WorkingTogether for a Healthy Texas

Final Report

Texas State Planning Grant

March 2002

Texas Department of Insurance
State Planning Grant Division

Texas State Planning Grant

Final Report to the Secretary
U.S. Department of Health and Human Services
March 2002

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TEXAS STATE PLANNING GRANT
FINAL REPORT - MARCH 2002

Prepared by SPG Staff
Texas Department of Insurance

Executive Summary

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

Because of the large number of uninsured Texans and the diversity of populations across different areas of the state, the SPG staff and working group agreed from the beginning that a significant reduction in the uninsured would require a multi-faceted approach that includes both private and public options. The cooperation of a large number of key stakeholders was essential to the success of the project and a key factor to the significant strides that have been made throughout the past twelve months. Members of the SPG Oversight and Implementation Working Group were chosen in large part due to their unwavering interest in the problems of uninsured Texans and their commitment to addressing the needs of these citizens. Further development of the policy options under consideration and plans for implementation will depend on their continued dedication.

Although Texas has not yet reached consensus on which policy options to pursue for adoption, all planned survey and research activities proposed in the original grant application have been completed. A number of options for expanding insurance coverage remain under review and will continue to be developed over the next 12 months. Following is a brief overview of the activities and the major highlights of the study. Comprehensive reports on all grant and survey activities are available at http://spg.tdi.state.tx.us.

Data Collection Activities

Texas' survey activities were designed to obtain information that would be most useful in developing policy options for expanding health insurance. The four primary data collection activities are summarized on the following pages.

a) Small Employer Survey

More than 50,000 surveys were sent to small employers in Texas to collect information on their attitudes and perceptions regarding insurance, and their ability and willingness to purchase private coverage. The development, implementation, and analysis of this survey activity were conducted entirely by SPG staff. More than 13,000 completed surveys were received, an indication of the importance of this issue among small businesses. Major findings of this study include:

- The primary reason employers do not offer insurance is because it is unaffordable;
- Approximately 23 percent of surveyed employers can afford to pay less than $50 per month per employee for coverage; 22 percent can pay no more than $50; and 20 percent can pay no more than $100;
- Nearly 14 percent of the small businesses would not purchase insurance at any cost;
- Employers are not aware of small business insurance reforms enacted in 1993 and 1995 that were designed to make insurance easier to obtain and more affordable;
- Only 10 percent of the employers believe employers are primarily responsible for assuring that individuals are insured; 27 percent believe the Federal government is responsible, 13 percent believe the State government is responsible, and 42 percent believe individuals are responsible; and
- 25 percent of small employers currently not offering health insurance report that they definitely will not offer insurance in the next three years, and 50 percent probably will not offer insurance.

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

Under contract with the SPG program, the Texas A&M University Survey Research Laboratory (SRL) conducted a telephone survey of uninsured households above 200% of federal poverty level (FPL). Modeled after a similar study conducted by the California Health Care Foundation, the survey questions were modified to address the need for specific information from Texas' uninsured residents. Individuals above 200% of FPL were selected due to the fact that most studies have concluded that families below 200% of FPL require some type of subsidy or substantial premium assistance from employers or other entities. More than 1.8 million uninsured Texans reside in families with incomes above 200% of FPL, but very little statistical data is available regarding why this large group of people remains uninsured. The household survey was designed to provide a more detailed picture of this population, including: the reasons they are uninsured; whether employment-based insurance is available; the reasons they decline such coverage; how much they are willing to pay for insurance; the extent to which they desire health insurance; the types of medical benefits they prefer in a health plan; their interest in a variety of public and private insurance options; and other important demographic and attitudinal information. Significant findings from the survey are:

- More than half of the non-poor uninsured adults are under the age of 40; 29 percent are between age 19 and 29, with 25 percent between 30 and 39;
- Though overall statewide rates of uninsured are highest among minorities in Texas, the majority (68 percent) of non-poor uninsured Texans are white non-Hispanic individuals;

- Sixty-five percent of the non-poor uninsured report they have not purchased insurance because it is too expensive;
- When looking at a number of different factors, sixteen percent of the non-poor uninsured can be considered reluctant to buy insurance at any cost; the majority of these individuals are young males who are healthy, prefer other job benefits to health insurance, and are satisfied with obtaining health care in low-cost public clinics;
- By occupation, the largest amount (42 percent) of non-poor uninsured adults are employed in professional jobs; other employment categories include sales (13 percent), clerical (12 percent), service jobs (11 percent), skilled blue collar (9 percent), laborers (7 percent) and semi-skilled workers (3 percent).
- Most of the non-poor uninsured are employed in small firms; 39 percent work in firms with less than 5 employees and 20 percent in firms with no more than 30 employees; and
- 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.

c) Survey of Health Insurance Carriers and Health Maintenance Organizations

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

- Average premium rates vary considerably among carriers and are generally higher for small groups than large groups;
- Carriers have sold very few of the two standard small employer plans required to be offered to all small groups, as only 398 Basic and Catastrophic plans were in force in calendar year 2000;
- The number of small employers with health insurance has continued to increase since 1993, but the rate of increase has dropped significantly within the past two years; and
- Average insurance rates have increased steadily over the past two years, particularly for small employer groups.

d) Focus Group Activities

Working with SPG staff, the Texas A&M University Public Policy Research Institute (PPRI) conducted focus group meetings in 15 cities across Texas representing all of the major geographical areas of the state. Three sessions were held in each location (a total of 45 sessions statewide), including one each for uninsured unemployed individuals, uninsured employed individuals, and small employers both offering and not offering health insurance. Initially, the staff planned to only include small employers who do not offer health insurance, but at the request of various groups decided to also include small employers who do offer health insurance since many expressed concern that they will be forced to drop the coverage they currently offer if

costs continue to rise. The personal stories expressed at these focus group sessions were both poignant and disturbing, and underscored the importance of continuing this effort to expand insurance to include all Texans. The more important findings obtained from the focus group sessions were:

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

Working Group Participation

Throughout this process, the SPG staff has worked with a supportive stakeholder group officially referred to as the Oversight and Implementation Working Group. This diverse group of people represents numerous organizations that have a crucial interest in the provision of health care in Texas. Members of the working group include staff representing the Governor, Lt. Governor, and Speaker of the House; members of key health-related committees in both the Texas Senate and the Texas House of Representatives; the Director of the Texas Legislative Budget Board; state agency representatives from eight different agencies, including the Department of Health, the state Medicaid Office, the Children's Health Insurance Program, the Health and Human Services Commission, the Texas Health Care Information Council, and the Office of Public Insurance Counsel; other representatives of consumer organizations such as the Texas Mental Health Association, Consumers Union, and Advocacy, Inc.; provider representatives from the Texas Hospital Association and the Texas Medical Association; representatives of the insurance industry and agent associations; public health and indigent care coalition advocates; and public health policy researchers and experts. The working group met four times between April and December 2001, and attended the statewide conference on January 31 - February 1, 2002. All working group meetings were broadcast via the internet and were open to the public.

Statewide Conference

To provide all Texans with the opportunity to participate in the SPG process and to provide a forum for discussing the various policy options that were developed as part of this study, the SPG staff hosted a statewide conference on January 31 - February 1, 2002. The focus of the conference was to review all survey and research activities and discuss the potential options for expanding insurance. Presentations were made summarizing highlights of the surveys and focus groups, and a detailed overview was provided for each of the policy options under consideration. Nine breakout sessions were held on the second day to allow participants to discuss the policy

options and to obtain feedback on the feasibility of each option. Though no consensus was obtained as to the best programs for expanding health insurance in Texas, the discussion generated some very worthwhile information and provided insight into some of the challenges that must be overcome to implement the various programs.

Development of Policy Options

Throughout the process of reviewing and developing policy options for expanding coverage, the working group and SPG staff maintained an open and receptive attitude towards a variety of public and private options. As time progressed, however, it became clear that developing consensus on possible solutions would require more than 12 months in order to prepare the level of detailed analysis that is necessary to understand the implications of various options. As such, the focus shifted from attempting consensus to developing a variety of options that would appeal to a broad audience. Though no single approach is being recommended at this time, the study yielded several options that are still being analyzed and remain under consideration for additional study by SPG staff and the working group. These options include:

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

With the extension granted to the Texas SPG program, staff will continue to develop these policy options, working with the actuarial consultants and working group members. A supplemental report on the additional grant activities will be submitted in February 2003.

Section 1: Uninsured Individuals and Families

Throughout much of this section, the March 2001 Current Population Survey (CPS) is the primary source for data on Texas' uninsured population. Other resources include the Medical Expenditure Panel Survey (MEPS) and information obtained through various data calls at the Texas Department of Insurance.

1.1 What is the overall level of uninsurance in your state?

Consistently over the last decade, Texas has experienced one of the highest rates of uninsured in the nation. In fact, Texas currently has the second highest rate of uninsured in the United States behind New Mexico. CPS data for 2000 shows that there were 4.5 million people without health insurance in Texas, which is about 21.4 percent of the total population. It is estimated by the Texas Health and Human Services Commission (HHSC) that roughly 1 million of these uninsured people (23 percent) are eligible for Medicaid but not enrolled. HHSC also estimates that approximately 1.4 million of the uninsured in Texas are children. Table 1.1 depicts the growth rate of Texans lacking health insurance over the past ten years.

Table 1.1: Number and Rate of Texas' Uninsured for Ages 0 through 64 (1991-2000)

Year	Uninsured Rate	Number Uninsured
1991	22.1%	3,755,000
1992	23.1%	4,144,000
1993	21.8%	3,981,000
1994	24.2%	4,580,000
1995	24.5%	4,615,000
1996	24.3%	4,680 000
1997	24.5%	4,836,000
1998	24.5%	4,880,000
1999	23.3%	4,664,000
2000	21.4%	4,500,000

Source: United States Census Bureau, Current Population Survey

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

The rate of uninsurance in Texas is over seven percentage points higher than in the nation as a whole, which is currently estimated at 14 percent. Table 1.2 reveals how Texas' uninsured rates have compared to the overall United States average since 1991.

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

Year	United States Uninsured Rate	Texas Uninsured Rate
1991	14.1%	22.1%
1992	15.0%	23.1%
1993	15.3%	21.8%
1994	15.2%	24.2%
1995	15.4%	24.5%
1996	15.6%	24.3%
1997	16.1%	24.5%
1998	16.3%	24.5%
1999	15.5%	23.3%
2000	14.0%	21.4%

Source: United States Census Bureau, Current Population Survey

1.2 What are the characteristics of the uninsured?

Income/Poverty Level

Eligibility for Texas' public health programs is determined by the federal poverty level guidelines, which are established by the United States Census Bureau. The 2001 FPL guidelines appear in Table 1.3.

