] http://www.mathematica-mpr.com/publications/pdfs/Dirigofinalrpt.pdf, p.xvii.
[31] http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=605785.

Expansion via Public Programs

Dirigo Health has additional initiatives in place that assist low-income residents access a health care coverage program. The program expanded eligibility for low-income parents of children eligible for Medicaid or CHIP program from 150 percent of FPL through 200 percent of FPL.

In addition, since 2002, the state covers low-income adults without dependent children (childless adults) through the 1115(a) demonstration project titled MaineCare for Childless Adults. Since Medicaid in general does not allow states to provide coverage to adults without dependent children and who do not have special health care needs, states are required to go through the waiver process to be able to provide coverage to this population. States also must identify existing sources of federal funds to pay for the coverage of these individuals. Maine is funding coverage for this group through redirection of $90 million from its disproportionate share hospital (DSH) allocation.

The program provides coverage to individuals with income at or below 100 percent of FPL and the enrollment is capped at 20,000 individuals. As of December 2006, enrollment in the program was near its cap, and the program instituted an interest list for potential enrollees.[32]

The program provides a comprehensive benefit, which is more limited than the traditional Medicaid package, delivered through a primary care case management model. Enrollees are responsible for nominal co-payments that do not exceed $3.

The Commonwealth Fund study done in 2007 showed that enrollment in the public coverage programs exceeded enrollment in DirigoChoice, suggesting that low-income individuals preferred fully subsidized coverage through public programs to partially subsidized coverage through a private plan.[33] In addition, the study concluded that even when small businesses are interested in signing up for new products and offering their employees coverage, there is a limit to the voluntary system. States with low employer offer rates may not be able to raise the offer rate substantially without incentives or mandates.[34]

Massachusetts –Massachusetts has implemented many coverage initiatives through a Section 1115 Medicaid waiver, titled Massachusetts MassHealth 1115 Demonstration. Originally the demonstration was implemented in 1997, and since then has gone through a number of renewals and amendments. Many coverage initiatives were incorporated in the MassHealth Demonstration during the renewal process in 2005. Additionally, a number of components of the state health reform law became part of the MassHealth Demonstration in 2006 in the form of the waiver amendment.

[32] Quarterly Report for the period October 1, 2006-December 31, 2006 (pp 1-2).
[33] http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=605785 and http://www.mathematica-mpr.com/publications/pdfs/Dirigofinalrpt.pdf , p. xiv.
[34] http://www.mathematica-mpr.com/publications/pdfs/Dirigofinalrpt.pdf , p. xix.

State law that was passed in 2006 created a new independent agency, the Commonwealth Health Insurance Connector, to implement coverage initiatives through the following programs:

- **Commonwealth Care**

  This program, which is part of the Section 1115 waiver, provides sliding scale premium assistance for the purchase of private health insurance to individuals with annual incomes up to 300 percent of FPL. Eligible individuals enrolled in the program receive their services through four MCOs. Qualified individuals can pick from four benefit plans that have the same basic benefits but different levels of premium contribution and out-of-pocket costs. Individuals with income below 150 percent of FPL are not required to make premium contributions. However, individuals between 100 and 150 percent of FPL have higher cost-sharing obligations and do not receive dental coverage. Individuals with income between 151 and 300 percent have a monthly premium contribution between $35 and $105. As of May 2007, about 70,000 individuals were enrolled in this subsidy program.

- **Commonwealth Choice**

  This program provides commercial health products to small businesses and uninsured individuals with incomes above 300 percent of FPL. This program is not part of the MassHealth Demonstration (waiver). Since October 2007, the program has provided affordable, but not subsidized, health insurance options from private insurance carriers to small businesses and uninsured individuals not covered through ESI.

- **Young Adult Plans**

  This program offers low-cost coverage to residents 19 to 26 years of age who do not have access to employer coverage and who are not eligible for Mass Health, which is the state's Medicaid program.

The state law also created a mandate for all residents age 18 and older to purchase or enroll in health coverage. The state uses this approach to spread the risk by enrolling low-cost healthy individuals who otherwise might have decided to opt-out from purchasing insurance. State law also established the criteria for "minimum creditable coverage" that all residents are required to maintain. This sets a bar for the benefit packages that have to be offered through individuals and ESI coverage. Certain populations are exempt from this requirement because of low income. These individuals are offered coverage through public programs. Massachusetts Medicaid covers parents and caretakers of children up to 133 percent of FPL. Children enrolled in the SCHIP program are covered up to 300 percent of FPL.

Even prior to implementing health care reform, the state had strong employer sponsored coverage with an ESI coverage rate significantly higher than the national average, especially among small employers. Additional initiatives are being implemented now to bring in new employers who previously have not provided coverage to their employees.

For a number of years, the state has assisted small employers (less than 50 employees) and their employees in providing and purchasing ESI. The Insurance Partnership (IP) program has two components: a subsidy (incentive payment) for qualified small employers; and premium assistance for their low-income employees. In order to qualify for a subsidy, employers must contribute at least 50 percent of the health insurance premium for coverage that meets a basic benefit level. Individuals with income up to 300 percent of FPL are eligible for the subsidy. The IP program has enrolled more than 5,900 employers and provided coverage to more than 16,000 low-income individuals (employees and their families).

Under the waiver agreement, the program provides subsidies to eligible employers who have not been offering health insurance during the last 12 months and agree to contribute at least 50 percent of the premium. Employers who had been providing coverage prior to implementation of the premium assistance program approved under the waiver receive assistance from the state without matching federal funds. Self-employed individuals and sole proprietors are also eligible for "employee" subsidies.

State law does not require employers to provide coverage. However, all employers with 11 or more full-time employees are required to set up an IRS Section 125 "cafeteria plan" that allows employees to set aside pre-tax amounts that can be used for purchasing health insurance, regardless of employer participation. It is estimated that participating employees can save from 28 percent to 48 percent of their premium contributions, depending on their income. If the employer chooses not to offer insurance to employees, the employer is required to pay an annual assessment for each employee (in 2007 the assessment was $295). This funding is used to subsidize health insurance or direct health care costs of uninsured individuals.

Program Funding

The state finances initiatives covered under the MassHealth Demonstration by using a number of state sources including general revenue funds, certified public expenditures, a provider tax on certain hospital revenues, and an insurer surcharge. The federal portion of the program funding comes from the savings that the state has created by implementing a number of initiatives in its regular Medicaid program. The federal government allows states to spend "savings" to finance various coverage initiatives. The state also used available Title XXI (SCHIP) funds to cover previously uninsured individuals. In 2008, according to the Kaiser Health Policy Report, the cost of the program was about $647 million.[35]

Insurance Reform

In addition to the reforms described above, the state has also merged the individual and small group insurance markets in an effort to lower the cost of insurance. Studies estimated that this

[35] Kaiser health policy http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=52254.

approach would decrease the cost of premiums in the individual market by 15 percent and increase small group premiums by 1 to 1.5 percent.[36]

Michigan – The Muskegon Community Health Project (Muskegon County) created Access Health in 1999 to provide comprehensive health coverage to uninsured workers (and their dependents) of businesses who did not previously provide such coverage. One of the first and most successful community-based approaches to health care expansion, Access Health's three-share plan has served as a model for other states and localities seeking similar community-based initiatives. The program targets county businesses and is intended for small to medium-sized employers, though there is no upper limit placed on an eligible firm's employee size. The program originally limited employer size to 20 full-time employees, but removed this cap due to its failure to reach enrollment projections.

"Three-share" refers to a cost-sharing distribution among three parties; in this case, employers and employees each pay 30 percent of the monthly premium while the community contributes the remainder. Employers may also choose to pay the employee share as well, but they are not required to do so. An employer may also choose not to offer coverage to its employees' dependents, but if it does choose to offer dependent coverage, it must do so for all eligible employees. Employers offering dependent coverage are also required to share their premium costs. The Access Health program serves over 400 small businesses accounting for approximately 1,500 lives.

To be eligible for the program, businesses must be headquartered within Muskegon County and have not offered health insurance for at least 12 months previous to enrollment. Additionally, the median wage paid by the employer cannot exceed $11.50 per hour, and the employer must offer insurance to all employees working an average of 15.5 hours per week. Employees who work this average weekly amount and are not eligible for any public program (Medicaid, Medicare, etc.) may enroll with Access Health.

Access Health is considered a stand-alone healthcare program and not an insurance product; as such, it is not subject to state benefit mandates or other insurance regulatory requirements. Through communication with potential members (both employers and employees), the program developed a target premium range and then developed a benefit package. Covered services include primary and specialty physician services, emergency room visits, hospital care, diagnostic services, and prescription drugs. Access Health only covers services received within Muskegon County. Some specific services such as neonatal intensive care, organ transplants, serious burn care, and automobile-related injuries are not covered. Specific examples of cost-sharing include co-payments of $10 for primary office visits, $25 for specialist and surgical office visits, and $75 for ER visits; inpatient and outpatient services require 25 percent coinsurance with a $300 out-of-pocket maximum per stay.

The benefit package is offered under two options, the C3 (Choice, Challenge, Change) Plan and Standard Plan. To qualify for the reduced premiums and co-payments of the C3 Plan, a member (and any dependents) must meet certain requirements, such as undergoing a health assessment

[36] Section 1115 Demonstration project Extension request, 2007, p. 12.

and meeting with an assigned health advisor who develops an "action plan" that must be followed. Additionally, the member must complete 2 health classes within the 12-month enrollment period.

Access Health pays physicians 120 percent of Medicare on a fee-for-service (FFS) basis, and in turn physicians return a 10 percent donation to Access Health to subsidize the cost of the program's administration. Due to its community-sponsored status and generous pay rates, the program has attracted participation from over 97 percent of the county's physicians. Hospitals are paid at 101 percent of Medicare's payment rate for diagnosis related groups (DRG), and the two in-county hospitals both participate. Access Health handles all medical claims internally (though it does contract out its pharmaceutical claims) and keeps costs low by providing utilization review, case management, and disease management. Additionally, it has its own sales staff and works closely with local brokers/agents.

For the community share, Access Health used available local funds, foundation funds, and certain federal funds including DSH and grants received from federal Health Resources and Services Administration (HRSA).

Michigan employs both rate bands and a modified community rating system in its private small group market, depending upon the type of carrier. Commercial carriers are regulated by rate bands and are allowed to up to 45 percent above or below the index rate for health status, industry, age, and group size. HMOs and BCBS of Michigan must use a modified community rating system that only includes industry and age of the group (up to 35 percent above or below the index rate).

Public Coverage Initiatives

Michigan Medicaid provides access to health care services to an optional population, parents, and caretakers of dependent children that the state is not required to cover under its State Plan. Michigan provides coverage to parents with income up to 185 percent of FPL. In 2004, the state received approval to implement through a HIFA waiver a coverage program for individuals without dependent children with an income at or below 35 percent of the FPL. The state estimated that it would provide coverage to 62,000 individuals through the Adult Benefits Waiver.

Michigan received CMS approval to use unspent federal SCHIP funds to provide coverage to this population. In order to stay within the available budget, the state can cap the enrollment or request benefit changes. The state share comes from state-funded programs that were already providing certain services to individuals eligible for the waiver.

Initially, the state covered inpatient, outpatient, physician services, x-ray and lab, pharmacy, and mental health and substance abuse services. However, the state later removed inpatient services from the list of covered benefits. Services are delivered through the fee-for-service model and managed care organizations, if available. Mental health and substance abuse services are delivered only through a Community Mental Health Service Program that operates statewide.

If an eligible individual has access to and wishes to enroll in ESI, the state pays the beneficiary for the amount of his or her share up to the amount the state would have paid for that individual enrolled in the state benefit.

In 2008, the program estimates that services will be provided to 62,000 individuals at an annual cost of $174.1 million, which includes $50.9 million in state funds and $123.1 million in federal funds.

Montana – Created in 2005, Insure Montana is a two-part program designed to assist small employers with the cost of health insurance. Businesses with 2 to 9 full-time employees and having no employees earning more than $75,000 per year may take advantage of the program in one of two ways: either through a tax credit system if they already offer health coverage to their employees; or a purchasing pool combined with a premium assistance plan for those do not. As of May 2007, Insure Montana covered 740 businesses and 5,100 lives through the purchasing pool, and 665 businesses representing 3,800 employees were enrolled in the tax credit program. Insure Montana is currently maintaining a waitlist for prospective employers interested in either facet of the program.

The purchasing pool reimburses both employers and employees for their monthly premium payments. Employers that meet the above requirements and have not offered health insurance to their employees in the previous 24 months are eligible to join the pool and receive subsidies. Employers are required to contribute 50 percent of the employee-only premium and, in return, will receive a reimbursement for half this amount. After the reimbursement, an employer's net contribution should generally be 25 percent of the employee premium. An employer may also choose to contribute more than the required 50 percent, but the reimbursement amount from Insure Montana will not increase.

All full-time employees (at least 30 hours per week – a business may choose to add those working 20 to 29 hours per week) of an eligible business may participate. Employees are responsible for the remaining 50 percent of the premium (or less if their employer pays a higher amount) and the entire premium for any dependents. Premium subsidies for workers are based on a sliding scale dependent upon annual family income and range from 20 to 90 percent of the cost. In May 2007, the average monthly assistance payment to employees was $158, while that paid to employers amounted to $203.