Table 1.3: 2001 Federal Poverty Level Income Guidelines

Family Size	100% FPL	133% FPL	150% FPL	185% FPL	200% FPL
1	$8,590	$11,425	$12,885	$15,891.50	$17,180
2	$11,610	$15,441	$17,415	$21,478.50	$23,220
3	$14,630	$19,458	$21,945	$27,065.50	$29,260
4	$17,650	$23,475	$26,475	$32,652.50	$35,300
5	$20,670	$27,491	$31,005	$38,239.50	$41,340
6	$23,690	$31,508	$35,535	$43,826.50	$47,380
7	$26,710	$35,524	$40,065	$49,413.50	$53,420
8	$29,730	$39,541	$44,595	$55,000.50	$59,460

Source: United States Census Bureau

Table 1.4 exhibits Texas' uninsurance rates by poverty level. Fifty-nine percent of uninsured citizens have household incomes below 200 percent of FPL, and more than one-quarter earn below 100 percent of FPL. Approximately 29 percent of uninsured Texans have incomes above 250 percent of the FPL, indicating that the non-poor uninsured are a major concern as well.

Table 1.4: Texas Uninsurance Rates by Poverty Range

Income/Poverty Level	Number Insured	Number Uninsured	Percent Uninsured within Income Category	Percent of Total Uninsured
Under 50%	739,187	466,670	38.7%	10.4%
51% to 99%	1,134,862	744,113	39.6%	16.6%
100% to 149%	1,322,318	787,617	37.3%	17.6%
150% to 199%	1,534,302	647,229	29.7%	14.4%
200% to 249%	1,569,169	551,402	26.0%	12.3%
250% +	10,225,826	1,289,019	11.2%	28.7%
Total	**16,525,665**	**4,486,051**	**21.4%**	**100.0%**

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

As in other states, the Medicaid and CHIP programs in Texas both rely heavily upon FPL guidelines for their eligibility requirements. Charts 1.1 and 1.2 summarize the specific eligibility criteria for these programs.

Chart 1.1: FPL Guidelines for Medicaid Eligibility in Texas

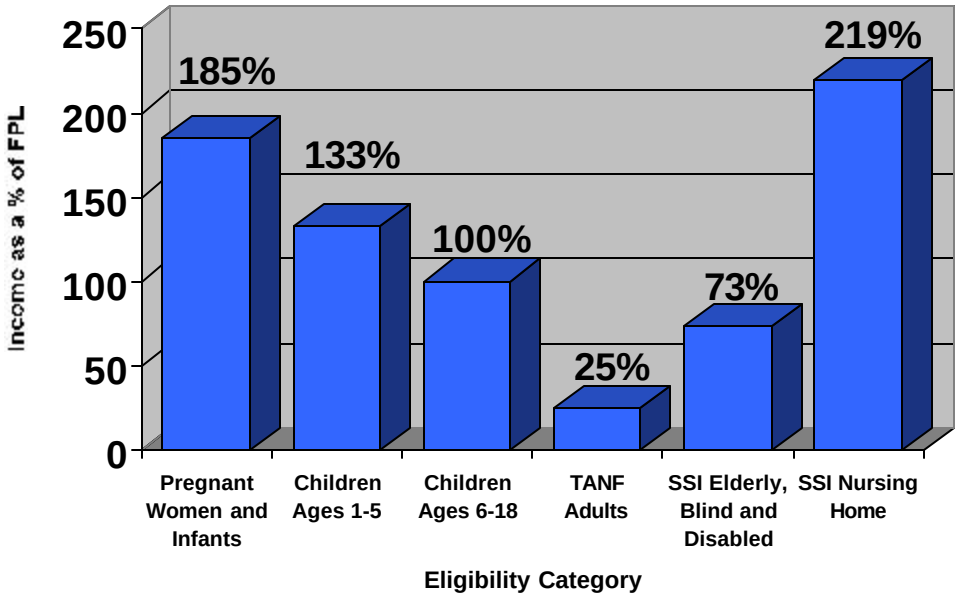
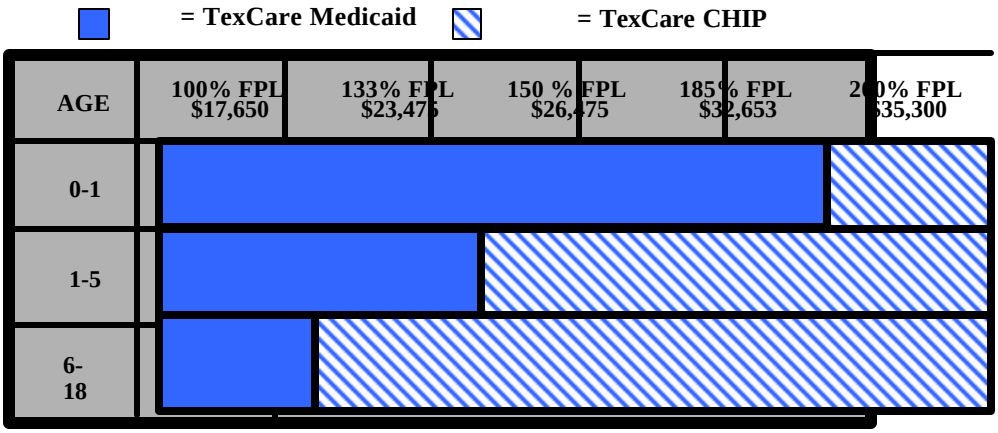


Chart 1.2: FPL Guidelines for TexCare Medicaid and TexCare CHIP



NOTES: 1) Income amounts reflect 2001 federal poverty guidelines for a family of four.
2) Children may be added or excluded, however, based on income deductions and asset tests.

Among persons under the age of 65, the rate of uninsurance is substantially higher for those with incomes at or below 200 percent of FPL. About 68 percent of uninsured dependent children under the age of 18 live in families and/or households with incomes under 200 percent of FPL. Dependent children in families with incomes of less than 100 percent of FPL have an uninsurance rate of about 33 percent, while those between 100 and 199 percent of FPL have a rate of 31 percent. The uninsurance rate decreases to 12 percent for children from families with incomes of 200 percent of FPL or higher. [i]

Age

The Current Population Survey data in table 1.5 shows that certain age groups are much more likely to be uninsured than others. Nearly 99 percent of people ages 65 and older have health insurance due largely to Medicare eligibility, while only 61 percent of people ages 18 to 24 are insured. Over 21 percent of children under the age of 18 are uninsured, and they account for nearly 30 percent of the state's overall uninsured population.

Table 1.5: Texas Uninsurance Rates by Age

Age Range	Number Insured	Number Uninsured	Percent Uninsured within Age Category	Percent of Total Uninsured
0 to 6	2,121,439	470,240	18.1%	10.4%
7 to 17	2,905,281	878,244	23.2%	19.5%
18 to 24	1,178,182	743,264	38.7%	16.5%
25 to 34	2,143,523	779,066	26.7%	17.3%
35 to 44	2,558,338	752,655	22.7%	16.7%
45 to 64	3,566,631	854,618	19.3%	19.0%
65 and Over	2,072,991	22,566	1.1%	0.5%
Total	**16,546,384**	**4,500,653**	**21.4%**	**100.0%**

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

Gender

Table 1.6 indicates that females are slightly more likely to be insured than males, who account for nearly 52 percent of Texas' uninsured population.

Table 1.6: Texas Uninsurance Rates by Gender

Gender	Number Insured	Number Uninsured	Percent Uninsured within Gender Category	Percent of Total Uninsured
Male	8,018,582	2,330,622	22.5%	51.8%
Female	8,527,802	2,170,031	20.3%	48.2%
Total	**16,546,384**	**4,500,653**	**21.4%**	**100.0%**

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

Employment Status

Table 1.7 reveals that, contrary to public perception, most uninsured Texans are either employed or live in families with an employed adult. Approximately 69 percent of all uninsured, non-retired adults ages 18 and older are employed. Unemployed adults make up less than eight percent of the total adult uninsured population in Texas, while individuals not currently in the labor force constitute 24 percent.

Table 1.7: Texas Uninsurance Rates by Employment Status (Non-retired persons 18 and older)

Employment Status	Number Insured	Number Uninsured	Percent Uninsured within Employment Status Category	Percent of Total Uninsured
Employed	7,621,942	2,089,800	21.5%	68.7%
Unemployed	230,615	225,793	49.5%	7.4%
Not in Labor Force	1,659,193	726,241	30.4%	23.9%
Total	**9,742,366**	**3,041,833**	**23.8%**	**100.0%**

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

One of the primary explanations for Texas' high uninsurance rate is that Texas workers generally are less likely to have access to employment-based health insurance coverage than workers in other states. Data from Historical Table 4 of the 2000 Current Population Survey indicates that 58.5 percent of Texas workers have employment-based health insurance coverage, compared to a national average of 64.1 percent.

The occupational composition of Texas workers has long been recognized as a contributing factor to Texas' uninsured problem. Studies conducted by the Texas Department of Insurance

indicate that most insurers or employers have provisions that exclude part-time employees, contract workers, and seasonal employees. This partly explains why certain occupations are more likely than others to remain uninsured. Texas also has a higher than average employment in both the retail trade and service industries, which traditionally are the least likely to offer insurance, and a lower than average employment in the manufacturing sector, where health benefits are more frequently provided. See Section 2 for more detailed information on insurance rates by industry sector.

Availability of Private and Public Coverage

Despite the number of uninsured residents, Texas is widely recognized as having one of the healthiest commercial insurance markets in the country. In 1998, accident and health insurers reported more than $10 billion in premiums written in Texas. Based on information reported to TDI, an estimated 3.6 million Texans were covered under fully-insured health plans regulated by TDI. An additional 3 million Texans were enrolled in basic service commercial Health Maintenance Organization plans, and an estimated 3.5 million were covered under self-insured employer group plans not subject to state regulation. When combining these figures with the Medicare and Medicaid population, the total number of Texans with some type of insurance coverage (public or private) exceeds 15 million.[ii]

The number of Texans enrolled in HMOs has grown considerably in recent years. However, like many other states, HMOs in Texas have suffered significant financial losses. Most if not all health plans have increased premium rates for plans issued in 1999 and 2000, and sizable premium increases are being reported for 2001. Despite these losses, the market for health coverage in Texas has remained competitive. Availability of insurance – either group or individual – has not been a problem for most Texans. Due to revisions in the regulation of group insurers and implementation of the Texas Health Insurance Risk Pool, even individuals with serious pre-existing medical conditions are guaranteed access to insurance. However, contribution and participation requirements continue to have an impact on the availability and affordability of coverage for some employers, and particularly for the smallest businesses.

Recognizing the physical and financial consequences of living without health insurance, lawmakers and policymakers have diligently worked to provide access to health care for those people without insurance. A report prepared by the State Comptroller's Office estimates that state and local government costs of providing care for uninsured Texans in 1998 totaled more than $4.7 billion, or nearly $1,000 per person.[iii] This included state and local disproportionate hospital share program eligible expenses; programs under the Texas Department of Health, Texas Department of Mental Health and Mental Retardation, Texas Department of Human Services, and other state agencies; local health care programs operated by county and city health agencies and school districts; charity care provided by individual physicians and university physician practice plans; and other charitable donations. It does not include out-of-pocket spending by uninsured individuals or state Medicaid and CHIP expenditures.

In fiscal year 2001, an average 1.8 million Texans were enrolled in Medicaid at any given time, and as of October 22, 2001, 476,844 children were enrolled in CHIP.

Race/Ethnicity

Table 1.8 reveals that approximately 68 percent of Texans without health insurance are African-American or Hispanic. Hispanics alone comprise nearly 58 percent of uninsured, and they are over three times as likely to be uninsured as people classified in the Anglo/Other category.

Table 1.8: Texas Uninsurance Rates by Race or Ethnicity

Race/Ethnicity	Number Insured	Number Uninsured	Percent Uninsured within Race/Ethnicity Category	Percent of Total Uninsured
Anglo/Other	10,261,933	1,420,140	12.2%	31.6%
African American	1,809,689	487,617	21.2%	10.8%
Hispanic	4,474,763	2,592,896	36.7%	57.6%
Total	**16,546,384**	**4,500,653**	**21.4%**	**100.0%**

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

Immigration Status

Not surprisingly, the rate of uninsurance is substantially higher among non-citizens than among citizens. As demonstrated in Table 1.9, non-citizens comprise about 24 percent of uninsured Texans. Approximately 18 percent of native U.S. citizens, 27 percent of U.S. naturalized citizens, and 52 percent of those who are not U.S. citizens are uninsured in Texas.

Table 1.9: Texas Uninsurance Rates by Immigration Status

Immigration Status	Number Insured	Number Uninsured	Percent Uninsured within Immigration Status Category	Percent of Total Uninsured
Native U.S. Citizen	14,957,289	3,213,386	17.7%	71.4%
Naturalized U.S. Citizen	595,250	219,393	26.9%	4.9%
Not a U.S. Citizen	993,846	1,067,874	51.8%	23.7%
Total	**16,546,384**	**4,500,653**	**21.4%**	**100.0%**

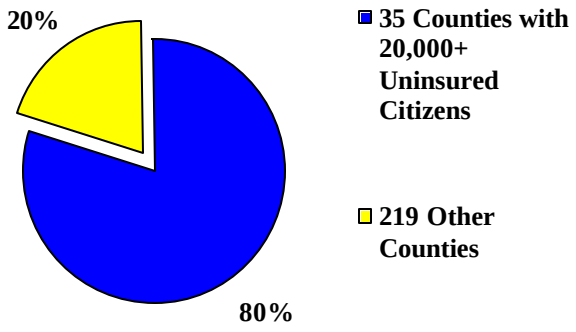
Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

Geographic Location

A widely held misconception is that Texas' uninsured population is primarily concentrated in the state's border counties. While the uninsured rate per capita is indeed significantly higher in the border region, only 25 percent of uninsured citizens reside in this area. Chart 1.3 and Table 1.10

show that the heaviest concentration of uninsured persons live in the larger urban areas, as an estimated 80 percent of uninsured Texans reside in 35 of the state's 254 counties.

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



Source: Texas Health and Human Services Commission, 2000

Table 1.10: Texas Counties with the Ten Largest Uninsured Populations

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

Source: Texas Health and Human Services Commission, 2000

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Though the SPG activities were intended to focus broadly on the entire population of Texans, three groups received particular attention:

1) Small Employers - Because 75 percent of the firms in Texas with fewer than 50 employees do not offer insurance, small businesses were the subject of both qualitative and quantitative research activities that yielded specific policy options. A statewide survey was mailed to 50,000 small businesses and focus group sessions were conducted with small employers in 15 cities across the state. The information obtained from these

activities led to a series of policy options that specifically address the concerns of small employers and the difficulties they encounter when trying to obtain insurance.

2) Non-Poor Uninsured – More than 1.8 million Texans reside in families with household incomes above 200 percent FPL. Research indicates that families below 200 percent generally require significant subsidies to afford the cost of private insurance. Since the non-poor uninsured are more likely to benefit from private insurance expansion options, this population group was also targeted for expansion efforts.
3) Low Income Adults – Low income adults who are not eligible for Medicaid are the third group identified for specific policy options. Many of these adults have children who are already covered under Medicaid or CHIP, which makes them likely candidates for an expansion of public programs.

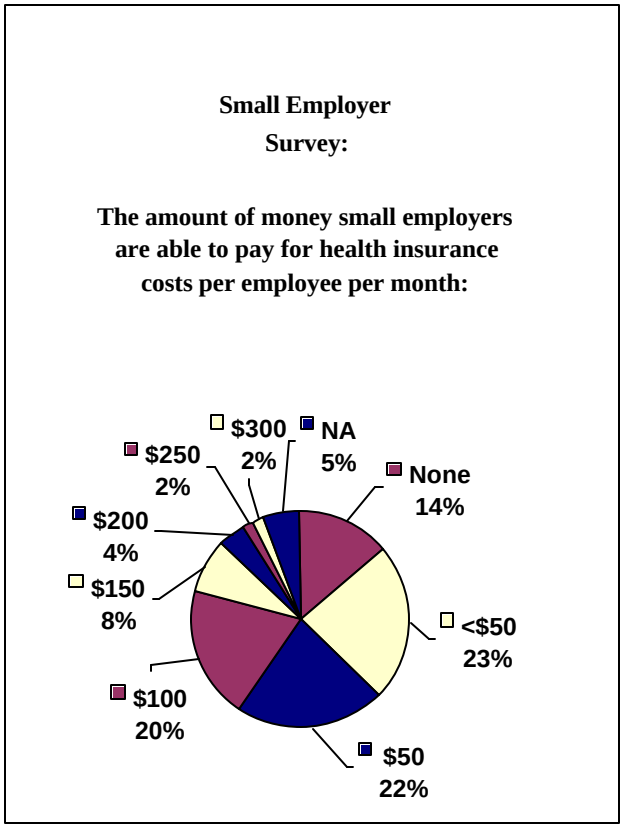
1.4 What is affordable coverage? How much are the uninsured willing to pay?

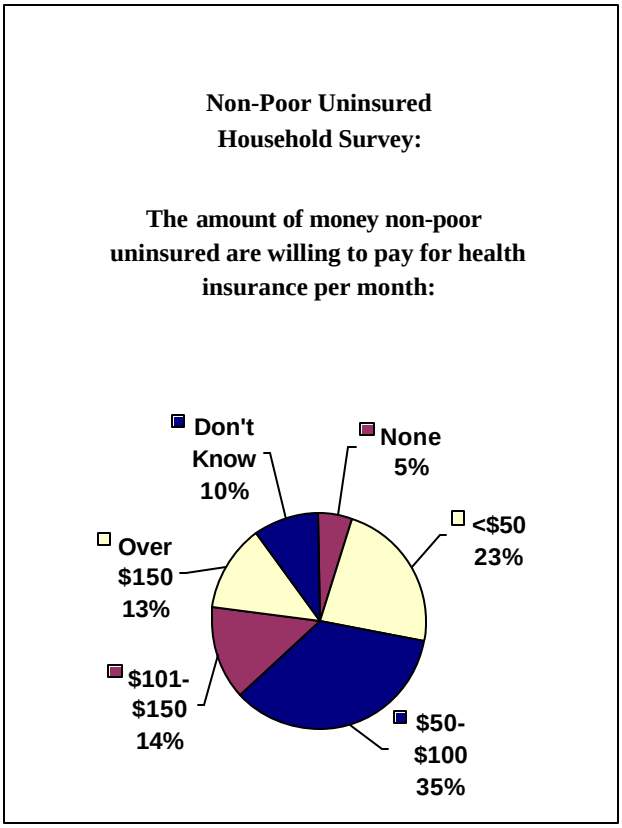
Some of the most important data obtained in the course of this study concerns how much money uninsured businesses and individuals can afford to pay for insurance. Though anecdotal information strongly suggests that cost is a primary factor in Texas' high uninsured rate, virtually no attempt has been made until now to determine how much these two groups can afford to pay for coverage. Only with this information can we begin to develop options with some understanding of the importance of affordability.

Employers responding to the SPG small employer survey that do not currently offer insurance were asked how much they would be able to contribute toward employee health insurance benefits. Twenty-three percent of respondents could only pay less than $50 per employee per month, and 22 percent could pay a maximum of $50. Another 14 percent would be unable to offer insurance at any price.

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

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





1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Though SPG survey activities did not address this question, responses of focus group participants suggest several reasons why people may not participate in public programs. Among those responses are:

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

There are close to 600,000 children eligible for Medicaid in Texas that are not enrolled. In addition, more than 400,000 children who appear to be eligible for CHIP are not enrolled. Some explanations for non-participation that have been provided by public health officials include:

- ? Many families do not realize they may qualify for these programs.
- ? Many families think of Medicaid as a "welfare" program instead of a health insurance program, and do not enroll due to the stigma associated with welfare.[iv]
- ? For many Texas families, the application process for Medicaid has been too burdensome.

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

To address the various obstacles in providing coverage to Medicaid eligible children and streamline the enrollment process, the Texas Legislature recently passed legislation to simplify Medicaid enrollment for children. Under Senate Bill 43, the Medicaid program will implement a one-page application as well as a simplified enrollment procedure that eliminates the face-to-face interview. In addition, DHS will implement rules to provide continuous eligibility for 12 months. These reforms are intended to dramatically improve the Medicaid enrollment of children and effectively increase the success of the CHIP program as well. They are a significant step towards assuring that public coverage will decrease the number of uninsured Texas children in the future.

1.6 Why do uninsured individuals and families disenroll from public programs?

None of the survey activities of the Texas SPG directly addressed this question. In November 1999, however, the Texas Healthy Kids Corporation (THKC) conducted an enrollee satisfaction survey in part to determine the reasons why parents terminated the subsidized coverage of their children provided through THKC. Of the 228 total families participating, 35 percent reported that they discontinued their coverage because they could no longer afford the premium payments, and an additional nine percent were canceled by THKC because they were late on their payments. Seventeen percent of the children dropped out because their parents received a new job offering insurance benefits, ten percent found another source of insurance, and five percent became eligible for Medicaid. A total of ten percent of those discontinuing coverage cited poor service and problems with benefits.[vi]

To more directly address this question, the Texas Health and Human Services Commission plans to field a CHIP survey in the near future that will include questions about disenrollment. Experience from other states suggests that disenrollment is most commonly due to increased income thresholds, failure to pay CHIP premiums, and alternate coverage sources. Anecdotal focus group findings point clearly to the issue of increased income thresholds, especially among single mothers.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

Respondents to the SPG small employer survey who offered health insurance were asked why employees most commonly declined coverage. Over 50 percent of companies indicated that employees who turned down coverage already had insurance through a spouse's or parent's plan. Surprisingly, only 16 percent of employers indicated that employees did not purchase employer-based health insurance because of cost. The SPG household survey of the uninsured above 200 percent FPL, on the other hand, revealed that cost was a definite factor; when asked the main reason they had not obtained insurance through their employer if it had been offered, over 57 percent said that the plan was too expensive. Another 11 percent indicated they simply were not interested in purchasing health insurance.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

The SPG small employer survey asked respondents not offering health insurance to describe their employees' level of interest in health insurance. Over one-half of the respondents indicated that employees were at least somewhat interested in whether employer-based health insurance will be offered, while slightly more than 20 percent felt that their employees were not interested. When asked which entity they believed was primarily responsible for assuring people have health insurance, only ten percent of companies not offering insurance believed that the companies themselves were responsible. Over 41 percent placed the primary responsibility on individuals, while over one-quarter responded with the federal government.