Insure Montana's purchasing pool contains two comprehensive health plans, both offered by BCBS of Montana. The Standard Healthlink Plan includes coverage for two physician office visits (paid at 100 percent), preventive services (paid at 70 percent), and two dental cleanings per year; coinsurance is rated at 30 percent and annual deductibles of $1,000 for individuals and $2,000 for families apply. The Premier Healthlink Plan includes similar services, but covers them at a higher rate in exchange for higher premiums. Annual deductibles are decreased by half and coinsurance is reduced to 20 percent.

The tax credit program was designed specifically for small employers already offering their employees health coverage and to provide them with incentives not to drop their coverage in favor of the purchasing pool. Tax credits cannot exceed more than 50 percent of an employer's

premium contributions. Participating employers receive a monthly credit of $100 per employee ($125 if the employee is aged 45 or older) and, if contributing towards dependent coverage, additional credits of $100 per spouse and $40 per dependent. So far, businesses have received an average annual tax credit of $5,300.
Montana regulates premiums in the private small group market through the use of rate bands. Each insurance company sets an index rate for similar employers seeking similar coverage, and the companies may charge up to 25 percent more or less for health status and up to 15 percent for industry. Montana human rights laws specifically prohibit the use of gender as an underwriting factor. Premium rates may be adjusted upwards to reflect medical loss trends, as well as an additional 15 percent for claims activity, health status, and policy duration.

Public Coverage Initiatives

Since 2004, Montana has established access to health care services for the parents and caretakers of dependent children with income at or below 33 percent of FPL through its Medicaid program, via a Section 1115 demonstration project. The benefit package approved under the waiver provides for a more limited benefit that excludes Medicaid optional services, such as dental services, dialysis, durable medical equipment, and eyeglasses, among others.

As of May 2008, about 7,500 individuals were enrolled in the program. Individuals enrolled in the new program access services through a fee-for-services arrangement and have the same cost-sharing as in the regular Medicaid program governed by the State Plan. Based on the state's documents submitted to CMS, the total costs of providing coverage for the newly insured group of eligible adults, parents of dependent children was $38.5 million in state and federal funds in 2005, with an average monthly premium of $317 for each covered individual. In 2008, the average monthly premium for each eligible individual has increased to $396.

In 2008, Montana has negotiated an amendment that includes additional groups of individuals in the waiver population: uninsured individuals in need of mental health services (previously funded with general revenue funds); certain former foster care members; and also premium assistance for an additional 150 individuals enrolled in the high risk pool with income at or below 150 percent of FPL.

New Mexico – In August 2002, New Mexico received a HIFA waiver to extend health coverage to uninsured parents of children enrolled in Medicaid and SCHIP and childless adults with family incomes up to 200 percent FPL. In pursuit of this goal, New Mexico created the State Coverage Insurance (NMSCI) program, which began enrolling employees of small businesses and individuals in July 2005. SCI provides access to a statewide, managed care system that offers a benefit package similar to a comprehensive commercial plan. After a competitive bidding process, three managed care organizations (MCO) were selected to administer the package. Two of the MCOs are active in the commercial market and the third contracts with the University of New Mexico Health Services Center. MCOs taking part in the NMSCI program must also take part in New Mexico's Medicaid managed-care program (Salud!).

Participating employers must not have more than 50 employees and must also not have offered commercial health insurance in the past 12 months. They are also required to make a premium

payment of $75 per employee per month. There are three tiers used to determine the amount of an employee's contribution to the premium based on family income: those earning up to 100 percent FPL pay no premium amount; those earning between 101 to 150 percent pay $20 per month; and those earning between 151 to 200 percent pay $35 per month. These tiered premium payments also apply to enrolled individuals who are not affiliated with an employer (the unemployed, self-employed, and those whose employers do not participate), who are also required to contribute the $75 per month employer share. This requirement was not originally part of SCI's cost-sharing plan, but was added due to concerns that initial enrollment was being driven from pent-up demand in the lowest income tier. Out-of-pocket limits are capped at five percent of annual income; enrollees are required to keep track of their out-of-pocket costs and provide evidence to the state for reimbursement should the cap be exceeded.

NMSCI's plan benefits include, but are not limited to, physician office visits, preventive services, inpatient hospital and home health (25 day combined limit) services, outpatient and emergency care, women's health, behavioral health, and pharmacy services. Examples of benefits that are not covered include hospice care, vision, and dental services. Co-payments are also based on the income tiers above; co-payments for physician office visits, for example, are $0, $5, and $7 for the low, middle, and high income levels, respectively. There are no annual deductibles at any level, though an annual benefit limit of $100,000 does apply.

An original estimate of the number of eligible individuals was 40,000, which included 11,000 childless adults and 29,000 parents of Medicaid and SCHIP-enrolled children.[37] As of December 2006, NMSCI covered 4,263 lives, of which 3,297, or 77 percent, had annual incomes of 100 percent or less FPL, 675 (16 percent) had incomes between 101 and 150 percent FPL, and 291 (7 percent) earned between 151 and 200 percent FPL. Parents accounted for 1,829 (43 percent) of lives and 2,434 (57 percent) were childless adults. Individual enrollees comprised 3,961 (93percent) of members while 292 (7 percent) had employers that paid part of the premium. The state contributes the low enrollment figures to unwillingness on the part of employers to pay premiums for the lowest income bracket, along with the CMS requirement that forbids federal or state money to be used for brokers' fees.

No differences exist in the plans offered by the three MCOs either in premiums or benefits (although an MCO may offer additional benefits if it so chooses). Premiums are based on a modified community rating which excludes medical history and employment industry. NMSCI's premium rates are "roughly equivalent" to those of the Health Insurance Alliance, a New Mexico non-profit alliance of insurers that offers relaxed requirements for small employers and individuals previously unable to qualify for commercial health insurance. The Health Insurance Alliance's small employer group rates equal the average of the highest and lowest rates in the commercial market for similar products and are approximately 25 percent higher than the healthiest groups could normally expect to pay and 25 percent below what the unhealthiest groups pay.

[37] New Mexico HIFA fact sheet

Under the HIFA initiative, the state funded coverage for the newly insured population with unspent SCHIP funds.[38] In 2007, average monthly premium assistance for eligible individuals was $272.

New Mexico regulates the premiums that carriers can charge in the private small group market through a rate band system that allows carriers to set rates up to 20 percent above or below the index rate based on health status. Unlike other states in this summary, though, New Mexico has an additional 250 percent band that allows carriers to consider age, gender, geography, industry, and tobacco use. New Mexico law allows carriers to adjust for loss trends during the renewal period, but limits carriers to a 10 percent increase in rates for claims activity, health status, and policy duration.

New York – One of the first market-based initiatives aimed at expanding coverage to the uninsured, the program titled Healthy NY, targets small businesses and their employees, sole proprietors, and working individuals who cannot obtain insurance through their employer. Whereas previous New York programs targeting low-income workers offered direct subsidies to the workers, Healthy NY provides subsidies to insurance carriers in the form of a stop-loss fund. This reinsurance program operates by reimbursing (after the fact) health plans 90 percent of all claims paid between $5,000 and $75,000. The plans are fully at risk for claims under $5,000 and above $75,000. Initially the stop-loss figures were for claims between $30,000 and $100,000, but these numbers were changed in 2003 due to lower than expected claims activity. This change resulted in approximate premium reductions of 17 percent. Overall, Healthy NY's reinsurance fund helps keep premiums 20 to 30 percent lower than they would be in the commercial small group market and 50 percent lower than in the individual commercial market. As of November 2006, Healthy NY covered 130,850 lives, of which 90,859 were subscribers and 39,991 dependents. The reinsurance subsidy is funded through state general appropriations, tobacco taxes, and employer and employee premiums.

Small employers with 50 or fewer employees may enroll in Healthy NY if at least 30 percent of their employees earn annual incomes of $36,500 or less (adjusted for inflation each year), they offer coverage to all employees who earn less than this amount and work at least 20 hours per week, and at least one of these employees chooses to participate. At least 50 percent of the employees must either participate in the program or have some other source of coverage. Once enrolled, an employer must contribute at least 50 percent of its employees' premiums, and while an employer may choose to offer dependent coverage, it is not required to contribute to dependent premiums.

Sole proprietors and other individuals must not have gross family incomes of more than 250 percent FPL, must have been uninsured for a period of 12 months, and are required to pay the entire premium. Additionally, at least one family member must be employed, or have been in the previous 52 weeks. Approximately 56 percent of Healthy NY subscribers were working individuals, 17 percent were sole proprietors, and small businesses accounted for the remaining 27 percent.

[38] New Mexico HIFA fact sheet

Healthy NY administers two essentially identical plans, one with and one without prescription drug coverage. Examples of covered services include inpatient and outpatient hospital and emergency care, physician and preventive services, diagnostic testing, and maternity care. In order to ensure low premium rates, certain benefits typically mandated in the small group and individual market policies are not covered, including inpatient and outpatient mental health, chiropractic services, and outpatient substance abuse. Most co-payments are $20 per visit; those electing prescription coverage have a $100 deductible and $3,000 annual maximum benefit level for use of the service.
In keeping with New York's requirements for the small group and individual commercial markets, Healthy NY is offered guaranteed issue and premiums are based on a pure community rating structure (cannot be rated by age, gender, health status, or occupation). Premium rates do not vary by category (small employer, sole proprietor, individual), though all subscribers are divided into four tiers – single adult, two adults, one parent with child(ren), and family. Each carrier sets their own community rate for each tier, which may vary by county or family composition.

All HMOs operating in New York must participate in Healthy NY, and other carriers may choose to do so if they wish. To receive benefits, enrollees must use a provider from within their HMO's network, whom the HMO pays a negotiated rate. In 2007, Healthy NY began offering a high deductible option, which was expected to reduce premiums up to 25 percent. Deductibles numbered $1,150 for individuals and $2,300 for families, and the plan is being offered in conjunction with a health savings account.

Public Coverage

Since 1997, New York has implemented a number of public coverage initiatives with goals of improving access to health care services for the Medicaid population, improving the quality of health care services, and expanding coverage to additional low-income residents with funding generated through managed care efficiencies. The state requested a Medicaid Section 1115 demonstration to implement the managed care in Medicaid. Savings generated through this initiative were used to fund coverage for additional groups of the uninsured. Since 2001, the state provides coverage under the demonstration for individuals eligible for the Family Health Plus program. Eligible individuals include childless adults with a gross income at or below 100 percent, and adults with dependent children with an income at or below 150 percent of FPL. Services in the Family Health Plus program are provided through contracts with commercial MCOs. The state provides additional services as wrap around services to meet the needs of individuals who require additional services. Benefits provided to these groups of individuals are less comprehensive than those offered under Medicaid. During 2008, the average monthly cost of providing coverage to an individual who is eligible for the program because he or she has a dependent child is $550. Projected enrollment in the program as of October 2008 was almost 521,000 individuals.

In 2006, the state received approval for another Medicaid 1115 demonstration, titled Federal-State Health Reform Partnership (F-SHRP). Under that waiver, the state received approval to deal with excess hospital and nursing home beds through closing or realigning facilities and work on initiatives to improve primary and ambulatory care. Funding for the waiver came from

the federal government providing federal match for several state-funded health care reform initiatives. One of these initiatives is the Healthy NY program. Funding for the initiatives related to the expansion of health insurance comes from allocation of portions of the state's tobacco settlement dollars and increased cigarette taxes. In addition, the state had revenue streams from an assessment on hospitals' net inpatient revenue and assessment on private insurance companies that were used to support various initiatives. At the beginning of the program, the state supported the reinsurance component of Healthy NY by providing $89.4 million.

The federal government included a requirement for the state in the F-SHRP waiver to implement a program that would increase the number of previously uninsured employed individuals who become insured by taking ESI if available. In 2007, the state proposed to implement a Family Health Plus Premium Assistance Program with access to cost-effective ESI. This program is similar in its structure to HIPP in Texas. New York requires that individuals with qualified and cost-effective ESI enroll in their programs. The state subsidizes the premium amount and reimburses deductibles and co-payment obligations to the extent they exceed what the individual would have paid in the Family Health Plus program. Wrap-around benefits are also provided to the individuals if necessary services are not covered by the ESI plan. The state projected that 5,300 individuals would be enrolled in this premium assistance program over a 36 month period. The estimated start date for the program was April 2008. The projected monthly average contributions for each eligible individual were $253.

Oklahoma – The Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program, which was implemented in 2005, is composed of two distinct parts designed to help small businesses and low-income working individuals, earning up to 200 percent FPL, pay for health insurance premiums. The first component, the Employer Sponsored Insurance (ESI) program, utilizes the private ESI market and grants monthly subsidies to small employers to help pay for their employees' premiums. The Individual Plan (IP) completes the initiative by providing low-income workers do not have access to a qualified health plan through their employer, the temporarily unemployed, and the working disabled a primary case management plan. The goal of the program was to provide coverage to 50,000 residents. As of October 2008, there were 3,435 employers accepted into the O-EPIC ESI program with 10,401 enrolled lives; an additional 4,467 members (including spouses) had enrolled in the Individual Plan.[39]

The ESI program uses established insurance carriers and health plans and are only available to small employers who offer a qualified health plan. Any plan that meets the state's minimum standards and is approved by the Oklahoma Insurance Commission is considered a qualified health plan. An employer enrolled in such a plan may apply for the ESI program provided that it has 50 or fewer employees. Originally, only employers with 25 or fewer employees were considered eligible; however, this was increased to 50 in October 2006 in an attempt to increase enrollment.