1.9 How likely are individuals to be influenced by the following: Availability of subsidies and tax credits or other incentives?

Both the small employer survey and the household survey included questions about the types of policy options the respondents would support. Twenty percent of small employers expressed strong support for a government subsidy to help low-income employees purchase insurance, and 29 percent generally supported the idea. Only six percent strongly opposed the idea. When asked how they felt about financial incentives to encourage small employers to provide insurance, 55 percent strongly supported the idea and 30 percent generally supported it.

Individuals who participated in the household survey likewise showed strong support for employer tax breaks. Thirty percent answered they strongly agreed and 62 percent generally agreed that small employers who offer health insurance should be given tax breaks. Only seven percent disagreed.

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

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Individuals participating in the focus group meetings were asked why they believe so many Texans are uninsured. Cost was the most significant factor, but other barriers were mentioned as well, including:

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

Employers participating in the SPG small employer survey cited cost as the primary reason they were uninsured, but offered other concerns as well. Fifteen percent reported that the majority of their employees did not want insurance because they already have coverage; five percent reported their employees prefer higher wages; and two percent do not want to deal with the administrative hassle.

1.11 How are the uninsured getting their medical needs met?

None of the survey or research activities directly addressed this question. However, several questions included in the household survey provide some anecdotal information. Though most people highly associate the presence of health insurance with access to health care, it is clear that not all Texans agree that insurance is a necessity. More than one-third (36 percent) of the non-poor uninsured report that they are satisfied with receiving their health care through public or free clinics. Twenty-five percent report that they agree with the statement "people who don't have health insurance have an easy time getting proper medical care."

1.12 What are the features of an adequate, bare-bones benefit package?

While SPG research did not attempt to determine the features of a bare-bones benefit package, groups have attempted to do so in the past with little success. However, the SPG small employer survey asked employers to indicate the types of benefits they want most in a health plan. Chart 1.6 on the following page summarizes the responses received.

Chart 1.6 - Employers' Opinions on the Importance of Various Health Insurance Benefits

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

Type of Health Insurance Benefit	A	B	C	D	E	NR
Visits to a primary care physician, such as a pediatrician or family doctor, but only when sick	41%	31%	15%	4%	3%	6%
Visits to a primary care physician when sick and for annual well-person check-ups	37%	30%	19%	6%	3%	5%
Visits to a specialist physician, such as a cardiologist or surgeon	40%	33%	16%	4%	2%	5%
In-patient hospital care (for surgery, illness, emergencies, etc.)	57%	28%	7%	1%	2%	5%
Maternity care for pregnant women	20%	21%	23%	14%	16%	6%
Laboratory services (such as getting blood work or having a biopsy analyzed)	35%	36%	18%	4%	2%	5%
Mental health services	12%	17%	29%	22%	15%	5%
Prescription drugs	41%	30%	17%	4%	3%	5%
X-Rays or MRI's	36%	37%	17%	3%	2%	5%
Alcohol or drug abuse treatment	7%	11%	27%	26%	23%	6%
Well-child care, including coverage for immunizations and routine check-ups	26%	25%	23%	10%	10%	6%
Chiropractic services	8%	14%	29%	22%	21%	6%
Preventive screenings (such as mammograms or prostate cancer testing)	35%	31%	19%	6%	3%	6%
Vision care (visits to the eye doctor, glasses, contacts)	14%	24%	30%	15%	11%	6%
Dental benefits	15%	23%	30%	14%	12%	6%

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

Due to the complexity of evaluating the extent to which people are underinsured, no attempt was made in this project to define this group. However, several working group members pointed out that many Texans with health insurance do not have coverage for prescription drugs or mental health care. To determine whether or not these people are underinsured, however, one must first determine the benefits needed by each person and the degree to which the lack of coverage prohibits access to care. Further study would be required to develop any meaningful data on the extent to which insured Texans are underinsured.

Section 2: Summary of Findings: Employer-based Coverage

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

2.1A What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer Size

An analysis of Texas-specific Medical Expenditure Panel Survey (MEPS) data provided by the Agency for Healthcare Research and Quality (AHRQ) reveals that large employers are much more likely than small employers to offer health insurance to their employees. As shown in Table 2.1, nearly 44 percent of small employers did not offer health insurance, compared to only three percent of large employers.[vii]

Table 2.1: MEPS Survey Data for All Private Sector Employees (1998)

Category	All Employers	Small Employers	Large Employers
Total Employees	7,906,500	2,231,600	5,674,900
Accepted Coverage	4,477,300 56.63%	784,900 35.17%	3,692,400 65.07%
Declined Coverage	693,500 8.77%	141,800 6.35%	551,700 9.72%
Ineligible Employees	1,594,700 20.17%	334,100 14.97%	1,260,600 22.21%
Not Offered Coverage	1,141,000 14.43%	970,800 43.50%	170,200 3.00%

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

The MEPS survey does not specify whether those who declined coverage were covered by some other means (i.e., a spouse's plan) or were uninsured. The survey also does not indicate the reasons why some employees are ineligible for coverage. Other studies, however, suggest that ineligible employees often have not been with a company long enough to meet waiting period requirements or work too few hours to qualify for benefits.

The SPG small employer survey reveals that companies offering health insurance have on average four more employees than employers not offering health insurance. The median and mode statistics in Table 2.2 further illustrate that larger companies are more likely to offer health insurance than smaller firms.

Table 2.2: Company Size and Health Insurance Status

Company Offers Health Insurance	Number of Employees		
	Mean	Median	Mode
Yes	13.3	9	5
No	9.1	6	4

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

Industry Sector

Data from the March 2001 Current Population Survey indicates that the level of uninsurance varies significantly across different industry sectors in Texas. Table 2.3 shows that several industries, including educational services, communications, public administration, mining, and utilities, experience an uninsured rate of less than ten percent. Other industries, however, report significantly higher uninsured rates; these include construction, personal services, entertainment, and agriculture, where more than 30 percent of the employees are uninsured. In fact, workers in construction, manufacturing, and wholesale and retail trade account for more than half (53%) of all uninsured Texas workers.[viii]

Table 2.3: Employer-Based Health Insurance Enrollees by Industry Sector

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

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

Forty-six percent of the SPG small employer survey participants report they do not offer health insurance to their employees. Employees working in service-related jobs represented nearly half (44 percent) of all uninsured workers. Employers in the food services industry were the least likely to offer health insurance (21 percent), but they only account for five percent of the total firms not offering insurance. Table 2.4 provides a detailed breakdown of the firms not offering insurance by industry.

Table 2.4: Companies Offering Employer-based Health Insurance by Industry Sector

Industry	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Industry	Percent of Total Not Offering Ins.
Agriculture, forestry, fishing	144	206	58.9%	4.1%
Construction	463	523	53.0%	10.4%
Food service	72	273	79.1%	5.4%
Manufacturing	479	242	33.6%	4.8%
Retail	555	702	55.8%	13.9%
Services	2,806	2,204	44.0%	43.8%
Wholesale	304	147	32.6%	2.9%
Other	1,050	701	40.0%	13.9%
No Response	45	39	46.4%	0.8%
Total	**5,918**	**5,037**	**46.0%**	**100.0%**

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

Employee Income Brackets

Table 2.5 demonstrates that lower-income individuals are generally more likely to be uninsured than those with higher incomes. Data from the Current Population Survey indicates that individuals with incomes below $20,000 are over 3.5 times as likely to be uninsured as individuals with incomes above $50,000. However, it is important to note that more than 1.5 million uninsured Texans report family incomes of more than $35,000, and nearly 928,000 have incomes above $50,000.

Table 2.5: Texas Uninsured by Income Level

Income Level	Number Insured	Number Uninsured	Percent Uninsured Within Income Category	Percent of Total Uninsured
$0-10,000	1,336,454	769,597	36.5%	17.1%
$10,001-15,000	897,978	512,958	36.4%	11.4%
$15,001-20,000	984,240	636,622	39.3%	14.1%
$20,001-25,000	1,039,616	354,225	25.4%	7.9%
$25,001-35,000	1,861,893	697,516	27.3%	15.5%
$35,001-50,000	2,621,495	601,826	18.7%	13.4%
$50,001 +	7,804,707	927,909	10.6%	20.6%
Total	**16,546,384**	**4,500,653**	**21.4%**	**100.0%**

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

Over two-thirds of small employers participating in the SPG survey that do not offer health insurance have average annual employee salaries below $25,000. In contrast, nearly 60 percent of small employers that offer health insurance have average annual salaries over $25,000. Companies where the average employee salary ranges between $50,001 and $75,000 are the most likely to offer health insurance, at 80 percent. Table 2.6 further demonstrates the relationship between average company salary and employer-based health insurance.

Table 2.6: Average Annual Salary of Small Businesses Employees

Average Employee Salary	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Insurance within Salary Category	Percent of Total Not Offering Insurance
Less than $10,000	51	316	86.1%	6.3%
$10,001-$15,000	194	841	81.3%	16.7%
$15,001-$20,000	686	1,162	62.9%	23.1%
$20,001-$25,000	1,312	1,130	46.3%	22.4%
$25,001-$50,000	2,985	1,224	29.1%	24.3%
$50,001-$75,000	377	94	20.0%	1.9%
More than $75,000	129	49	27.5%	1.0%
No Response	184	221	54.6%	4.4%
Total	**5,918**	**5,037**	**46.0%**	**100.0%**

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

The small employer survey also confirms a definite relationship between the type of workers employed by a company and whether or not it provides health insurance benefits. As shown in Table 2.7 below, only 11 percent of companies with a majority of minimum-wage workers offer health insurance, and companies primarily hiring independent contractors offer health insurance one-third of the time. On the other hand, companies predominantly having salaried employees are the most likely to offer coverage at 66 percent, and those with a mix of several types of employees follow closely behind with 62 percent.

Table 2.7: Predominant Wage Type of Small Business Employees

Predominant Employee Wage Type	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Wage Category	Percent of Total Not Offering Insurance
Minimum Wage	21	170	89.0%	3.4%
Hourly, More than Minimum Wage	2,105	2,630	55.5%	52.2%
Salaried	2,323	1,176	33.6%	23.3%
Independent Contractors	71	142	66.7%	2.8%
Mix	1,328	811	37.9%	16.1%
Hourly Plus Tips	25	54	68.4%	1.1%
No Response	45	54	54.5%	1.1%
Total	**5,918**	**5,037**	**46.0%**	**100.0%**

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

Finally, the small employer survey attempted to determine if a correlation exists between the number of low-wage employees in a firm and whether or not it offers health insurance. Table 2.8 reveals that 60 percent of companies responding to the survey reported having no employees earning less than $8.00 per hour, but 38 percent of these do not offer health insurance. On the other hand, nearly 55 percent of small employers with more than 41 employees earning less than $8.00 per hour offer health insurance.

Table 2.8: Small Business Employees Earning Less than $8.00 Per Hour

Number of Employees Earning Less than $8.00 per Hour	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Number Category	Percent of Total Not Offering Ins.
0	3,524	2,145	37.8%	42.6%
1-2	1,224	1,349	52.4%	26.8%
3-5	601	782	56.5%	15.5%
6-10	274	405	59.6%	8.0%
11-20	151	196	56.5%	3.9%
21-30	45	51	53.1%	1.0%
31-40	10	21	67.7%	0.4%
41-50	13	11	45.8%	0.2%
No Response	76	77	50.3%	1.5%
Total	**5,918**	**5,037**	**46.0%**	**100.0%**

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

Percentage of Part-time and Seasonal Employees

According to the 1998 MEPS survey, full-time employees were much more likely to be offered health insurance than part-time employees. The data in Tables 2.9 and 2.10 shows that approximately twice as many part-time employees were not offered health coverage, as were full-time employees. In addition, part-time employees were about three times as likely to be ineligible for coverage.**1**

Table 2.9: MEPS Survey Data for Full-time Private Sector Employees (1998)

Category	All Employers	Small Employers	Large Employers
Total Full-time Employees	6,847,500	1,802,800	5,044,700
Accepted Coverage	4,371,000 63.77%	767,900 42.59%	3,603,100 71.42%
Declined Coverage	638,700 9.36%	133,400 7.40%	505,300 10.02%
Ineligible Employees	1,018,400 14.87%	218,300 12.11%	800,100 15.86%
Not Offered Coverage	819,500 12.00%	683,300 37.90%	136,200 2.70%

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Table 2.10: MEPS Survey Data for Part-time Private Sector Employees (1998)

Category	All Employers	Small Employers	Large Employers
Total Part-time Employees	1,059,000	428,800	630,200
Accepted Coverage	106,300 10.04%	17,000 3.96%	89,300 14.17%
Declined Coverage	54,800 5.17%	8,400 1.96%	46,400 7.36%
Ineligible Employees	576,300 54.42%	115,800 27.01%	460,500 73.07%
Not Offered Coverage	321,500 30.36%	287,500 67.05%	34,000 5.40%

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

The SPG small employer survey asked respondents to indicate their total number of employees, part-time employees, and contract employees. Employers were not asked for the number of seasonal employees. Survey results show that the average percentage of part-time and contract employees for companies that offered health insurance was almost 15 percent, while for companies not offering health insurance it was about 24 percent.

Geographic Location

The SPG Small Employer Survey asked each company responding to the survey to provide its zip code. By doing so, we expected to be able to isolate companies' locations in the state and provide analysis to that effect. Unfortunately, a large percentage of respondents did not provide

this information. As a result, any analysis with regard to business location would be skewed and unreliable. Therefore, we chose not to pursue further evaluation in this area using the data from the small employer survey.

2.1B For those employers offering coverage, please discuss the following:

Cost of Policies and Level of Contribution

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

Texas insurers that provide coverage for small employer health plans are required to offer two standard health plans, Basic and Catastrophic, to all small businesses. TDI has collected average rate information on the two standard plans as well as the insurers' most popular small employer plan for several years. As is discussed later in this report, the standard plans have not been popular among insurers. This is demonstrated by the fact that only three carriers were able to provide rate information for the standard plans in 2000. Rates vary considerably even among those three, making it difficult to develop an "average" rate that accurately reflects what small employers pay for health insurance. As shown in Table 2.11, rates for employee-only coverage in 2000 for the Basic Coverage Plan range from $2,518 to $3,902 - more than a 50 percent difference in cost. The cost differences are even more dramatic for employee-plus-spouse premiums, which have a rate differential of more than 80 percent.

Table 2.11: Texas Small Employer Basic and Catastrophic Coverage Health Plan Average Annual Premiums (1999 - 2000)

Co. ID	1999				2000			
	Emp. Only	Emp. + Children	Emp. + Spouse	Emp. + Family	Emp. Only	Emp. + Children	Emp. + Spouse	Emp. + Family
Basic Coverage Plan								
A	$1,992	$3,547	$4,443	$5,818	$2,518	$3,856	$4,633	NA
B	$3,279	$7,877	$7,075	$11,673	$3,902	$9,374	$8,419	$13,891
C	$1,948	$3,966	$3,966	$5,715	$3,058	$6,225	$6,225	$8,969
Catastrophic Coverage Plan								
A	$1,429	$2,543	$3,186	$4,172	$2,316	$4,592	$5,516	$6,522
B	$2,261	$5,083	$4,821	$7,644	$2,691	$6,049	$5,737	$9,096
C	$1,403	$2,856	$2,856	$4,115	$2,200	$4,478	$4,478	$6,451

Source: Texas Department of Insurance Annual Group Accident and Health Data Call, 1999-2000

Average annual rates for the non-standard "most popular small employer plan" also demonstrate a considerable cost difference among carriers. As shown in Table 2.12 below, rates for employee-only coverage ranged from a low of $1,611 up to $3,821 for the year 2000. The most striking difference can be found in the employee-plus-family premiums, where there is a rate differential of 98 percent.

Table 2.12: Texas Small Employer Most Popular Non-Prototype Health Plan Average Annual Premiums (1999 - 2000)

Co. ID	1999				2000			
	Emp. Only	Emp. + Children	Emp. + Spouse	Emp. + Family	Emp. Only	Emp. + Children	Emp. + Spouse	Emp. + Family
A	$2,265	$4,032	$5,051	$6,614	$2,761	$4,926	$5,990	$7,950
C	$1,954	$3,978	$3,978	$5,733	$3,067	$6,244	$6,244	$8,997
D	NA	NA	NA	NA	$1,686	$3,217	$5,131	$6,662
E	$2,959	$5,959	$6,388	$9,390	$3,604	$7,259	$7,781	$11,438
F	$2,307	$4,474	$5,092	$7,219	$2,888	$5,408	$7,517	$8,855
H	$1,323	$1,186	$2,376	$3,832	$1,611	$3,668	$4,885	$5,779
I	NA	NA	NA	NA	$2,731	$3,720	$5,873	$6,862
L	NA	NA	NA	NA	$2,216	$4,210	$4,432	$7,091
M	$2,032	$3,230	$5,367	$5,545	$2,160	$3,430	$5,700	$5,890
N	$1,833	$3,011	$4,641	$5,260	$2,038	$3,297	$5,242	$6,034
O	$3,272	$5,538	$6,631	$8,896	$3,821	$6,463	$7,736	$10,381
P	$2,507	$4,556	$5,572	$7,883	$2,913	$5,294	$6,475	$9,159
Q	NA	NA	NA	NA	$2,586	$4,914	$5,173	$7,889

Source: Texas Department of Insurance Annual Group Accident and Health Data Call, 1999-2000

Unlike the standard Basic and Catastrophic plans discussed above, comparisons of average costs for the non-standard plans cannot be made because we have no information on how the benefits or coinsurance requirements (i.e., deductibles, co-pays, annual out-of-pocket limitations) compare for the plans offered by these insurers. The information in Table 2.13 does show, however, that a wide range of "average" prices exists for the determined shopper who is knowledgeable enough to compare different policy options and has time to shop around for the best value.

Table 2.13: Fully-Insured Group Accident and Health Survey Results
Texas Average Annual Premium Cost Per Person by Plan Size, 1999-2000

Co. ID	Group Size 2-50		Group Size 51+	
	1999	2000	1999	2000
A	$2,025	$2,429	$1,813	$2,194
B	NA	$2,429	NA	$2,140
C	$3,470	$4,030	$3,384	$3,764
D	NA	$1,943	NA	$944
E	$1,190	$2,783	$1,272	$1,510
F	$1,869	$2,099	$1,252	$1,599
G	$1,667	NA	$1,667	NA
H	$1,381	$1,939	$1,160	$1,313
I	NA	$2,048	NA	$1,689
J	$2,155	NA	$1,760	NA
K	NA	$2,060	NA	$1,842
M	$1,506	$1,530	NA	$1,917

Source: Texas Department of Insurance Annual Group Accident and Health Data Call, 1999-2000.

Employee and Family Health Insurance: Average Premiums

To assess how Texas premiums compare with other states, the Medical Expenditure Panel Survey provides average insurance rate information for Texas and most other states. As shown in Table 2.14, average premiums for single-coverage of employees in Texas are generally roughly equal to the national average. Premiums for small businesses have remained consistently higher in Texas than the national average, but only by a very slight margin.

After 1996, average family premiums were higher in Texas than the national average. The increase in premiums particularly affected the small business market, with premiums averaging five percent higher in Texas than the United States between 1997 and 1999.

Table 2.14: Average Single and Family Premiums in Establishments that Offer Health Insurance by Firm

	Texas				United States			
	1996	1997	1998	1999	1996	1997	1998	1999
Average Single Premiums								
All Establishments	$1,969	$2,193	$2,087	$2,336	$1,991	$2,050	$2,174	$2,325
Small Businesses	$2,086	$2,172	$2,270	$2,539	$2,070	$2,107	$2,235	$2,475
Large Businesses	$1,931	$2,200	$2,030	$2,261	$1,965	$2,029	$2,151	$2,269
Average Family Premiums								
All Establishments	$4,899	$5,693	$5,588	$6,209	$4,953	$5,332	$5,590	$6,058
Small Businesses	$5,070	$5,534	$5,575	$6,486	$4,937	$5,178	$5,441	$6,062
Large Businesses	$4,875	$5,727	$5,590	$6,161	$4,957	$5,366	$5,621	$6,057

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Employee and Family Health Insurance: Contribution Levels

Payment for the premiums of employer-based health insurance is often divided between the employer and each employee. The average amount an employee pays for his or her own portion of the premium is called the "average single employee contribution." As indicated in Tables 2.15 and 2.16, average single employee contributions in Texas were comparable to the national average. However, contribution levels required by employees for family coverage were significantly higher in Texas - almost 25 percent higher than the national average from 1996 through 1999. For small employers during the same time period, the average employee contribution required for family coverage was almost 50 percent higher in Texas than the U.S. average.