Employees of businesses registered in the O-EPIC ESI program must also apply for acceptance. To meet the eligibility requirements, employees must be an adult, aged 19 to 64, earning 200 percent or less FPL, and not eligible for Medicare or Medicaid. Employees are responsible for up to 15 percent of the premiums for the employee and spouse, while the employer

[39] http://www.ohca.state.ok.us/WorkArea/showcontent.aspx?id=9350.

contributes 25 percent of the employee-only premium. The state pays the remaining 60 percent of the employee premium and 85 percent of a spouse's.

At the end of 2006, the average monthly premium for covering an individual through the program was $334, out of which the employer contributed on average $84, the employee $50, and the premium assistance contributed about $200. Since the ESI program uses the existing private ESI market, benefits and cost-sharing differ widely among individuals. There are minimum standards, though, that a plan must meet in order to be approved. These include coverage for office visits, physician, hospital, lab, and pharmacy services. Additionally, the maximum out-of-pocket cannot be more than $3,000 per year; if this maximum exceeds 3 percent of a member's gross annual income, the state will reimburse the member up to $900.

In the private small group market, Oklahoma's regulations place rate band restrictions on accepted premiums. Carriers may rate up to 25 percent above or below the index rate for health status and up to 15 percent for industry. The renewal period allows adjustments to be made for medical loss trends, as well as claims activity, health status, and policy duration.

The Individual Plan is administered by SoonerCare, the state's Medicaid agency, and makes use of its infrastructure, including staff and provider networks. It was designed as a "fallback" program for those ineligible for O-EPIC ESI and, as such, offers somewhat limited benefits. Covered services include 4 office visits per month, 1 wellness exam per year, 1 mammogram per year, 24 inpatient days per year, maternity care, and 6 prescription drugs per month (of which a maximum of 3 can be brand name). Monthly premiums range from $0 to $51.39 for an individual and $0 to $68.91 for families. Examples of co-pays include $25 per office visit, $30 per emergency room visit, $5 for generic prescription drugs, and $10 for brand name prescription drugs; however, the amount that the individual is required to contribute is limited to 5 percent of his or her gross income. The Individual Plan places a $1 million maximum limit on lifetime benefits.

The eligibility requirements for the Individual Plan are generally the same as those of the ESI program, except that the worker must either be ineligible to receive ESI coverage, temporarily unemployed, or disabled with a ticket to work.

This program was implemented in 2005 as a Section 1115 Medicaid demonstration project and is funded with state and federal funds. The state share of the program's funding is generated by a tobacco tax; the federal share is Title XIX funding. The state's initial estimates for the annual cost of the program included $50 million in state funds and $100 million in federal funds.

Oregon – In 2002, under the authority of a Section 1115 HIFA waiver, the state implemented the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance through ESI or through the individual market. FHIAP provides premium subsidies to uninsured individuals and families with incomes up to 185 percent FPL. Initially the state financed the coverage of low-income individuals with income up to 185 percent with available SCHIP funds, but starting in 2007, the state funded the program with Medicaid funds that were saved by the state through other initiatives.

Subsidy amounts in FHIAP equal 95 percent of premiums for individuals or families with incomes between 0 and 125 percent FPL, 90 percent for those that earn 126 to 150 percent FPL, 70 percent for those earning 151 to 170 percent FPL, and 50 percent for those with incomes ranging from 171 to 185 percent FPL.

As of February 11, 2008, a total of 17,020 individuals were enrolled and receiving an average monthly subsidy of $249.52. Due to a lack of funds, FHIAP is not accepting new applications; in February of 2008 the program's waiting list contained 27,320 individuals, with an estimated waiting period of 1 and one-half to 2 years to receive an application.

In addition to the income requirement, prospective applicants must be uninsured for the previous 6 months, not be eligible for or receiving Medicare, and have investments and savings less than $10,000 (including rental property).

Whether obtained through an employer or individually, a chosen health plan must meet minimum standards to qualify for a subsidy. These standards include coverage for 20 benefit categories, a $750 maximum annual deductible, a $4,000 maximum out-of-pocket limit, and a $1,000,000 maximum lifetime benefit limit. Additionally, members are responsible for any co-payments, coinsurance, and deductibles their health plan might require.

Oregon regulates the private small group market through an adjusted community rating system, which only allows carriers to take into consideration age (43 percent of average area rate) and geographical location. This system, though, only applies to groups with 2 to 25 members; for groups with than 25 workers, health status can be used to determine the group premium.

Chapter 4

Subsidy Program Design Options

Most existing state premium subsidy programs use federal and state Medicaid and/or SCHIP funds to finance coverage. Federal requirements vary depending on the target population and their income levels, source of funds (Medicaid or SCHIP), the type of subsidy offered, and an assortment of other conditions that determine how funds may be used and what health care services must be provided. These requirements strongly influence the design of a program and will limit to some extent the options available.

Despite the challenges and administrative demands involved in establishing a premium subsidy program, interest across the country remains high as more states look for opportunities to build on the existing employer-based insurance market in order to leverage premium contributions employers bring to the arrangement. States that have implemented successful subsidy programs report a variety of benefits, including:

- **Improved access to health care.** The availability of coverage increases the likelihood that families will find a medical home and will obtain preventive and primary health care services. Parents that have health care are also more likely to obtain appropriate health care services for their insured children.

- **Increased availability of employer sponsored insurance.** Due to minimum participation requirements for small employer plans, many small businesses are unable to qualify for coverage because workers are unable to afford the premiums and decline to enroll. Unable to meet the insurer's minimum enrollment requirements, the employer cannot offer insurance to *any* workers. Subsidies allow low income workers who otherwise could not afford coverage to enroll, enabling the employer to meet the participation requirements and offer coverage to all employees, including workers who do not qualify for subsidies but are willing and able to pay for coverage.

- **Enabling transition from public programs to private employer sponsored coverage.** Subsidies enable parents to enroll in an employer-sponsored plan, at which time children who previously received coverage under Medicaid or CHIP also become eligible for ESI. Without parental enrollment, dependents are not eligible for employer sponsored coverage under a plan offered by a parent's employer. By increasing the availability of employer-sponsored coverage, more low-income parents will have access to private coverage for their children who may move out of Medicaid/CHIP and into private coverage.

- **Reduced burden on hospital emergency rooms.** As uninsured individuals obtain insurance coverage through subsidy programs, they obtain treatment from primary care physicians rather than relying on hospital emergency facilities to provide basic health care services simply because they have no other place to go.

- **Maximizes use of public and private funds.** Subsidy programs take advantage of the fact that employers are often willing and able to contribute some funds for premiums. The employer's premium contribution in combination with the subsidy assistance can greatly lower the employee's financial responsibility, allowing more workers to obtain coverage. Subsidy programs that do not build on the existing employer-based market miss an opportunity to partner with employers who want to offer insurance benefits but need a more affordable option.

- **Reduced impact of cost shifting to the insured.** Providers who are not compensated for the treatment they provide to uninsured Texans frequently charge higher health care prices to insured patients in order to compensate for the unpaid care. This cost shifting contributes to rising insurance premium rates and results in more employers dropping coverage as premiums continue to escalate. Premium assistance programs reduce the incidence of uncompensated care and should reduce the extent of cost-shifting to insured patients. As a result, even employers who do not qualify for premium assistance should benefit from reductions in cost-shifting over time.

Program Design

Texas is fortunate to have the experience of other states to refer to in the development of a premium subsidy program. Though no two states have implemented identical programs, and no state has perfected the premium subsidy model, there are many program similarities as well as some important distinctions. The experience of those states provides a road map for Texas to consider, including important "lessons learned" for both what not to do and what works. This section of the report provides an overview of key design elements and various options for designing a Texas subsidy program. A brief summary of both advantages and disadvantages of various approaches is provided. While many options are available for consideration, it is important to note that "key decisions" do not operate independently. Each program design decision will influence the effectiveness of other program decisions. Some decisions will significantly influence insurers' willingness to participate; others will determine whether employers and employees will support the program. In some cases, a decision works in favor of one stakeholder group but may adversely affect other stakeholders. Each of these options must be carefully considered in the context of the overall program design, with an understanding of the consequences of each choice.

Key Decision: State-Only vs. State/Federal Funding

Perhaps the most important first step in designing a subsidy program is to determine whether the state intends to use federal funds. If the intent is to seek federal approval and funding under either Medicaid or SCHIP, all subsequent design elements of the program will be affected, including eligibility, participation requirements, benefit plan, and carrier participation. If the Legislature relies solely on state and or/other funds, excluding federal money, the design of the program is unrestricted and provides for greater latitude to develop a program that is uniquely suited to Texas. If, on the other hand, federal funds are approved, the state's financial cost is significantly reduced, and may provide opportunities for a more expansive subsidy program that could reach more employers. Regardless of which approach is used, all other decisions will be

directly impacted by the source of funding. As such, this is the first decision that should be made in development of a premium assistance program.

Key Decision: Employer and Employee Eligibility

Determining who is allowed to participate in a premium subsidy program is a key issue that must be decided in the early stages as it also will affect all other decisions in the program design. Other states have struggled with eligibility provisions in an effort to develop a fair program that doesn't favor or penalize some employers or employees over others while also ensuring that subsidy money is used to pay for new coverage and not replace or subsidize coverage that employers already provide. This section discusses some of the options related to eligibility provisions and the impact such decisions may have on the overall success of the program.

- **Crowd Out: Limit participation to currently uninsured employers vs. inclusion of employers who already offer insurance.**

  In an effort to discourage small employers from dropping existing coverage in order to qualify for the subsidy program, most state subsidy programs limit enrollment to only those employers who have not offered coverage for the past 12 months. In a few cases, the restriction is limited to the past six months. While this approach is effective in eliminating the potential "crowd out," it does create an unlevel playing field for employers who already pay for health insurance when competitors who have chosen not to offer coverage can suddenly qualify for the subsidy. Whereas before, the employer offering the coverage may have done so, in part, to attract and retain qualified employees, that firm now must compete with other firms who not only offer insurance but pay a reduced price due to their participation in the state subsidy program.

  A decision to allow firms that are currently insured to participate may change other important plan features of the program. For example, if the subsidy program requires participating insurers to comply with rating, benefit and enrollment requirements features that are unique to this program and do not apply to the rest of the group market, allowing the participation of currently insured firms that operate under different market rules may create administrative challenges. To address this concern, the state could create two separate qualifying programs with different participation requirements – one for currently insured firms and one for new firms that are obtaining insurance for the first time through the subsidy program. The state could still impose certain participation requirements, though the provisions would be slightly different for the two groups.

  While this approach will likely appeal to more insurers and employers, it also limits the effectiveness of the subsidy funding. Restricting eligibility only to uninsured firms maximizes the ability to reduce the uninsured population and ensures that subsidy dollars are used to fund only new coverage. Allowing currently insured firms to enroll will replace private insurance premium dollars currently provided by employers and employees with public subsidy dollars. Also, if federal funding is used for part of the premium assistance, CMS would require a crowd-out period to safeguard against dropping private coverage.

Whether or not currently insured firms will be allowed to participate will significantly impact other design features and cost estimates.

- **Group Size Requirement: Allow participation of any small employer group with 2 to 50 eligible employees, or restrict participation to smaller groups (i.e., 2 to 10 or 2 to 25 employees) that represent the majority of uninsured small firms.**

  Limiting participation to the smallest groups may allow more employers to participate, particularly if the program limits enrollment to a certain number of enrollees. The smallest firms often have the most difficulty obtaining insurance, and usually pay higher premiums due to higher rates imposed based on the smaller group size. However, other states that have attempted to restrict enrollment to the smallest groups have reported much lower participation levels than expected. Including larger groups of 25 to 50 employees may allow for higher overall participation, but a lower number of participating firms.

  Allowing all group sizes (2 to 50) also improves the risk factor of the entire group by attracting more healthy individuals. Insurers are more likely to participate in the program if the larger groups of 25 to 50 employees are allowed to enroll. Restricting enrollment to only groups of 2 to 10 may increase the risk of adverse selection by attracting a higher number of unhealthy, older participants, resulting in higher premiums for the entire program.

- **Minimum Employee Participation Requirements: Require a certain percentage of eligible employees to enroll in order for employer to participate in program.**

  As allowed by state law, small group insurers require enrollment of 75 percent of all eligible employees. This provision presents a significant challenge for many firms with low income workers who often are unable to afford their required premium contribution. Providing subsidies for these workers would not only enable the low income workers to access health insurance, but would enable many employers to offer insurance to all other workers due to the group's ability to meet the insurer's minimum participation requirements.

- **Financial Eligibility: Allow all employees in a firm to receive subsidies, or only low-income workers (such as those whose wages do not exceed a certain value).**

  Allowing all employees to receive subsidies would likely entice more employers to offer coverage, but would also direct subsidy funds to employees with higher incomes. Such an approach may be easier to administer as it would minimize the income eligibility verifications. However, subsidizing all workers also could substantially reduce the number of low-income workers who receive subsidy assistance and may not be the most effective use of the subsidy money. One variation would be to provide sliding scale subsidies for workers with higher incomes, thus allowing all workers to benefit from the program but directing the highest payments to the lowest paid workers.