Table 2.15: Average Single and Family Employee Contributions in Establishments that Offer Health Insurance by Company Size

	Texas				United States			
	1996	1997	1998	1999	1996	1997	1998	1999
Average Single Employee Contribution								
All Establishments	$342	$309	$384	$448	$342	$319	$383	$420
Small Businesses	$250	$292	$309	$402	$303	$283	$308	$378
Large Businesses	$371	$315	$407	$465	$355	$333	$411	$436
Average Family Employee Contribution								
All Establishments	$1,469	$1,768	$1,623	$1,798	$1,275	$1,304	$1,382	$1,438
Small Businesses	$1,881	$2,209	$2,043	$2,728	$1,367	$1,426	$1,551	$1,656
Large Businesses	$1,412	$1,675	$1,566	$1,637	$1,255	$1,277	$1,346	$1,390

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Table 2.16: Average Total Premium per Enrolled Employee by Company Size (1998)

Company Size	Texas		United States	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
All Establishments	$2,087	$5,588	$2,174	$5,590
Small Businesses	$2,270	$5,575	$2,235	$5,442
Large Businesses	$2,030	$5,590	$2,152	$5,622

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Employee and Family Health Insurance: Contribution by Company Size

Table 2.17 reveals that Texas employers make almost identical levels of contribution to their employees' single coverage as the national average. However, Texas employers provide less than the national average for family coverage, particularly in companies with 50 or fewer employees.

Table 2.17: Employer Contribution toward Coverage by Company Size (1998)

	Texas		United States	
	Employer	**Employee**	**Employer**	**Employee**
Single Coverage				
All Establishments	81.6%	18.4%	82.4%	17.6%
Small Businesses	86.4%	13.6%	86.2%	13.8%
Large Businesses	80.0%	20.0%	80.9%	19.1%
Family Coverage				
All Establishments	71.0%	29.0%	75.3%	24.7%
Small Businesses	63.3%	36.7%	71.5%	28.5%
Large Businesses	72.0%	28.0%	76.0%	24.0%

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Employee and Family Health Insurance: Contribution by Wage Level

Table 2.18 shows that, in Texas, a company's contribution towards employee health insurance increased as the salary of the majority of workers increased. This is true for both single and family coverage.

Table 2.18: Average Employer Contribution toward Coverage by Wage Level (1998)

Wage Level	Single Coverage	Family Coverage
Low Wage: More than 50% make less than $6.50/hour	72%	53%
Moderate Wage: More than 50% make between than $6.50 + $15/hour	81%	59%
High Wage: More than 50% make more than $15/hour	88%	73%
Other	74%	69%
Total	**79%**	**65%**

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Level of Contribution

Of those employers who responded to the SPG small employer survey and who offer insurance to their employees, 60 percent require no employee contribution. Thirteen percent of the employers require employees to contribute less than $50.00 each month.

Percentage of employees offered coverage who participate

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

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Cost is the main reason small employers reported they do not offer health insurance benefits to their employees. Sixty-two percent of the SPG survey respondents either assume that health insurance is too expensive or have tried to purchase health insurance and found it unaffordable. The next most frequent reason for not purchasing health insurance was because employees already had coverage through other means (15 percent of respondents).

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

This question was not addressed in any of the survey or research activities.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

In the SPG survey of small employers, employers that did not offer health insurance were asked to describe their reason for not offering health insurance. Sixty-two percent indicated that cost was the reason. Another seven percent said that the majority of their employees were not able to pay for their share of the premium. With over two-thirds of respondents indicating cost as justification for not offering health insurance, we can infer that a further increase in health insurance premiums and/or an economic downturn would likely discourage the majority of these small employers from providing health insurance.

Small employers who did offer health insurance were asked how likely the company was to discontinue providing health insurance within the next five years. Less than 15 percent said they were almost certain or very likely to discontinue providing health insurance benefits. Another 21 percent indicated that they were somewhat likely to discontinue. If an economic downturn or an increase in premiums were to occur, it stands to reason that those employers who are "somewhat likely" to discontinue might become "very likely" to discontinue.

2.5 What employer and employee groups are most susceptible to crowd-out?

This information was not addressed within any of the data collected in the survey activities. However, the groups that would appear to be most susceptible to crowd-out are those with a high number of low-income workers who are more likely to qualify for public programs.

2.6 How likely are employers who do not offer coverage to be influenced by the following factors: Expansion and development of purchasing alliances, individual or employer subsidies, additional tax incentives?

SPG employer survey results show that the overwhelming majority of small employers surveyed who do not offer health insurance benefits to their employees support the concept of small employer health purchasing alliances. Of the employers surveyed, 91 percent support purchasing alliances, with 66 percent strongly supporting the concept. Purchasing alliances were also popular among employers who participated in focus group discussions throughout the state. In virtually every focus group discussion, at least one employer suggested the creation of a statewide purchasing alliance as a possible solution for the uninsured with a significant agreement among other focus group participants.

However, Texas' earlier experience with purchasing cooperatives suggests that a successful cooperative may be difficult to establish. Thus, while it is clear that employers support the concept of a purchasing alliance, that support may not translate into actual participation unless significant cost savings can be provided and maintained.

On the subject of tax subsidies and tax incentives, limited information is available. Fifty-two percent of small employers surveyed who do not offer insurance support subsidies and 40 percent do not. No specific question was asked relative to tax incentives, primarily because of the limited ability of the state to provide them (i.e., Texas does not have a corporate or personal income tax). However, the survey did address the broader issue of financial incentives to small employers. According to the final results of the SPG survey of small employers, 84 percent or employers surveyed support financial incentives, with 55 percent strongly supporting the idea.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

The working group considered other alternatives to motivate employers to offer insurance but was unable to develop any specific financial incentives. Local property tax incentives are a possible option that was not evaluated due to time restrictions.

Section 3: Summary of Findings: Health Care Marketplace

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

Evaluating adequacy of coverage in relation to affordability is a subjective task that is difficult to measure through surveys. To adequately assess whether coverage is adequate for one particular person or a group of people, numerous factors must be considered including but not limited to: the premium cost of the insurance; the individual's income level and personal expenses that impact the affordability of coverage; additional deductible and coinsurance costs and any other out-of-pocket costs associated with the insurance; the types of benefits provided and whether they meet the personal health needs of the individual; and accessibility of providers. Due to the complexity of measuring these variables, Texas did not attempt to collect specific data on the adequacy of existing insurance through SPG survey activities or focus group sessions. However, the issue of adequacy of coverage was discussed in general at every Working Group meeting and during most focus group sessions. Focus group participants in particular expressed frustration with the lack of affordable coverage for individuals with pre-existing health conditions and found it ironic that sick people who need coverage the most are also the group most likely to be refused coverage at any cost. While many focus group participants were aware of the availability of coverage for individuals with pre-existing conditions through the Texas Health Insurance Risk Pool, they also found the premiums to be unaffordable and felt their experience was fairly typical of many uninsured Texans.

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

At the same time, other Working Group members argue that, while it is true most group policies in Texas are comprehensive and provide adequate, even generous, coverage for most people, there are clearly areas where they feel the market is lacking. This is particularly true in the individual insurance market. While Texas has a relatively healthy individual market compared to many other states, the cost of individual coverage is often unaffordable for much of Texas' uninsured population. Individual policies generally provide lower benefits compared to group plans, require higher out-of-pocket expenses, and often exclude coverage that individuals with pre-existing health problems are likely to need. Several members of the Working Group and numerous focus group participants also expressed particular concern over the lack of coverage for mental health treatment and prescription drugs in both group and individual plans.

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

When the Texas Legislature considered small employer group reforms in 1993 and 1995, lengthy discussion took place regarding the specific benefits that should be included in "standard" benefit plans. In 1993, the Legislature established certain specific benefit requirements for three standard health benefit plans in the small employer market. The law required TDI to adopt rules establishing the actual benefits that must be included. After considerable public and industry participation and discussion about adequacy of coverage, TDI adopted three benefit plans that provided varying levels of coverage and, in theory, offered employers a range of choices. However, the three plans were not at all popular, and the Legislature in 1995 eliminated the three plans and replaced them with two standard plans - the basic and catastrophic. Again, TDI worked for months with the public and the industry to establish new benefit levels for the two plans. However, those plans today are still extremely unsuccessful and demonstrate the difficulty of reaching consensus on what must be included in an "adequate" benefit plan.

While Texas, like other states, requires insurers to include certain benefits in all health insurance plans, carriers have a great deal of flexibility in customizing benefit plans to meet the specific requests and needs of their clients. In the past, the Texas Department of Insurance did attempt to collect information on the extent to which certain benefits were included in group policies, but the data reported by insurers and HMOs was inconsistent and yielded information of limited value due to the complexity of comparing actual benefit levels. For example, the survey asked insurers to report the percentage of insureds covered under policies that provided certain benefits including: inpatient hospital, physician inpatient and outpatient coverage, home health care, prescription drug benefits, vision care, maternity coverage, family planning benefit, organ transplants, and other common benefits. However, without providing corresponding data on maximum benefit levels and cost-sharing requirements for each of the benefits provided, the data gives an incomplete picture of the extent to which people have adequate coverage. Although TDI attempted to design a more complex reporting format that would provide some of that critical information, the Department was unable to develop a survey instrument that would accurately reflect the many variables selected by employers. Without that information, it is impossible to reach any meaningful conclusions about the adequacy of coverage available.

3.2 What is the variation in benefits among non-group, small group, large group, and self-insured plans?

Texas law requires insurers to include specific benefits and policy provisions in group and individual health plans and all policy forms must be approved by the Texas Department of Insurance for sale in Texas. However, self-insured plans are not subject to state regulation and TDI has no authority to collect premium or benefit information on these plans. As such, the information on self-insured plans is very limited.

In a benefit comparison of fully-insured small and large employer health plans completed by TDI in March of 2000, the Department determined that most types of group plans provide many of the same benefits. Virtually all group plans (including the Small Employer Basic and Catastrophic plans, the HMO standard small employer plan, "typical" small employer indemnity and HMO plans, and "typical" large employer indemnity and HMO plans) included a wide range of coverage including: physician or other health care practitioner services, hospitalization coverage, miscellaneous hospital services and supplies, anesthesia coverage, assistant surgery fees, outpatient services for emergency care, durable medical equipment, radiation therapy, inhalation therapy and chemotherapy; x-ray and laboratory services, maternity benefits, complications of pregnancy, physical therapy, occupational and speech-language therapy, home health care services, mammography screening, and numerous other benefits.