Financial Eligibility: Provide subsidies based on employee wages or family incomes.

If the subsidy program uses federal funds, CMS will have requirements on how eligibility must be determined. If state-only funds are used, or if state-only funds are used to provide subsidies to enrollees who do not qualify for federal money, then the state has wide latitude in determining whether subsidy assistance is based on employee wages or on an employee's family income. As most employers will not have access to an employee's family income, subsidy programs that supplement employer coverage are often based solely on the employee's wages. If subsidies are provided directly to the employee rather than the employer (or insurer), family wage qualifications are a reasonable option. Using employee wages would allow some employees who live in families with relatively high incomes to qualify for the subsidy; based on family income, those employees may not qualify. Using family incomes will likely increase administrative requirements for both the subsidy administrator as well as the employer and employee, and may discourage some employers from participating if the administrative burdens are viewed as excessive.

Key Decision: Benefit Plan Design

The subsidy program will need to specify which benefit plans are eligible for subsidy payments. The state could allow all plans to qualify, may restrict eligibility through a certification process, or could establish one or more standardized plans that are uniquely qualified for the subsidy assistance.

- **Require Minimum Standards for Qualified Benefit Plans: Allow insurers to offer an array of benefit plan options as long as they meet certain minimum standards.**

  Small employer benefit plans sold in Texas are not subject to minimum benefit standards. While all plans must comply with certain policy provisions and must provide the applicable mandated benefits, plans are not required to provide a minimum level of coverage. As such, some plans provide minimum benefits that often fail to provide coverage for even typical health care costs. For example, some plans provide total benefits of $5,000 or less, leaving individuals uninsured for any health care expenses that exceed the $5,000. Plans also may exclude or severely limit commonly used services that are typically found in most comprehensive benefit plans. Though the wide range of benefit options provides more choices for consumers, the variations also allow for the sale of plans that provide very limited protection.

  If the state allows the sale of existing benefit plans under the subsidy program, the state may require certification of plans to ensure that subsidy funds are used to purchase benefit plans that provide a minimum level of insurance protection and reduce the frequency of "underinsurance". If federal funds are used to finance subsidy payments, CMS will almost certainly require that the subsidized benefit plans comply with certain benefit requirements. If only state funds are used, the state also will likely want to establish a process by which plans must be certified for subsidy eligibility to ensure the subsidized plans are providing health benefits that a typical individual will need. Without a certification process, subsidies could be used to purchase reduced benefit plans that provide minimal protection, leaving

enrollees uninsured for anything more than very basic health care services and reducing the value of a subsidy program.

- **Create one or more qualified standard plans that insurers must offer to participate.**

  In lieu of allowing any group insurance plan to qualify for subsidy participation, most states have restricted eligible plans to a limited number of qualified plans. The restriction is less costly to administer and provides the state more oversight to ensure that subsidies provide the maximum value by ensuring enrollees receive the most comprehensive health care coverage possible. The standardized requirements could allow limited areas of benefit variability (such as different levels of prescription drug coverage), but would provide a "core" set of benefits that are identical, regardless of which plan is selected. This arrangement is less complicated for employers to navigate, allows more direct comparison of plan costs and value for employers shopping for coverage, and is easier and less costly to administer. Limiting the number of plans and providing a measurable standard also would enable the state to compare and evaluate the performance of the insurance plans to determine whether some plans are more effective and provide better value for the state and better benefits for the insureds.

- **Allow any small employer plan to qualify for subsidy assistance**

  Insurers in the small employer market offer a large number of health insurance benefit plans that vary dramatically in the types of coverage offered and the level of benefits. Subsidies could be available to an employer that offers any small employer benefit plan, regardless of the level of coverage or benefits provided. Such an approach would be relatively easy to administer, but is unlikely to meet CMS approval if federal funds are used. This approach also eliminates the state's ability to ensure that subsidy funds are used to purchase adequate coverage.

Key Decision: Insurance Premium Rating

As explained in Chapter 1 , insurer rating variations allow for huge rate variations among different employer groups depending largely on the demographics of the employers' workers. Firms with one or more older workers or employees with a pre-existing health condition may pay insurance rates three or more times higher than a competing firm that has younger workers and no health problems. While these rate differences are designed to keep coverage affordable for young, healthy workers, the substantial variations create significant challenges when creating a subsidy program. The value of a subsidy will vary widely based on each employer's premium cost. Following are two premium rating design alternatives to consider.

- **Allow participating insurers to continue using the current premium rating practices used in the existing small group market.**

  If the existing rating system applies to groups participating in the employer subsidy program, insurers will continue to charge higher rates for groups that include older workers and/or an employee with pre-existing conditions. Higher rates will discourage some of the higher risk groups from applying. Conversely, younger, healthier groups with lower rates may be even

more attracted to the program if the size of the subsidy significantly lowers the cost of insurance. To reduce the perceived inequity among employers who are charged higher rates due to their group composition, the value of the subsidy could be determined as a percentage of the premium rather than a flat rate. However, the administrative costs of implementing and overseeing such variations will be significant. If federal funds are used for subsidies, varying rates may not receive federal approval. This is particularly true if the cost of coverage is not related in some way to the value of the benefit plan. From a cost effectiveness perspective, such variability is extremely difficult to monitor.

- **Require participating insurers to use a modified community premium rating methodology.**

  As a condition of participating in the subsidy program, the state could require carriers to use a modified community rating methodology that limits rate variability based on certain characteristics. For example, the state could specify that only gender and age may be used to determine rates of participants, and that rate variations are limited to a certain percentage (i.e., no more than a 25 percent variation from the highest to lowest rate). While this restriction on its own might encourage individuals to wait until they "need" coverage because they become sick, other enrollment restrictions and plan designs can be developed to minimize the risk of adverse selection. In addition, because this is a group plan and not available to individuals, the risk of adverse selection is further reduced as employers are less likely to wait until an employee becomes sick to enroll in the plan.

  Although insurers in Texas have expressed reluctance to adopt a modified community rating methodology in the commercial market due to fears that they will be at a competitive disadvantage, the uniqueness and limitations of this program should not be compared with the open market. Only qualified employer groups will be eligible for the program, and "crowd out" can be minimized by restricting the plan to employers who are currently uninsured. Limiting open enrollment periods also will serve to alleviate adverse selection concerns.

Key Decision: Insurer Participation

Insurer participation is an important issue that can significantly impact the level of success of a subsidy program. Other state programs have tried several different approaches, each with varying levels of success. Issues that should be carefully considered in evaluating the various options include administrative oversight requirements and related costs, specific participation requirements in order for an insurer to be selected or "approved," and the impact such a decision will have on premium costs.

- **Allow all small employer insurers who agree to certain conditions to participate in the program.**

  Allowing all small employer insurers to participate spreads the enrollment across a large number of companies and may especially appeal to smaller carriers who see this as an opportunity to increase enrollment. The program will need to establish clear participation requirements that address rating provisions, benefit plan requirements, administrative oversight and reporting responsibilities. States with a small number of carriers may find such an inclusive approach to be both cost effective and practical. However, allowing all carriers to participate will result in higher administrative costs to the state due to the volume of companies that will be subject to compliance oversight, financial reporting, subsidy payment distribution, and other administrative activities that will be required to implement and oversee the program. The broader distribution in enrollment among a high number of carriers may also result in higher premiums than might be achieved if participation is restricted to one or several carriers.

- **Select a limited number of insurers to participate through a competitive bidding process.**

  Restricting participation to one or several insurers, selected through a competitive bidding process, would likely appeal more to the larger carriers in the state who may be better positioned to compete for large blocks of business. Limiting insurer participation also ensures that participating carriers will experience higher enrollment volume, which may result in lower premium costs. The program also should incur lower implementation and administrative costs due to the smaller number of plans that would be subject to oversight and compliance operations.

Key Decision: Agent/Broker Participation

Small employer coverage in the commercial market is sold through independent agents and brokers in exchange for a commission that is based on a percentage of the total annual premium of the group that is enrolling. Depending on how the program is structured, a few state programs do not include agents in the marketing and enrollment process; some include agents but limit the commissions paid. States with programs that provide subsidies for employer-based programs generally allow full agent participation.

- **Allow insurance agents to enroll members, receive commissions.**

  Under this arrangement, insurance agents and brokers would continue to provide all the services they normally provide for the commercial small employer market. This includes marketing and explanation of program benefits, assisting employers with the application process, meeting with employees to answer questions and complete forms required for health underwriting and enrollment, providing and explaining premium cost estimates, collecting initial premium payments, and providing ongoing customer assistance once the policy is issued to the group. Agents are paid a commission to provide these services, usually based on the annual premium of the group. Additional commission incentives may be applicable in some cases. Allowing agents to continue providing these standard services reduces the

demand on insurers and ensures employees receive more attention than they are likely to receive from an insurance central office. Agent services are an important part in the marketing and promotion of a subsidy program. States generally report that agent services are crucial to the success of a program. New programs in particular usually require extensive marketing and information in order to attract enrollees. These are critical services agents are well suited to provide.

- **Provide on-line enrollment, excluding agents from marketing and enrolling small firms.**

  If agents are excluded from enrolling plan participants, employers would enroll directly with the insurance carrier, or an administrator that provides enrollment services. Depending on the structure of the program, employers could also enroll on-line via a web connection. Excluding agents from the subsidy program may save at least part of the funds that would otherwise pay for commissions. However, some services provided by agents cannot be replaced; the administrator or insurer would still have to provide enrollment, process forms, respond to inquiries, provide educational services, and provide ongoing customer service once members enroll. Removing the agent also will require increased marketing expenses to compensate for the one-on-one marketing agents provide when meeting with employers who are looking for insurance. If agents are not providing information directly to employers, the employers will have to obtain the information from other sources.

Key Decision: Administrative Oversight

- **Delegate program development and oversight to an existing state agency.**

  The Legislature will determine who should administer a premium subsidy program. If federal funds are used, the program will need to be administered or overseen by HHSC. TDI could assist as needed to coordinate and or/regulate the private insurance component. If state-only funds are used and no federal oversight is involved, the program could likely be administered by the agency selected by the Legislature.

- **Delegate oversight to a newly-created agency.**

  The Legislature also could create a new agency to administer the premium subsidy program. If federal funds are used, the new program would have to closely coordinate administration with HHSC. This approach may incur more significant start up costs than using an existing agency, but may operate more efficiently once established.

Key Decision: Value of Subsidy

Subsidy values can be determined in a variety of ways, including flat-rate subsidy values that are constant for all enrollees, subsidies that vary based on the cost of coverage, and sliding scale subsidies that vary based on the enrollee's income. Each comes with advantages and disadvantages.

- **Provide a flat-rate subsidy for all qualified enrollees**.

  Likely the easiest subsidy arrangement to administer is a flat-rate subsidy that is equally distributed to all participants. For example, a subsidy of $100 a month could be provided for each enrollee. Employers will know in advance exactly what the subsidy value is and can quickly determine whether the value of the subsidy is sufficient to enable them to afford coverage for their firm. The predictability of the subsidy may also encourage some employers to participate if they know the value will remain constant in future years.

  From a budgetary perspective, a flat-rate subsidy is relatively easy to manage through enrollment caps. Depending on how much money is allocated for subsidy payments, enrollment limitations can be established to ensure the program does not exceed the cap. For example, if $20 million is appropriated for subsidy payments (not including additional administrative costs), and subsidy payments are fixed at $100 per month, the program would be able to provide subsidies for 200,000 member months. This type of approach works best in an environment where employer premiums vary little, if any, to ensure the value of the subsidy is equal or relatively equal for all participating firms. This program is relatively simple to administer as equal payments are made for each enrollee.

- **Provide subsidies that vary based on the cost of coverage.**

  If subsidies are used to pay for insurance plans obtained in the open insurance market, subject to the existing rating structure, subsidy values could be determined based on a percentage of the premium cost. For example, subsidies of one-third or one-half, or 20 percent of the cost of coverage could be provided. The value would change based on the actual premium cost for each employee.

  This approach is the most difficult and costly to administer and may encounter some challenges under the federal Health Insurance Portability and Accountability (HIPAA) non-discrimination provisions. Subsidy values would need to be updated annually for each enrollee. Budget projections for future costs would be extremely vulnerable to error as benefit plans and premium rates are adjusted. A 20 percent subsidy in year one could equal $100 a month, but due to changes in the group's composition (i.e., hiring an older worker or aging of existing employees), or changes in the benefit plan, the 20 percent subsidy could increase to $150 a month in year two as the price of insurance for the group increases. These types of variations are virtually impossible to predict or estimate in the open commercial market given the variations of the population, the insurance products, and the premium rating process.

- **Provide subsidies on a sliding scale basis, based on the wages/income of qualified enrollees.**

  One of the concerns in structuring a subsidy value based on an employee's income is the possibility that such a program may discourage employers from offering wage increases if employees would subsequently lose the subsidy. This is especially important in small firms that barely meet the minimum participation requirement where losing one employee's participation results in the entire group losing their insurance eligibility. Subsidy programs

also want to maximize the subsidy dollars available, distributing funds to as many employees as possible.