Despite the fact that most plans include very similar coverage, insurers generally have resisted efforts to standardize benefit plans. The standard Basic and Catastrophic benefit plans have been extremely unpopular and insurers have indicated to TDI, the Legislature, and in public working group sessions that they prefer to market their unique company plans rather than sell standardized plans required by state laws. Insurers and agents indicate that they need the flexibility provided under non-standard plans to meet the unique needs of their customers so that benefits can be adjusted as necessary and as requested by their clients.

Many of the provisions required of group plans also apply to individual plans, so to a large extent, both types of plans have many of the same benefits. However, individual plans often include higher deductible and coinsurance requirements and may exclude some of the benefits commonly provided in group plans. For example, benefits for maternity coverage and prescription drugs are not standard benefits for individual plans but are provided in the large majority of group plans. However, one of the most significant differences in benefits provided under individual and group plans is that individual policies often exclude coverage of pre-existing health problems that are generally covered under group plans. Numerous focus group participants indicated that they had attempted to purchase individual health insurance products but could not get coverage for existing health problems. The inability to get a policy that provided the benefits they most needed led several participants to decide against purchasing individual coverage.

While Texas does not have the authority to collect information on self-insured plans, as part of a review of mandated benefits for the Texas Department of Insurance, the actuarial firm Milliman and Robertson (now Milliman USA) conducted a survey to determine the extent to which self-insured plans covered mandated benefits required in fully-insured plans. In its report, Milliman

reports that for 10 of the 13 benefits reviewed, 89% or more the surveyed companies responded that they fully cover the mandated benefits.[ix] Though no information was provided on other benefits, there is no data that suggests self-insured plans in Texas provide benefits that differ significantly from those provided under fully-insured plans.

3.3 How prevalent are self-insured firms in your state? What impact does that have in the State's marketplace?

Because self-insured firms are not subject to any state regulation or reporting requirements, information on the number of self-insured employers is difficult to determine. However, the Texas Department of Insurance estimates that approximately 5 million Texans are covered by self-funded plans. This represents about 40 percent of all Texans with private coverage, including both group and individual insurance. There is no known estimate of the actual number of firms providing such coverage.

The most common concerns raised with regard to self-funded plans in Texas deal primarily with the fact that self-funded plans are not subject to state-premium tax requirements and thus put fully-insured plans at a disadvantage since they must include premium tax payments in the premiums charged their fully-insured clients. Insurers sometimes claim they are unable to compete on a level playing field and are concerned they may be losing business because of the inequities created under ERISA (Employees Retirement Income Security Act). In addition, because self-insured plans are not subject to assessments by the Texas Health Insurance Risk Pool, these costs are shifted entirely to fully insured plans and the employers who purchase them.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

The State of Texas (including federal and state spending on public programs) is the largest single payer of health care services in the state and, as such, has a significant impact on the provision of health care services. A comprehensive analysis by the Texas Comptroller of Public Accounts shows that State and Federal Government spending on Texas healthcare services in 1998 represented 40% of all health care expenditures in the state.[x] A breakdown of health care expenditures paid under programs administered by the State is presented below:

Table 3.1: Texas State Government Health Care Expenditures – FY 1998[xi]

Type of Program	Total Health Care Expenditures In FY 1998
State Employees Health Insurance	$993,025,993
Medicaid - State and Federal Expenses	$9,929,927,295
Other non-Medicaid State/Federal Health Expenditures (i.e., MHMR, Texas Rehabilitation Commission, Texas Department of Criminal Justice, etc.)	$2,755,168,323
Total	$13,678,121,611

3.5 What impact would current market trends and their current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

No analysis was conducted that would enable us to respond to this question.

3.6 How would universal coverage affect the financial status of health plans and providers?

No analysis was conducted that would enable us to respond to this question.

3.7 How did the planning process take safety net providers into account?

Although the level of detail for policy options did not proceed to the point where the details of the policy options were determined, the working group was constantly mindful of the providers in general. The working group and SPG staff realized that one of the primary considerations throughout the process was to do nothing that would negatively impact existing programs or hinder the work of safety net providers. This issue became particularly apparent while discussing the CHIP buy-in options. Several public health representatives pointed out that providers have already expressed extensive concerns over reimbursement rates and administrative burdens under CHIP and Medicaid, and any attempts to expand those programs must be coordinated with providers. At the same time, safety net providers are overburdened and cannot continue to adequately serve the uninsured without some assistance. If the uninsured population continues to grow as some expect due to economic conditions this year, the safety net system will be further stressed. This is particularly true with regard to the mental health providers. Several inpatient treatment centers have closed within recent months and the remaining treatment facilities report long waiting lists for patients. These issues must be considered and addressed if any expansion of insurance programs is to be effective.

3.8 How would utilization change with universal coverage?

No analysis was conducted that would enable us to respond to this question.

3.9 Did you consider the experience of other states in regard to the following issues:
1) expansions of public coverage 2) public/private partnerships 3) incentives
2) for employers to offer coverage 4) regulation of the marketplace?

The SPG staff devoted an extensive amount of time to researching the experiences of other states in these and many other areas. The information was presented in working group sessions and in packets of information provided to working group members and posted on the SPG website. While the comparison provided some useful background material, the significant differences in the composition of public programs and regulatory requirements in Texas as compared to other states made a number of the programs in other states impractical for Texas.

Section 4: Options for Expanding Coverage

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credit for employers or individuals, etc.)?

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

Throughout the course of this project, SPG staff and working group members remained keenly aware of the challenge of developing options that could be supported by a broad group of stakeholders and political leaders given the diverse interests and needs of uninsured individuals and political subdivisions across the state. To add to the challenge, Texas, like other states, has experienced significant economic changes during the course of the 12 months covered by the SPG study. Even before the tragic events of September 11th, the Texas economy showed signs of slowing down, raising concerns among some working group members that options for expanding health insurance would likely need to be limited to those that do not require additional state funds. In addition, successful outreach efforts for the state's Children's Health Insurance Program resulted in a significant increase in enrollment of children in both Medicaid and CHIP, leading to higher costs and increased demand for services under both programs. These factors coupled with increasing budget concerns after September 11th had a significant impact on the policy options that were realistically available for expanding health insurance. Although much of the initial discussion had already focused on options that would not require additional state funding, the primary focus of the work completed since October were limited almost entirely to private/public partnerships and other options that require little if any state funds.

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

However, recognizing that we could not wait for finalized data to begin discussions about insurance expansion options due to time constraints, the SPG staff and working group members

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

After discussing all policy options at two separate meetings, the Working Group was asked to vote on each option, indicating on a scale of one to five the level of interest they still had. Several members stipulated that they did not want their votes to be interpreted as support for or opposition to any particular options, but were simply an indication that the discussion on those options should continue. The results of the Working Group Survey appear on the following page.

During the remaining months of the project, attention was focused on three general areas that received the most support and appeared to be most logical based on the preliminary survey results: small employer insurance reforms; CHIP buy-in options; and education/information activities for individuals and small businesses. The actuarial firm Milliman USA served as consultant on the project and assisted in the development and analysis of specific options under each of the three categories. In January, a statewide conference was held in Austin to present the project survey results and discuss the various options that had been developed, with presentations by the survey contractors and actuarial consultants with Milliman USA. The conference was widely advertised across the state and more than 200 people attended the two-day event. General feedback from conference attendees was very positive and encouraging with many people expressing a desire to become more involved with this project. However, it was clear from discussions within the break-out sessions on the second day of the conference that attendees wanted additional work to be completed on the options presented before they could reach any consensus on how Texas should proceed. Most participants agreed that it was premature to reach any conclusions about what specific steps Texas should take at this time, particularly given the economic uncertainty and budget concerns for the next biennium. As such, the policy options presented below are still under review and are presented in this report as options and not

recommendations. With the 12-month grant extension that was authorized in February, Texas will continue to develop in more detail each of the policy options and will continue meeting with the Working Group and state policymakers with the hope of developing a consensus on more specific recommendations.

Following is a review of the three general areas of policy options that are still under consideration.

Small Employer Reforms

The majority of people with health insurance in Texas and throughout the United States obtain coverage as a benefit provided by their employer. More than 60 percent of insured Texans are covered under employment-based plans. However, many working Texans are employed at firms that do not offer insurance. Many of these businesses are small firms with 50 or fewer employees. Small business employees and their families are about twice as likely to be uninsured as workers employed by large firms. Nearly one-half of uninsured working Texans are employed by firms with less than 25 workers according to Current Population Survey (CPS) data. An additional 14 percent are employed in firms with 25 to 99 workers.

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

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

While these reforms have helped increase the number of small firms that offer health insurance, many small employers continue to find that the cost of health insurance is unaffordable. Insurance enrollment information filed with the Texas Department of Insurance (TDI) indicates that 97,793 small employers provided health insurance benefits for their employees in the year 2000. While this number is up significantly from 36,952 in 1993, it still represents only 25 percent of all small firms in Texas. Most small employers continue to not offer health insurance.

To better understand the reasons why small firms in Texas do not offer coverage, the TDI State Planning Grant program mailed surveys to 50,000 small employers throughout the state. The

survey requested information on why employers do not provide insurance and what type of changes they would like to see implemented to make insurance more affordable and attractive to small business owners. This information, along with suggestions provided by focus group participants, directed the development of several options designed to address the low number of small employers with health insurance. Following is a brief overview of the options that are still being considered.

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

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

Regardless of the reasons, the working group and other stakeholders agree that both the Basic and Catastrophic plans need to be revised and updated to compare more favorably with current "shelf" products marketed by insurers. Some of the specific revisions under consideration include:

a) Increasing the deductible ranges allowed under the Basic plan;
b) Allowing the use of, rather than require, the current internal policy limits so carriers have the flexibility to make adjustments consistent with their standard products;
c) Allowing carriers to add transplant benefits to the Basic Plan (which are currently excluded) to improve the marketability of the plans;
d) Reducing the number of catastrophic plan deductibles that must be offered from four to two; and
e) Including the benefits required under the chemical dependency rider and mental health rider in the base plan, or excluding them entirely since most carriers are supplementing the actual cost of the riders in the premiums charged for all plans due to adverse selection concerns, regardless of whether the employer purchases the benefit.

Target Population: Small employers

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

Logistical Requirements: TDI would have to adopt rule changes to implement any revisions to the standard benefit plans. In some cases, legislation may be required if recommendations vary from what is currently required by statute.

2) Revise rating requirements for small employer health plans

Insurers have generally strongly opposed any attempt to reduce their ability to underwrite and rate small groups based on the anticipated risk of each individual group member. While the definition of a large group varies from company to company, most groups with more than 50 people are sufficiently large to not be subject to the individual underwriting that smaller groups face. While the actual rating formulas and underwriting criteria used by insurers are closely guarded trade secrets, most carriers develop rate calculations on several standard factors, including the applicants' age, gender, health status, the location of the group, and type of industry. Based on these different characteristics, insurers determine how much risk a particular applicant represents and calculates a rate accordingly. As a result, any one of these characteristics may result in a significant increase or decrease in a particular person's rate, even when they are part of a group. For example, the older a person is, the higher the insurance rate so that a 24 year old healthy male will pay considerably lower premiums than an equally healthy 50 year old male. Because of the ability to rate group members as individuals, insurance costs for small firms vary significantly based on the characteristics of the group members. As such, it is possible that a business with only 8 employees may pay significantly higher insurance costs than a firm with 15 employees if the smaller business has employees who are older and/or less healthy than the employees at the larger firm.