To ensure subsidy dollars are directed to employees with the highest financial need while providing reduced subsidies for employees who have higher incomes but still need assistance, the state could provide subsidies on a sliding scale basis. Subsidies variations may also encourage employers to provide wage increases if they know employees will still qualify for some assistance. A sliding scale approach could also be used to gradually phase out premium assistance over a period of years, using a subsidy payment schedule that decreases each year, or decreases as an employee's wages increase over time.

Key Decision: Employer Premium Contribution Requirements

The amount of money employers must pay in premium contributions for eligible employees will be influenced by other factors, particularly the value of the subsidy payment and the total cost of the insurance premium. Insurers may also have strong preferences, depending on other features of the program design. For example, the cost of the program and the extent to which premium costs vary among employers will depend entirely on the rating methodology selected. This decision will have a direct bearing on the cost to the employer and will, therefore, strongly influence the employers' preferences regarding contribution requirements. Again, this is an example of how one program design decision will have significant implications on other design decisions.

- **Require employers to contribute a standard, fixed premium contribution per employee per month, which does not vary by employer. For example, require all employers to pay $100 (or some amount) per-employee-per-month.**

  As with subsidy payment amounts, fixed employer contribution requirements are relatively easy to administer. However, if the fixed contributions are used in a program where each group's rates vary widely (as under the existing small group insurance market), a fixed contribution level may not be adequate or appropriate for groups with higher total premium costs compared to other groups. Conversely, a fixed amount may be overly generous in groups that would be charged significantly lower premium rates. Insurers may not support the concept of fixed employer contribution amounts if the employer's contribution payment is so low that it discourages the healthiest employees from enrolling. Employee support will also vary depending on the economic status of the employee and the final cost of the employee's contribution requirements after the subsidy and employer contributions have been considered. Employers may prefer the level premium contribution approach due to the predictability of the cost. A fixed, flat-rate-per-employee is easier to budget for than a percentage of premium which could fluctuate widely depending on the premium rating methodology used in the program, changes in employee demographics, and future rate increases.

- **Require employers to contribute a percentage of the total premium cost-per-employee-per-month.**

  Employers participating in the premium assistance program could be required to contribute a percentage of the total premium cost-per-employee-per-month. For example, employers could be required to pay at least 50 percent of the cost of employee-only coverage. Although employers in small firms often pay higher contribution rates than 50 percent in order to reach the minimum participation rate required to enroll, the availability of premium subsidies in addition to the employer's contribution should provide an adequate reduction in premium cost to incentivize employees to participate. The final decision on employer contribution payment amounts should take into account the value of the subsidy and the cost of coverage to ensure the employer contribution is sufficient to reduce premiums to a level that is affordable for the target audience of employees. As discussed above, this will also vary depending on the rating mechanism used, and the extent to which premium costs vary based on each group's demographic characteristics. If rate variations are restricted through a modified community rating methodology or some other alternative, a percentage of premium contribution requirement may be more acceptable to employers with high cost workers. Without some restrictions on rate variations, employers with relatively high-cost workers will be required to pay significantly higher premiums contributions. Those employers are more likely to prefer a flat rate premium contribution rather than a contribution based on a percentage of the premium.

Key Decision: Enrollment Periods/Duration of Enrollment

- **Require 12-month enrollment periods.**

  Insurers offering group employer benefit plans require coverage for a 12-month period. Although employers may drop coverage before the end of the 12-month period, there may be penalties if an employer attempts to purchase coverage in the future. The insurance application process can require a great deal of time of employers, employees, and agents. This is particularly true if an employer applies for coverage with multiple health plans in an effort to compare the options available. For each plan the employer applies for, separate application forms and health underwriting forms must be completed for each employee and any enrolling dependents. First-month premiums are also usually required at the time of application, which may discourage some employers from obtaining competitive quotes from multiple companies. Due to these administrative expenses associated with enrollment and the challenges in predicting policy costs for short term periods, most insurance carriers would be reluctant to participate in any program that allows or encourages policy periods of less than 12 months.

- **Offer continual open enrollment throughout the year.**

  While employers offer a single enrollment period during a calendar year, premium subsidy programs are sometimes available throughout the year, thus allowing an employer to enroll at any time. This approach is especially useful in states that struggle with attracting employers. At the same time, the ability to enroll at any time may discourage employers from taking advantage of a limited opportunity if they know they can delay their decision until later.

Insurers are usually opposed to unending enrollment periods as it allows an employer to defer enrollment until a time when they "need" it (i.e, when they or an employee become sick and need insurance). Unending enrollment also makes it difficult to predict costs since participation can change at any time.

- **Offer limited open enrollment periods throughout the year.**

  In lieu of unending enrollment periods, many subsidy programs and all employer-based insurance plans provide limited enrollment periods. Employers and employees must enroll during the limited timeframe or wait until the next enrollment period. A program could offer a single enrollment period or several opportunities during a calendar year as long as subsidy funds are available. If enrollment is still lower than expected, additional enrollment periods can be added. This approach is probably favored the most by insurers as it allows them to better anticipate costs based on predictable enrollment numbers.

Summary of Program Design Alternatives

Program Design Alternatives	Advantage(s)	Disadvantage(s)
Employer Eligibility		
Must not have offered coverage for past 6-12 months.	Minimizes crowd-out by ensuring subsidy dollars are used to provide new coverage, maximizing reductions in the number of uninsured. Brings new employers into the private market, which appeals to insurers.	Provides a competitive and economic advantage for employers who do not offer insurance and appears to punish employers who do offer insurance.
Available to any small firm, regardless of whether or not they already offer insurance.	Creates a more level playing field among competing small business owners. May increase support from the business community for such an initiative.	Substitutes the use of public funds for private dollars that are currently paying for health insurance. Decreases the impact on the uninsured population. May decrease support from insurance industry depending on how eligibility is structured.
Restrict eligibility to firms that have one or more low wage workers.	Allows a more targeted approach to ensure subsidies are provided to the lowest wage firms. May enable more families with children in Medicaid/SCHIP to access employer sponsored coverage.	Increases the program administrative costs in order to verify income eligibility. May discourage some employers from participating due to administrative requirements. May encourage some employers to suppress employee wages in order to qualify for program.
Employee Eligibility		
Restrict subsidies to employees with wages or family income below a certain level.	Ensures subsidies go to employees with greatest financial need. May enable more families with children in Medicaid/SCHIP to access	Increases administrative costs associated with income verification. May discourage some employers from participating due

Program Design Alternatives	Advantage(s)	Disadvantage(s)
	employer sponsored coverage.	to increased administrative eligibility requirements. May encourage some employers and/or employees to suppress employee wages or wage increases in order to qualify for program. Depending on number of employees receiving subsidy may prevent some firms from meeting minimum employee participation requirements.
Provide subsidy to all employees in a qualified small firm.	May increase employer and employee participation. Increases chance that employer will be able to meet minimum participation requirements.	Subsidizes premiums of higher wage employees who may not need subsidy.
Minimum Employee Participation Requirements		
Require firms to enroll 75 percent of eligible employees, as required in existing group market.	Compatible with existing small group requirements and does not require any changes to existing practices. Reduces risk of adverse selection.	Prevents some small employers from participating. Reduces access to employer sponsored coverage for employees who are willing and able to pay premium contribution requirements if other employees are unable or unwilling to participate
Require firms to meet minimum participate requirement below 75 percent.	Allows more firms to participate, which could improve enrollment in the program.	Increases risk of adverse selection, which could lead to higher premium rates. Insurers may be less likely to support.
Impose no minimum participation requirement.	Allows more firms to participate.	Greatly raises adverse selection risk and premiums. Insurers unlikely to participate. Discourages healthy employees from enrolling. Employers may be less generous in their premium payments if they are not necessary to enhance participation.
Employer Premium Contribution Requirements		
Require employers to contribute fixed amount of premium per employee (i.e., $100 per month), with subsidies covering balance of premium cost.	Fixed amount is easier to administer. Employers know up front what financial contributions are expected of them.	May result in higher subsidies required for certain groups with premium costs that are higher than average due to insurer pricing. Could be alleviated with rating revisions that provide more level premiums for all participants.
Require employers to pay a percentage of premium cost per employee, with subsidies covering balance of eligible	Variable subsidy payments may allow funds to cover more employees, depending on the cost of the enrolling employees.	More difficult to administer as premium contribution requirements for employers will vary based on each individual's

Program Design Alternatives	Advantage(s)	Disadvantage(s)
premium cost.	Percentage payments may distribute subsidies more equitably if insurers are allowed to vary rates based on age and gender, or other rating characteristics.	cost of coverage (unless rates are standardized). Difficulty in budgeting due to variability among premium costs and subsidy payments, unless pure community rating is used (i.e., standard premium for all enrollees).
Subsidy Values and Allocation		
Provide level subsidies to all eligible employees.	Fixed amounts are easier to administer. Employers and employees can predict in advance what to expect. May encourage higher enrollment of younger (and lower cost) employees.	Depending on insurer rating requirements, subsidy variations may not be sufficient for some higher-cost employees. Older workers may be disadvantaged if insurance premium rates vary based on age.
Vary subsidy based on income of employees.	Subsidy contributions will be more directly targeted to the lowest wage workers.	Varying subsidies is more challenging for employers and administrators of the program. May encourage employers to suppress employee wages to maintain continued eligibility for the program.
Vary subsidy based on premium cost.	Ensures subsidy can be adjusted to provide higher subsidies for groups with higher premium costs. May increase affordability for highest cost groups (depending on how premium rating is structured).	More complicated to administer as premiums subsidies could significantly vary among companies. May encourage higher risk groups to enroll, increasing the risk of adverse selection and reducing insurance carriers' support for the program
Subsidy Distribution		
Pay subsidy directly to employee.	Is relatively simple to administer. May provide employee with more flexibility to choose either employer coverage or qualified individual coverage.	More difficult to verify. Subsidy is used to pay for health insurance and increasing the cost of administration. Also requires processing and delivery of separate checks to each enrollee, further increasing administrative expenses. Could discourage some employees from participating if compliance requirements are complex.
Pay subsidy directly to employer.	Relatively easy to administer. Employer can combine subsidy with employer contribution and send one payment check to insurer. Provides employer with more control and responsibility. May serve to reinforce the value of the program	Must verify that employer purchases insurance and that every employee for whom a subsidy is awarded is enrolled.

Program Design Alternatives	Advantage(s)	Disadvantage(s)
	as employers receive the premium assistance checks each month.	
Pay subsidy directly to insurer.	The simplest approach to administer. Requires the fewest number of financial transactions. Ensures regular source of predictable revenue for insurers; even if premium from employer is late, partial payment will be received from state in the form of a subsidy payment.	
Administrative Oversight		
Delegate program administration to existing state agency or agencies (HHSC, TDI, or both).	Allows for quicker implementation of program since agency is already established. Maximizes use of existing infrastructure. Likely to incur fewer start-up costs that a newly created agency would incur.	
Create new entity to administer program.	May provide more flexibility; sole focus of agency will be implementation and management of the subsidy program.	Would likely take significantly longer to implement program. May incur relatively higher start-up costs in order to establish core-business functions of a new agency. May create administrative challenges in coordinating certain functions with Medicaid program if federal funds are used. May suggest to employers that program is subject to discontinuation if operated by a separate entity.
Financing Alternatives		
Use state/federal funds.	The availability of federal funds will significantly reduce the reliance on state funding and provide a larger revenue base on which to build the program. Will allow for higher participation due to increased funding levels. May provide more long-term stability compared to reliance solely on state funds.	Requires the state to comply with significant federal provisions. May limit the variety of plan design options available to the state. Will increase administrative costs in order to meet federal reporting/compliance.
Use only state funds.	Provides the greatest flexibility. Allows the state to fully control program. Results in lower administrative costs.	Limits the availability of funds, resulting in lower subsidy funding and reduced enrollment.
Fund with a combination of state funds and matching funds from various sources (local governments, private	Allows the state to fully control program. Provides access to increased funds with non-state contributions. Allows for expanded	Will result in higher administrative costs. Local/private funds may not be sustainable for long term.

Program Design Alternatives	Advantage(s)	Disadvantage(s)
donations, grants), excluding the use of federal funds	enrollment due to higher funding level. May increase public interest if local governments/entities are involved in program.	
Benefit Plan Design		
Require participating insurers to offer one or more standardized plans.	Standardized plans are easy for employees/employers to compare. Financial and claims experience is easy to monitor. If multiple insurers participate, comparisons among insurers are easy to perform. If federal funds are used,plan standardization can streamline CMS review. Reduces administrative costs and it is easier to ensure plan benefits are suitable and provide adequate level of coverage.	Limits the number of plan options available to employees.
Require insurers to obtain certification of any plans that meet minimum benefits standards.	Allows insurers to offer more plan options, providing more choices for subsidy recipients.	More difficult for employers/employees to compare and select an appropriate plan. Requires more complex administrative oversight to monitor multiple plans. Must ensure all plans meet CMS requirements if federal funds are used. Monitoring financial performance of varying benefit plans is more complicated.
Allow subsidies for any small employer benefit plan sold in Texas, regardless of the level of benefits provided.	Allows widest range of plan choices for employees and employers.	Cannot ensure subsidy funds are used to purchase adequate coverage. Unlikely to meet CMS requirements to use federal funds. Difficult to administer and monitor financial performance of a large number of plans. Premium rates will vary widely, in some cases substantially limiting the value of the subsidy.
Insurer Participation Requirements		
Allow all insurers who agree to certain conditions to participate.	Provides access to a wide range of benefit plans.	Would involve monitoring dozens of contracts, requiring financial monitoring and auditing of each individual contract. Would increase administrative costs. More difficult for employers/employees to assess value and select carrier. May discourage carriers from participating if they are not

Program Design Alternatives	Advantage(s)	Disadvantage(s)
		guaranteed adequate enrollment to protect against adverse selection. Difficult to negotiate best price if multiple carriers participate.
Limit participation to a one or several insurers, selected through competitive bidding.	Provides for simplified administrative oversight. Easier to monitor financial performance. More cost effective to administer. Provides state with best negotiating position in order to obtain lowest cost. Insurers more likely to commit to multi-year term if contract limited to a few companies.	Provides fewer options for program participants.
Insurance Premium Rating Issues		
Allow rating of premiums using existing small group market methodology.	Will appeal to insurers. May reduce risk of adverse selection.	Value of subsidy will vary significantly among groups depending on employee age, health status, and group size. Subsidies may be insufficient for higher risk groups. Employers may be reluctant to participate due to complexities. Administration of subsidy payments will be more complex, assuming subsidies will vary based on cost of coverage. More difficult for state to assess cost effectiveness and evaluate financial performance. CMS unlikely to approve if federal funds are used.
Require modified community rating or pure community rating.	Easier to administer; simplifies enrollment process. Easier for employers to estimate costs, determine whether they can afford premium costs. Subsidy values will vary little, if any, among groups, depending on extent to which premium rates may vary. More likely to receive CMS approval if federal funds are used.	May increase risk of adverse selection. Some insurers may be unwilling to participate.
Insurance Agent Participation		
Allow agents to market subsidy plans.	Increases agent support for program. Takes advantage of agents' ability to provide marketing, enrollment, education services. May reduce (but not eliminate) program marketing costs and staff needs. Provides local level of information and ongoing customer service attention that may	Will need to pay agent commissions or fees with state funds or from additional assessment. Federal funds cannot be used for payment of the commissions or fees.

Program Design Alternatives	Advantage(s)	Disadvantage(s)
	not be possible at the plan administrator/insurer level. Some employer will prefer to work directly with an agent.	
Do not allow agents to market subsidy plans.	Will save money that would have been paid on commissions. Allows employers to directly enroll on-line, or through some other methods, which may be less time consuming and preferred by some employers.	Will incur higher marketing, administrative costs to replace services normally provided by agents. Agents are likely to oppose creation of the program. Program might have lower than desired enrollment.

Chapter 5

Program Design Recommendations

Creating a premium subsidy program can be an effective tool for providing affordable health insurance options for the uninsured. However, a subsidy program must be carefully designed to appeal to both employers and employees and must consider the needs of all stakeholders. Affordability is a critical issue that cannot be overemphasized. Regardless of how comprehensive a plan is or how simply the program is designed, if the premium cost requirements for employers or employees are too high, the program will not be accessible to those for whom it is designed. If enrollment is inadequate, the long-term viability of the program is threatened.

This final chapter of the report provides recommendations for building a successful premium subsidy program that will complement and coordinate with the Texas private market and public programs. As described in Chapter 4, most of the plan design decisions are interrelated and cannot be determined exclusive of other decisions. Each decision will impact other factors and outside forces may help, as well as, hinder the program's success. The insurance rating methodology is a key decision that will affect premium costs and, therefore, other plan design options. Likewise, if federal funds are obtained, the program must comply with CMS requirements, which will vary depending on the target population and will affect many program features. Thus, in the absence of some of these critical directives, some of the recommendations provided in this section are general in nature and may need to be reconsidered in the context of a specific program design once more information is available.

One of the first decisions that must be made is who will be allowed to enroll in a premium assistance program. Other states have taken a variety of approaches, but most allow either low-income individuals, all employees working for uninsured small employers, low wage workers employed by small firms, or a combination of these population groups. Most state subsidy programs have focused on working adults and families with incomes below a certain poverty level, depending in part on the extent to which Medicaid already covers low-income adults. In Texas, most discussions of premium subsidy programs have focused on low-income adults below 200 percent of the federal poverty level. As Table 5.1 indicates, an estimated 1.9 million adults have family incomes below 200 percent of the federal poverty level. If the targeted audience is employees working in small firms that do not offer insurance, the total number of potential enrollees is 982,366. Though it is difficult to predict how many people might actually enroll in a program without knowing other details, the data in the table below provide general estimates of the number of people who *might* potentially be eligible, depending on how the Legislature defines "eligibility."

In addition, the separate study of a "Healthy Texas" insurance program for small employers may also provide additional opportunities for Texas employers. If enacted, the need for additional subsidies under a premium assistance program may be greatly diminished or even eliminated. If the Legislature chooses to enact both apremium assistance plan and "Healthy Texas" plan,

development of the programs should be closely coordinated to ensure the programs complement rather than contradict one another.

Table 5.1: Uninsured Population Estimates for Potential Subsidy Program Participation

Uninsured Adults with Incomes Below 200% FPL	1,957,703
Number of workers in small firms that do not offer insurance	982,366
Number of small firms that do not offer insurance	199,381
Number of workers in small firms who are uninsured	1,245,120
Total Uninsured Population Below 50% FPL	662,042
Total Uninsured Population Between 51% to 99% FPL	966,794
Total Uninsured Population Between 100% to 149% FPL	936,302
Total Uninsured Population Between 150% to 199% FPL	829,448
Total Uninsured Population Between 200% to 249% FPL	672,556
Total Uninsured Population 250% FPL or higher	1,616,123

Although the numbers above demonstrate the maximum number of individuals within certain categories who might be eligible, the actual number of enrollees in a premium subsidy program will be considerably lower than the total that are eligible. Other states with subsidy programs report relatively low take-up rates, particularly in the first few years of a new program. Texas has several tools to ensure enrollment is managed at a level that is appropriate based on the funds available, regardless of which eligibility categories the Legislature selects.

Subsidy Program Design Recommendations

The recommendations included in this section are based on a review of other state programs and joint analyses by the Health and Human Services Commission (HHSC) and the Texas Department of Insurance (TDI) to determine the program design features that both agencies believe would reach the most Texans in the most efficient, cost-effective manner possible given Texas' existing private health insurance market. Recommendations also are based, in part, on the small employer health insurance market research conducted by TDI as part of the federal State Planning Grant (SPG) program. Employers' and employees' recommendations and preferences were considered in determining specific features that would enhance employer participation, while providing benefits that would also appeal to employees.

1. Design a program that is affordable for the target audience.

The key factor in achieving a successful subsidy program is ensuring the cost of coverage is affordable for both the employees and employers for whom the program is created. Affordability is a critical issue; if the employers' and/or employees' contribution requirements are too high, people will not enroll. Other factors are also important, but no matter how appealing the benefit plan is, or how generous the subsidy, if it still requires a premium that is unaffordable, the program will experience very low enrollment. In addition, the program will attract those individuals who need the coverage the most, increasing the risk of adverse selection and threatening the long-term viability of the program.

As discussed in Chapter 1 of this report, TDI has collected data from uninsured employers and families to determine how much money employers are willing to pay for coverage. In 2004, 37 percent of employers reported they can pay at least $100 per-employee-per-month. An additional 17 percent would pay $50 per-employee-per-month. The remaining employers would pay $50 or less, with 14 percent reporting they would pay no amount of money for health insurance.

TDI also surveyed uninsured families above 200 percent of the poverty level to determine how much they will pay for coverage. In 2002, 29 percent would pay less than $50 a month for family coverage. However, 26 percent would pay at least $100 a month.

This data is critical information that should be carefully considered when determining how much the subsidy program will cost for both employers and employees. To better advise the Legislature on an appropriate target price for small business owners, TDI is in the process of re-surveying small employers to update the information collected in 2001 and 2004 in order to determine with better accuracy how much money uninsured employers are able to contribute to a health insurance plan. Hopefully, the information will enable the Legislature and plan administrators to build a program that will be both appealing and affordable for the people for whom it is intended.

Several other recommendations that follow could significantly impact the cost of the program for all participants. In particular, recommendations 3, 4, 7, and 8 should be closely considered in the context of how those decisions will impact premium rates. Other important decisions that will directly impact employer and employee costs are benefit plan design and premium subsidy values, the impact of which may vary based on the target population.

2. Provide benefit plans that appeal to both employers and employees to maximize interest and enrollment in the program.

In order to attract both employers and employees to the program, benefit plans must be designed to appeal to employers who generally want protection from catastrophic losses and lower paid employees who are more interested in protection from the more typical health care costs. Offering at least two separate benefit plans that appeal to both types of target enrollees will likely appeal to more people and will increase participation. Prototype benefit plans (Appendix A) were developed for the Houston pilot project discussed earlier in this report and are a suggested starting point for a dual-option benefit program. Both employers and employees are more likely to respond favorably to a program that provides them at least two choices. Additional plan options may also be offered if necessary to meet financial limitations or to comply with CMS benefit requirements. However, the number of plan options should be limited in order to reduce the risk of adverse selection, reduce the cost of administrative oversight, and maximize the benefits of pooling large numbers of enrollees in order to achieve cost reductions.

If multiple plan options are provided, employees and employers should each have the option to select the benefit plan that best meets their personal medical and financial needs.

Minimum participation requirements should apply to the aggregated enrollment and should not restrict employees from selecting a plan that is different from what the employer chooses.

3. Require employers to contribute a percentage of the premium cost based on the cost per employee.

As within the commercial market, employers should be required to contribute a percentage of the premium cost per-employee-per-month. Employer contributions are an important mechanism for sharing the cost of insurance and encouraging workers to enroll. The amount of that contribution will depend on many factors, including the benefit plan design, the rating methodology used to determine rates for different groups and, most importantly, the total amount of money employers are able to pay per-employee-per-month. The Legislature may want to initially consider a minimum employer contribution requirement of no less than 50 percent of the total cost of employee-only coverage, which is consistent with requirements within the existing small group market. The Legislature may also want to require that the plan design be re-evaluated annually to ensure the cost of the program continues to remain affordable. As the cost of health insurance increases over time, the benefit plan design may need adjustments in order to keep premium costs for both employees and employers at a targeted level.

4. Create one or more standardized benefit plans for subsidy program participants.

In order to ensure the benefit plan or plans offered under the subsidy program provide at least a minimum level of insurance protection, creation of one or more standardized plans is recommended as an option for consideration. While the private market offers a wide variety of plan options and choices for employers, the administrative costs associated with accepting many different insurance plans for subsidies will be significant. In surveys and focus groups conducted by TDI, small business owners and their workers have reported a strong preference for standardized plans as an important way of simplifying the challenges of purchasing insurance. Employers also report that standardization by the state provides assurance that the plan provides an appropriate level of coverage. This is particularly important among those small employers who have little experience with the private insurance market and are overwhelmed by the complexity of options that are available.

Offering a limited number of plans provides several advantages:

- Simplifies administrative oversight and reduces costs.
- Simplifies the enrollment process for employers and employees.
- Allows the state to provide meaningful cost/benefit analysis of the program.

Perhaps one of the most meaningful benefits of providing a standardized plan is the ability to ensure that subsidy program participants will receive adequate benefits that will reduce the incidence of uncompensated medical care. Some of the low level benefit plans that are currently available in Texas provide such limited insurance that many workers find the coverage insufficient for even routine health care. If a subsidy program is created, the state will want to ensure that the funds are used to provide the most comprehensive care possible

at a reasonable cost. Adoption of standardized plans will greatly improve the state's ability to monitor cost effectiveness and ensure that the state is getting the most value for its investment.

Finally, if federal funds are used to subsidize coverage, compliance with CMS' benefit requirements will be much simpler if standardized plans are developed.

5. To address crowd out concerns, restrict enrollment to previously uninsured firms and employees in order to discourage employers from discontinuing other private coverage.

One of the most challenging decisions in designing a subsidy program is whether enrollment should be restricted to previously uninsured firms in order to minimize "crowd out" (i.e, the practice of dropping existing insurance to enroll in the subsided program.) Most states have elected to require subsidy program enrollees to be uninsured, often for a minimum amount of time. If federal funds are used for the subsidy program, CMS will likely require the state to impose crowd out restrictions. In order to ensure the limited subsidy dollars are used to provide coverage for uninsured Texans, participation in the subsidy assistance program should be limited to only those small firms that have not offered insurance for a minimum period of time. Although a lesser period could be used, 12 months is suggested. If the time period is too short (such as six months), some employers may drop existing coverage in order to qualify for the program. If a longer uninsured time period is selected, employers are less likely to risk going without insurance for such an extended amount of time.

In addition, the Legislature should consider prohibiting enrollment of any employee who already has existing insurance. Exceptions could be made if an employee's existing coverage is less comprehensive than what would be provided through the subsidy program, or if CMS prohibits such restrictions. Exceptions could also be made if existing coverage is more costly than participation in the subsidy program.

To address concerns that restricting coverage to uninsured firms penalizes employers who *do* offer insurance, the following recommendation is also suggested if the restriction is enacted.

6. Consider providing a tax credit to reward employers who already provide insurance and cannot qualify for the premium subsidy program.

If employers who already offer insurance are ineligible for the premium subsidy program, the state should consider offering an alternative financial reward for those employers who have been providing coverage. Offering a tax credit addresses concerns that providing subsidies for some employers puts other ineligible employers at a competitive financial disadvantage. It also acknowledges that the state recognizes the benefits to the state when employers offer insurance benefits, reducing the number of uninsured and providing health care for employees who might otherwise have no insurance. Both the Senate Finance Committee and the Joint Interim Committee on Health and Long-Term Care Insurance Initiatives are studying opportunities for health insurance tax credits and may provide recommendations the Legislature can consider. Employers participating in the subsidy program would not be eligible for this tax credit.

7. Limit participation to one or several insurers.

Due to the complexities of offering a premium subsidy program, it is recommended that the number of insurers participating in the program be limited to one or several firms, selected through a competitive bidding process. For a subsidy program to succeed on a long-term basis, insurers will want sufficient enrollment volume to ensure an adequate number of "healthy" enrollees to offset the risk of increased adverse selection. Reduction in adverse selection will also result in lower premium costs. In addition, limiting participation to a few insurers significantly reduces the administrative costs of overseeing the subsidy program. If, over time, the program continues to grow and enrollment is adequate to justify adding new carriers, the program could be expanded to include additional insurers.

If the Legislature prefers to allow all insurers to participate, it is recommended that participants must meet specific participation requirements and must offer qualified benefit plans that meet the state's requirements. If federal funds are used, CMS will require that the benefits meet specific requirements.

8. Require participating insurers to use either a pure community rating methodology or modified community rating.

Although the Texas commercial insurance market is not subject to community rating or modified community rating requirements, subsidy programs using government funds are subject to different standards. Wide rate variations that exist in the private market are not feasible within a subsidy program as they create complex administrative burdens and will discourage many employers from participating. Subsidy values in relation to the premiums charged different employer groups would vary widely and would likely be insufficient to subsidize coverage for business firms that employ older workers or an employee with a pre-existing health condition. CMS is less likely to approve the use of federal funds unless premium rates are subject to tighter restrictions than those that apply in the commercial small employer market.

To ensure subsidies are adequate and that employers have access to coverage that is equally affordable to all enrollees, the premium rates should be based on a pure community rated program whereas rates are equal for all participating firms or vary minimally based on gender and/or age. Even those variations should be restricted to keep premiums affordable. The exact rating methodology should be determined as part of the competitive bidding process through which participating carriers will be selected.

9. Provide two limited open enrollment periods annually, with an option to add additional enrollment periods as needed.

Restricting enrollment opportunities during the first year is strongly recommended for several reasons. A limited enrollment period will give the program time to gradually expand, providing valuable experience data that will allow the state to better estimate and predict long-term costs. Interested employers may also be encouraged to enroll sooner if they know the enrollment opportunity is limited. If the enrollment is lower than desired, the enrollment

period can always be extended, or additional opportunities added at a later date. Most importantly, employers who know they can join at any time are more likely to delay enrollment until they or an employee actually needs medical services. While pre-existing condition limitations may minimize the impact of such delayed enrollments, federal benefit requirements (if federal funding is used) may limit the ability of the state to impose pre-existing condition restrictions. Under those circumstances, limited enrollment periods become an even more critical option for managing the risk of adverse selection by unhealthy groups that delay enrollment.

10. Allow agents to participate in the marketing of subsidy plans.

Agents provide a value service in providing information and enrollment assistance and should be allowed to participate in the premium subsidy program. Agents have established relationships with employers and employees in local communities and are the primary point of contact for information on health insurance. Reaching local employers throughout the state is a challenging, expensive endeavor; agents are already strategically placed to assist in this process. The inclusion of agents should result in a reduction of marketing expenses and reduce other administrative costs, such as expenses associated with enrollment.

While agents traditionally receive a percentage of the total premium cost in exchange for their services, the subsidy program may want to consider paying a flat fee per enrollee or group. If commissions are used, the state may want to consider basing commissions solely on the premiums contributed by employers and employees. If federal funds are used for the program, CMS may not allow federal funds to be used for commission payments.

11. Offer enrollment to employees and their eligible dependents.

In order to attract both employers and employees to the benefit program, employees should be allowed to enroll their spouse and dependent children. Employees with family members often prefer to keep their family under one benefit plan. Depending on the cost of the plan and the availability of subsidies for children who would otherwise qualify for Medicaid and/or SCHIP, providing family coverage may encourage some employees to switch their children from Medicaid/SCHIP into the employer sponsored plan (subject to CMS approval). Though they should not be required to do so, some employers will likely decide to pay part of the dependent/spouse premium, which will improve the affordability of coverage for the employee. Offering dependent coverage is also consistent with benefit plans offered in the commercial market.

12. Provide subsidy payments directly to the insurer rather than sending payments to the employer or employee.

This approach guarantees insurance is obtained and subsidies are used to pay for health insurance. Sending payments directly to the insurer is also simple to administer and cost effective. Participating insurers will receive a single payment for all enrollees on a monthly basis. Insurers would be required to provide regular enrollment information and enrollees

will be verified by the plan administrator. If an individual or group disenrolls, the insurer will be responsible for informing the administrator.

13. Require 12-month enrollment periods and annual re-verification of eligibility.

Twelve month enrollment periods are consistent with private market conditions and are necessary to attract insurers to the plan. The requirement also stabilizes the population and ensures employees that coverage will be available for at least one year. Upon renewal each year, the employer group and/or eligible employees should be subject to re-verification to assure subsidies are not renewed for participants who no longer qualify.

14. Consider allowing local communities to "buy-in" to the state-operated subsidy program.

Several Texas communities are in various stages of developing local three-share premium assistance programs that provide affordable health care programs for small businesses. The plan requirements vary by community, with some considering fully-insured health plans while others instead focus on limited health care programs using local community provider arrangements that are not insured benefit plans. Regardless of the program design, the primary goal is to provide access to affordable health care by sharing the cost of coverage among employers, employees, and a third party (usually a local government entity created specifically for the three-share program). Communities considering a three-share program may be interested in participating in a statewide subsidy program instead. The 3-Share contribution mechanism could still be utilized, allowing employers, employees, and the local government to contribute to the cost of coverage. Subsidies could be used to subsidize the employees' share only, or it could be structured to subsidize all of the contributing sides. This option may appeal to communities that do not have significant sources of funds for the community share of the premium.

15. Require participating enrollees to complete a health risk assessment upon enrollment.

Health risk assessments have been proven to be an effective tool for medical case management. All enrollees should be required to complete a brief health questionnaire in order to allow the insurer the opportunity to identify insureds with medical conditions that are eligible for case management. Employees who refuse to complete the risk assessment form may be subject to rejection from the program, or may lose the subsidy contribution, or may be subject to higher co-payment and/or premium contributions.

16. Consider alternative group minimum participation requirements.

One of the primary barriers to providing coverage for many small businesses is the requirement to enroll 75 percent of eligible employees. The Legislature should consider lowering the participation requirement for groups enrolling in the premium assistance program. This would allow more firms to offer coverage to their workers who are willing to pay for insurance and would particularly benefit border communities that face particular challenges in meeting participation requirements.

Funding Options

Federal Funding: Coordination with HOP

States with existing premium assistance programs have used a combination of state and federal funds. As it was mentioned in Chapter 2, the Texas Legislature has directed HHSC to seek a Section 1115 Medicaid waiver to create the Texas Health Opportunity Pool (HOP) trust fund. If approved, the HOP fund will allow Texas to provide premium subsidies for uninsured adults below 200 percent of poverty.

The Medicaid waiver will make subsidies available based on individual eligibility criteria. If CMS approved the state's waiver request, eligible individuals would be able to use their subsidies to purchase employer-sponsored insurance currently available or newly available options through small employer premium assistance programs that might be developed. As long as the benefit design and cost-sharing requirements of the program meet CMS' criteria for a qualifying ESI benefit, a small employer program might see increased participation with more low-income employees having access to individual subsidies to help them pay for their share of insurance.

State Only or State/Local Funding

If the state does not secure federal funding for a premium assistance program, the state could choose to fund a premium assistance program using state-only funds or a combination of state and local funds. The primary advantage to using state-only funds is that the state has complete control over the program design and is not subject to the federal provisions that can significantly impact program features. While the absence of federal dollars may limit the extent of the program, the ability to leverage state funds with employer and employee funds provides a significant opportunity to reach uninsured workers.

Appendix A
Small Employer: Prototype Benefit Plans

	Plan A Revised Prototype: Catastrophic Care Plan	Plan B Revised Prototype: Basic Benefit and Preventive Care Plan
Plan Basics		
Approximate Avg. Monthly Premium Cost Per Adult	$156	$129
Approximate Monthly Premium Cost Per Child	$72	$59
Annual Deductible	$1,000	$250
Coinsurance	30%	20%
Out-of-pocket Maximum (Including deductible)	$11,000	$1,250
Annual Maximum Benefit	$300,000	No specified dollar limit
Hospital Benefits		
Inpatient Hospital Stay	Covered	Five days covered annually
Outpatient Hospital Surgery	Covered	Two visits covered annually
Hospital Outpatient Radiology, Pathology, and Diagnostic Tests	Covered	Two surgeries covered annually
Emergency Room Visits	Covered	Two visits covered annually
Physician Benefits		
Inpatient Hospital Care	Covered	Five days covered annually
Outpatient Hospital Care	Covered	Two visits covered annually
Doctor Office Visits and Preventive Care	The first two visits have a $25 co-pay for adults, and the first four visits have a $25 co-pay for children under age two; all other visits are subject to the deductible and coinsurance requirement	Six visits covered annually; the first two visits have a $25 co-pay
Doctor Office Visits for Substance Abuse and Psychiatric Care	First two visits have a $40 co-pay; all other visits are subject to the deductible and coinsurance requirement	Covered
Radiology and Pathology	Covered	Two visits covered annually
Prescription Drug Benefits		
Deductible	$500	None
Coinsurance	30%	None
Co-payments	None	$10 for generic drugs, $20 for formulary brand name drugs, and $30 for non-formulary brand name drugs
Annual Maximum Benefit	None	$1,000

	Plan A Revised Prototype: Catastrophic Care Plan	Plan B Revised Prototype: Basic Benefit and Preventive Care Plan
Additional Covered Services		
Ambulance	Covered	Covered
Private Duty Nursing	Covered	Not Covered
Home Health Care	Covered	Not Covered
Durable Medical Equipment	Covered	Not Covered
Prosthetics	Covered	Not Covered
Maternity Care	Covered	Covered
In-Patient Psychiatric Care and Substance Abuse Treatment	Covered	Not Covered
Vision Exam	Not Covered	Covered
Glasses or Contacts	Not Covered	Not Covered
Dental Coverage	Two annual preventive visits are covered at 100% after $25 co-pay	Two annual preventive visits are covered at 100% after $25 co-pay
Chiropractic Care	Not Covered	Not Covered
Podiatrist	Not Covered	Not Covered

Appendix B

Summary of State Premium Subsidy Programs

Table B.1: Eligibility Summary

State	Target Population	Employer Eligibility	Employee Eligibility	Funding
Arizona (HCG)	• Sole proprietors. • Small employers. • Governmental subdivisions (cities, counties, etc.).	• Businesses must be sole proprietorship or have 50 or fewer employees. • Not offered health coverage prior 6 months. • Health coverage rate of 80% (or 100% if 5 employees or less.	• All full-time employees (at least 20 hours per week) of participating businesses may enroll. • NOT based on income or wages. • Dependents may also enroll.	• Employers not required to contribute to cost of employee premium. • Stop-loss reinsurance fund keeps premiums lower than commercial market. • Reinsurance funded by member premiums.
Arizona (Health Care Cost Containment System -Section 1115)	• Individuals with dependent children with income between 100 and 200 percent of FPL. • Individuals without dependent children with income at or below 100 percent of FPL.	• This subsidy program is not tied to employment. • Individuals with access to ESI can enroll in the employer-sponsored coverage if the employer contributes at least 50 percent toward an employee coverage and 30 percent toward the cost of dependent coverage.	• This subsidy program is not tied to employment. Subsidy eligibility is based on the individual's income (see Target Population description).	• The program uses state and federal SCHIP funds. The state has the authority to use Medicaid funds if SCHIP funds are exhausted.
Arkansas (ARHealth Networks)	• Employees of small businesses (2-500 full-time employees) and their spouses having incomes at or below 200% FPL.	• Not offered insurance in previous 12 months. • All employees must participate or have outside coverage. • At least one employee must qualify to receive subsidies.	• Work at least 30 hours per week. • Must have annual family incomes of 200% or less FPL to qualify for subsidized premium. • Employees' spouses also eligible.	• As of July 2007, employee premium contributions averaged $13 for a fully subsidized employee and $500 for an unsubsidized one. • Average employee premium contributions of $25/mo. • Subsidies only for employees with annual family incomes of 200% or less FPL. • The subsidy portion is funded with state and federal funds. Federal funds include unspent SCHIP funds and Medicaid funds.
Maine (Dirigo Choice)	• Low-wage employees of small businesses (50 or fewer employees), the self-employed, and individuals earning 300% or less FPL.	• May enroll even if currently offering coverage. • 75% of eligible employees must enroll. • Must offer dependent coverage, but not required to contribute to cost.	• Employees must work at least 20 hours per week	• Employer and employee contributions. • Assessments on insurers. • "Savings offset payment" approach that calculates savings to providers from lower uncompensated costs.

State	Target Population	Employer Eligibility	Employee Eligibility	Funding
Maine (Medicaid and Waivers)	• Expanded eligibility for low-income parents with income between 150 and 200 percent of FPL. • Childless adults with income at or below 100 percent of FPL.	• This subsidy program is not tied to the employment.	• This subsidy program is not tied to the employment. See target population for eligibility description.	• Expanded coverage is funded with Title XIX funds for low-income parents and redirected DSH funds for childless adults.
Massachusetts	• Commonwealth Care: individuals with income up to 300 percent of FPL (subsidized program). • Commonwealth Choice: provides access to affordable insurance to small businesses and uninsured individuals with income above 300 percent of FPL (non-subsidized coverage.) • Young Adult Plan: provides low-cost coverage to 19-26 year old individuals without access to ESI.	• The state provides a subsidy (incentive payments) to small employers that contribute at least 50 percent of the premium amount and provide coverage that meets a basic benefit level.	• Employees of the small businesses with income at or below 300 percent of FPL. • Self-employed with income at or below 300 percent of FPL. • (Note: also includes individuals without access to ESI with income at or below 300 percent of FPL.)	The funding for various initiatives comes from: • General revenue funds. • Assessments on hospitals, insurers and employers who choose not to offer insurance. • Federal funding that includes Title XIX (Medicaid) funds and available SCHIP funds. • Employer contributions. • Individual contribution (for those with income above 150 percent of FPL).
Michigan (Access Health)	• Uninsured workers (and their dependents) of small to medium-sized businesses.	• Headquartered in Muskegon County. • Not offered insurance in previous 12 months. • Median wage paid cannot exceed $11.50/hr. • Offered to all employees working 15.5 hrs/week.	• Employees must work an average of 15.5 hours/week. • Must not be eligible for any public program (Medicare, Medicaid, etc.).	• Three-share program: employers and employees each contribute 30% of premium, while community contributes remainder.
Michigan (Adult Benefits waiver)	• Individuals without dependent children with income at or below 35 percent of FPL.	• This subsidy program is not tied to the employment.	• This subsidy program is not tied to the employment. See target population for eligibility description.	• The program is funded with state and federal funds. Federal funds include unspent SCHIP funds.

State	Target Population	Employer Eligibility	Employee Eligibility	Funding
Montana (Insure Montana)	• Small employers (between 2-9 full-time) and their employees.	• Between 2-9 employees. • No employee (other than owner) may earn more than $75,000 per year. • Not offered insurance in previous 24 months.	• Must work at least 30 hours per week, though employer can choose to offer to those that work at least 20 hours/week.	• Employers 50% of employee premium; reimbursed half of that amount. • Employee responsible for remainder; subsidies based on annual family income and range from 20-90% of contribution. • May 2007: $158 average employee subsidy, $203 average employer subsidy.
Montana (1115 Demonstration)	• Parents and caretakers of dependent children with income at or below 33 percent of FPL.	• This program is not tied to the employment.	• This program is not tied to the employment. See target population for eligibility description.	• State and federal Title XIX funding.
New Mexico (SCI HIFA waiver)	• Uninsured, low-income individuals and employees of small businesses whose family income 200% FPL or less.	• Between 2-50 total (full and part time) employees. • Not offered insurance in previous 12 months.	• Annual family income may not exceed 200% FPL.	• Employers must pay $75 per employee per month. • Employees pay according to income tiers: $0 for up to 100% FPL, $20 for 101-150% FPL, and $35 for 151-200% FPL. • Individuals may enroll but are required to pay $75 employer contribution. • The average monthly subsidy amount in 2007 was $272. • The subsidy portion is funded with state funds and available federal SCHIP funds.
New York (Healthy NY)	• Small businesses and their employees, sole proprietors, and working individuals without access to employer coverage.	• 50 or fewer employees. • 30% of employees earning less than $36,500 per year. • 50% employee participation; at least earning >$36,500/year. • Not offer insurance in previous 12 months.	• Employees of participating businesses are eligible. • Individuals must not have had insurance in previous 12 months and have family incomes at or below 250% FPL.	• Employers pay 50% of employee premium. • Employees pay remainder; individuals pay entire premium. • State pays 90% of claims between $25,000-$75,000: keeps premiums 20-50% lower than commercial market.
New York (Family Health Plus - 1115 Demonstration)	• Low-income parents with income at or below 150 percent of FPL. • Childless adults with income at or below 100 percent of FPL.	• This program is not tied to the employment.	• This program is not tied to the employment. See target population for eligibility description.	• State and federal Title XIX funding.

State	Target Population	Employer Eligibility	Employee Eligibility	Funding
Oklahoma (OEPIC Section 1115 Demonstration)	• Employees of small businesses (ESI program) and individuals (IP program) earning up to 200% FPL.	• 50 of fewer full-time employees. • Enroll or be enrolled in a health plan that meets specified minimum standards.	• ESI: employees must earn 200% or less FPL; not eligible for Medicare or Medicaid. • Individual: same requirements as above; must either not have access to employer coverage, temporarily unemployed, or disabled worker.	• ESI: employer pays 25% of employee premium; employee pays 15% for employee and spouse; state pays 60% for employee and 85% for spouse. • Individual: sliding scale premiums based on family income; $0-$51.39 (individual) and $0-$68.91 (families). • Subsidy is funded with state (tobacco tax) and federal Title XIX funds.
Oregon (FHIAP HIFA Waiver)	• Individuals and families with incomes below 185% FPL.	• N/A	• Annual family income 185% or less FPL. • Uninsured for previous 6 months. • Have investments and savings less than $10,000 (including rental property). • Individuals and families with annual family incomes 185% FPL or less eligible for subsidies.	• Sliding scale subsidies based on annual family income; 4 income tiers. • Subsidy payment equals 95% of premium for 0-125 FPL, 90% for 126-150 FPL, 70% for 151-170 FPL, and 50% for 171-185 FPL. • Subsidies used to purchase either employer-sponsored insurance or individual coverage (plans must meet state's minimum standards). • The subsidy is funded with state and federal (SCHIP and Title XIX) funds.

Appendix B

Summary of State Premium Subsidy Programs

Table B.2: Plan Specifics

State	Premiums / Subsidies	Enrollment	Underwriting	Delivery System and Benefit
Arizona (HCG)	• Employers not required to contribute to cost of employee premium. • Stop-loss reinsurance fund keeps premiums lower than commercial market.	• 24,562 individuals enrolled as of December, 2006. • HMO plans account for 90% of enrollment.	• HCG Program: Guaranteed, community rated. • State: Guaranteed for small businesses. No community ratings, but does employ rate bands.	• Commercial plans with several packages offered: comprehensive benefit and more limited benefit with high deductible.
Arizona (Health Care Cost Containment System Section 1115)	• The state subsidizes coverage for eligible individuals who are not required to pay for a portion of the premium. • Employers are required to contribute 50 percent of the premium if an individual eligible for the state subsidy enrolls in ESI.	• Approximately 48,000 individuals were estimated to be eligible for the coverage. • In federal fiscal year 2008, the state estimated that the coverage would be provided to more than 11,000 individuals.	• Individuals have access to the program if they meet income eligibility criteria and contingent on the availability of funding.	• County-owned health plans provide a comprehensive benefit package.
Arkansas (ARHealth Networks)	• Average premium of $25 / month. • Subsidies provided for employees earning 200% or less of FPL.	• As of July 2007, 665 people enrolled from 178 businesses.	• Guaranteed, community rated.	• Single limited benefit plan with $100 deductible and $15 co-insurance. Annual out-of-pocket maximum of $1,000; annual maximum benefit level of $100,000.
Maine (Dirigo Choice)	• Eligible enrollees receive premium subsidies and reduced deductibles and out-of-pocket costs • Enrollees receive sliding scale subsidies based on FPL up to 80% of premium cost	<u>February 2008:</u> • 23,000 individuals • 725 small businesses	• Premiums are established using a modified community-based approach.	• Two high deductible plans, with deductibles of $250 (individual) / $1,000 (family) and $500 / $1,750. • Commercial reimbursement to providers.

State	Premiums / Subsidies	Enrollment	Underwriting	Delivery System and Benefit
Maine (Medicaid and Waivers)	• The program fully subsidizes coverage of eligible individuals. • Enrolled individuals have nominal cost-sharing obligations.	• Almost 20,000 childless adults are covered through the waiver.	• Individuals have access to the program if they meet income eligibility criteria (contingent on the availability of funding).	• Primary care case management model. • The benefit is more limited than traditional Medicaid coverage.
Massachusetts	• Individuals with income above 150 percent of FPL have monthly premium contributions between $35 and $105.	September 2008: • Approximately 176,000 individuals were enrolled in Commonwealth Care (reported in March 2008) (subsidized program). • More than 140,000 enrolled in ESI (non-subsidized but more affordable insurance). • The program has also expanded Medicaid coverage under the State's Medicaid Plan to an additional 72,000	• Individuals have access to the subsidized program if they meet income eligibility criteria.	• Managed Care Organizations. • Employer-sponsored insurance plans.
Michigan (Access Health)	• Three-share program: employers and employees each contribute 30% of premium; community contributes remainder.	• Over 400 small businesses accounting for approximately 1,500 lives.	• Rate bands and modified community rating.	• Two comprehensive health plans covering services received within Muskegon County. • Plans are similar in design but one contains reduced premiums and cost sharing.
Michigan (Adult Benefits Waiver)	• Individuals enrolled in the program do not have monthly premium contributions	• This program is capped at 62,000.	• Individuals have access to the program if they meet income eligibility criteria (contingent on the availability of funding).	• Fee-for-service model and managed care organizations where available. • Mental health and substance abuse services are delivered through a Community Mental Health Service Program. • Major services are covered through the program with the exception of inpatient services.

State	Premiums / Subsidies	Enrollment	Underwriting	Delivery System and Benefit
Montana (Insure Montana)	• Subsidies based on family income: range from 20-90% of employee contribution. • May 2007 averages: $158 employee subsidy; $203 employer subsidy.	May 2007: • 740 businesses representing 5,100 lives. • Additional 665 businesses (3,800 lives) in tax credit system.	• Small group market uses rate bands.	• Two comprehensive health plans offered by BCBS. Both plans cover similar services, yet one covers at higher rates in exchange for higher premiums.
Montana (1115 Demonstration)	• Individuals enrolled in the program do not have monthly premium contributions, but do have cost-sharing obligations.	May 2008: • 7,500 individuals.	• Individuals have access to the program if they meet income eligibility criteria.	• Fee-for-service model. • The benefit covers services similar to what is provided in the state's Medicaid program with the exception of optional services (e.g. dental, dialysis, durable medical equipment, eyeglasses, among others).
New Mexico (SCI)	• Employees pay according to income tiers: $0 for up to 100% FPL, $20 for 101-150% FPL, and $35 for 151-200% FPL. • Individuals may enroll but are required to pay $75 employer contribution.	December 2006 • 4,263 enrolled lives of which 93% individuals and 7% employer-based. • 77% with incomes less than 100% FPL.	• Program: modified community rating – excludes medical and employment history. • State: rate bands.	• Plans that are a part of the Medicaid program but which also have commercial presence. • Comprehensive benefit with some cost-sharing for individuals above 100% FPL. $100,000 annual maximum.
New York (Healthy NY)	• Stop-loss reinsurance program: state pays 90% of claims between $25,000-75,000. • Premiums 20-50% lower than commercial market.	November 2006: • 130,850 total lives covered.	• Pure community rating.	• All HMO plans must participate; other carriers allowed to participate as well.
New York (Family Health Plus - 1115 Demonstration)	• Individuals are not required to pay a portion of the premiums but do have cost-sharing obligations.	October 2008: • Projected enrollment of 521,000 individuals.	• Individuals have access to the program if they meet income eligibility criteria.	• The state contracts with commercial managed care organizations. • Benefit package is more limited than what is covered under the State's Medicaid program, but the state can provide additional wrap-around services as needed.

State	Premiums / Subsidies	Enrollment	Underwriting	Delivery System and Benefit
Oklahoma (OEPIC Section 1115 Demonstration)	• ESI: employee pays 15% for employee and spouse; state pays 60% for employee and 85% for spouse. • Individual: sliding scale premiums based on family income; $0-$51.39 (individual) and $0-$68.91 (family).	October 2008: • ESI: 3,435 employers accounting for 10,401 lives. • Individual: 4,467 lives.	• Rate bands.	• ESI program uses existing private insurance market, though certain minimum standards must be met. • Individual : administer by state Medicaid agency; services are somewhat limited in comparison to ESI.
Oregon (FHIAP)	• Subsidy payment equals 95% of premium for 0-125 FPL, 90% for 126-150 FPL, 70% for 151-170 FPL, and 50% for 171-185 FPL. • Subsidies used to purchase either employer-sponsored insurance or qualified individual plans. • Average monthly subsidy payment of $249.52.	February 2008: • 17,020 lives enrolled. • Waiting list contains 27,320 lives after enrollment freeze.	• Modified community rating.	• Employs commercial market; plans must meet minimum standards with coverage for over 20 services.