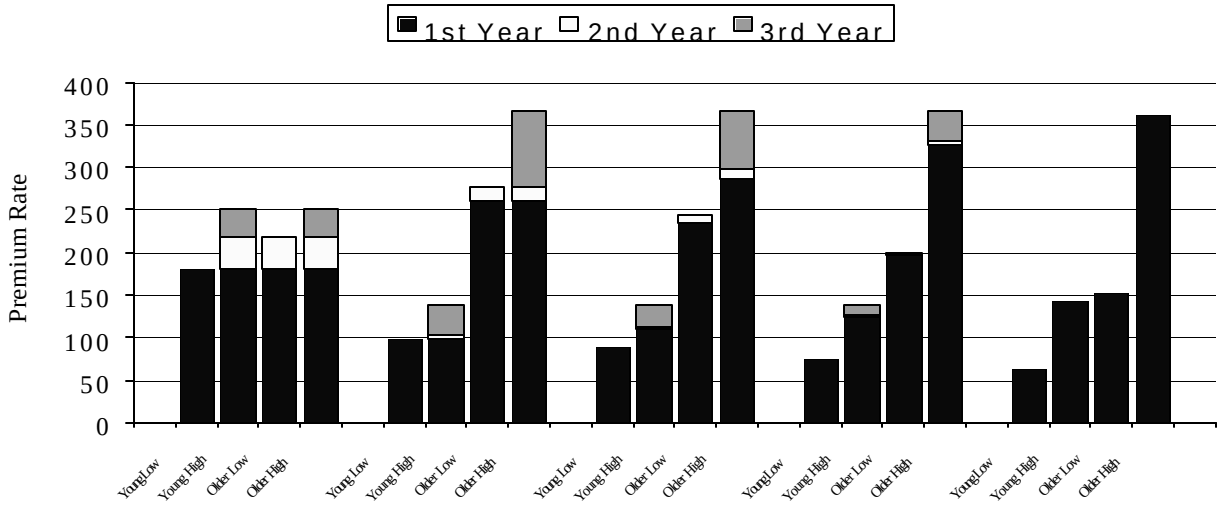
These disparities are one of the main reasons why many states, including Texas, have enacted rate reforms designed to limit wide rate differences within small employer market. New York implemented a true "community rating" system that basically requires all insured people to pay the same rate, regardless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

Most states have implemented less extensive rating reforms with varying degrees of success. Texas law allows small employer carriers to adjust premium rates based on age, gender, area, industry and group size. Rates can also be adjusted plus or minus 25 percent on the basis of health status. When all the various factors are considered, the rate difference between groups within the same class can be no more than 67 percent higher or lower. While this has lowered rates for some groups that previously were not subject to any limitations, some employers would

like to see the rate bands lowered even more. There is also some support for further restricting or even eliminating the ability to use health status factors in calculating rates.

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

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



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

Target Population: Small employer groups

Funding Source and Mechanism: Small employer premium payments

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

3) Create a statewide small employer purchasing alliance

As part of the small employer health insurance reforms enacted in 1993 and 1995, Texas law authorized the creation of public and private small employer purchasing alliances. The Legislature also directed the state to establish a statewide purchasing alliance, which was organized under the name of the Texas Insurance Purchasing Alliance (TIPA). While TIPA experienced significant success in the beginning, after five years the alliance dissolved due to a number of complex problems.

Despite the failure of TIPA, purchasing alliances remain an extremely popular option among employers and individuals who believe an alliance will provide significant cost savings. Small employers participating in focus group sessions throughout Texas have repeatedly expressed their desire to participate in a purchasing alliance. Ninety-five percent of the small employers who participated in the SPG employer survey indicated they want a purchasing alliance, with 77 percent expressing strong support. However, most surveyed employers – 72 percent – also were unaware of the fact that Texas law already allows for the creation of private purchasing alliances. Only one fully-insured alliance currently exists in Texas with approximately 2700 total participants. Insurers generally have shown little interest in working to establish private alliances.

In reviewing the experiences of TIPA and other state purchasing alliances that suffered similar problems, several important factors were identified that should be addressed to avoid the previous mistakes under TIPA if Texas decides to create another statewide alliance. Those factors include:

a) Involving agents and brokers from the beginning to assure effective marketing of the alliance;
b) Limiting the number of carriers allowed to participate in the alliance;
c) Limiting the number of health plan choices offered to a reasonable level that will allow for adequate enrollment and maximum administrative costs savings;
d) Negotiating rates with carriers;
e) Implementing strategies to reduce the risk of excess adverse selection compared to the regular commercial market; and
f) Investing in a strong marketing and advertising program in the initial phase of the program to assure employers are aware of the availability of the alliance.

Target Population: Small employers

Funding source and mechanism: No state money is necessary for a private alliance, which insurers or employers can establish under current law. If a statewide alliance is initiated similar

to TIPA, the Legislature could fund initial start-up costs. However, private insurer funds could also be used to cover start-up costs. Once the alliance is in place, costs would be covered entirely by premiums paid by small employers.

Logistical requirements: Legislation would be needed for the state to establish a statewide alliance. No legislation would be required for a privately sponsored alliance.

CHIP Buy-In Options to Expand Coverage to Parents

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

Because Texas currently has unused federal SCHIP funds, the opportunity to use this money to expand coverage to low-income adults through a CHIP "buy-in" program has been raised as one alternative. Through administrative efficiencies and the purchasing power generated from pooling with subsidized programs, CHIP buy-in programs have the potential to provide coverage to thousands of adults who cannot afford coverage in the commercial market. However, the success of a buy-in program and the extent to which it increases affordability depends largely on how the program is designed.

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

The Texas SPG Working Group discussed the benefits and disadvantages of both a full-cost buy-in and a subsidized buy-in using both state and federal funds, as well as a state-only subsidized program. The buy-in option was also presented at the state conference and was the subject of three separate break out sessions. While there was a great deal of interesting discussion and debate about how such a program could be implemented in Texas, there were also a number of concerns raised. Numerous participants pointed out that the state has encountered some difficulties negotiating rates with current providers in order keep them in the program. If the program were to be expanded to include adults (full cost or subsidized), the state may have problems finding enough providers to serve the added population without significant reimbursement rate increases. Several people commented that CHIP is already growing at such a

rapid pace that it is premature to consider adding adults. Others felt that Texas should focus more on locating and enrolling uninsured children who are eligible for but not enrolled in CHIP before we consider expanding the program to adults.

In addition, because Texas' CHIP enrollment is growing at a rapid pace, there is some concern that the state could reach its full SCHIP federal allotment in as little as two years. If that should happen, there will be no federal funds to spend on an expansion for adults since Texas' entire allotment will be spent on children unless Congress provides additional funding. Clearly the most difficult problem identified, however, is how to fund the state's contribution required for a state/federal subsidized buy-in. While there are many who strongly advocate maximizing our ability to use federal money, the current fiscal outlook is not conducive to expanding coverage to adults in a way that requires significant state funds.

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

During the most recent Texas legislative session, the Legislature directed that a study be conducted to determine the feasibility of expanding CHIP to include adults. The SPG staff has worked to coordinate its efforts with the Health and Human Services Commission (HHSC). Working with the actuarial and consulting firm Milliman USA some preliminary data has been presented to the working group and conference attendees. SPG staff will continue over the next few months to work with Milliman and HHSC to develop this option and to address numerous unanswered questions, including alternative funding sources. A report on the study findings will be delivered to the Legislature later this year.

Insurance Education and Information for Small Businesses and Individuals

One of the most consistent issues raised by focus group participants focused on the lack of information to assist them in purchasing insurance. Both groups specifically requested that the state provide more brochures to help consumers shopping for health care coverage, and employers in particular want a rate guide to serve as a resource for comparing prices. To address these concerns, several options were developed to respond to these very specific requests for assistance.

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

Many consumers, both individuals and small employers, complain about the inability to compare health insurance premium rates due to the huge variation in benefits and plan designs. Participants in focus group sessions have expressed overwhelming need for a rate guide that would allow them to compare insurance prices. Several specifically referred to the Medicare supplement rate guide published by TDI and suggested that the state publish a similar guide for

both individual and small group insurance. Employers stated they find it difficult and intimidating to shop for insurance, and would like to have a "non-biased" resource that would allow them to get at least a rough estimate of how costs compare among different carriers. While some employers stated they were pleased with their personal agent and felt the agent worked hard to get them the best deal, the general feeling among focus group participants is that most agents are trying to sell them the most expensive plan in order to maximize commissions. Without some means of comparison, employers have no way to evaluate or compare premium prices and have no choice but to rely on what the agent tells them. Employers also pointed out that the time they have to spend shopping for insurance is much more limited than a large company with a human resource department, and anything that can be done to make the process more simplified would be welcomed.

Small employers also complained that applying with several different companies for the purpose of comparing prices is not practical since agents/insurers will not provide a "final" price quote until the employer has submitted detailed health applications for every individual employee and dependents. The agent provides a basic rate quote based on a few group characteristics, but the final quote is not available until after the underwriting department has reviewed the application of each group member. Numerous employers felt that some agents deliberately underestimate the initial premium quote when they know the final quote will be significantly higher based on what the employer has told them about the group. However, in order to get the final premium rate, the employer is required to pay at least one month's estimated premium at the time the application is submitted. Employers explain that they cannot afford to go through this process with more than one company at a time, thus making it difficult if not impossible to obtain price estimates from several different companies. Once they have gone through the lengthy and time-consuming process with one company, many employers do not have the time to re-start the process and are reluctant to terminate the coverage they already have, leaving them and their employees uninsured again while they continue to shop around.

While developing a rate guide would create some challenges because of the lack of uniformity among policies, several states have developed guides using hypothetical individual and group applicants. To develop a rate guide for small employer plans, carriers could be required to provide quotes for several standard cases, each with different rating characteristics (age, sex, health status, geographical region, employment classification.) for the two standard, mandatory small-group plans (i.e., basic and catastrophic). Carriers could also be asked to provide cost information for the same hypothetical cases for their most popular non-standard benefit plan. Although not a perfect solution since few employers would exactly match the hypothetical groups described, this would provide consumers with at least a framework for assessing and comparing the rates of each insurance carrier. A printed rate guide would be published annually, with quarterly updates provided via the web.

Target Population: Small employers with 2 to 50 employees

Funding Source and Mechanism: The production and publication costs of developing the rate guide and maintaining the web database would be paid by TDI. To reduce printing costs, paper copies of the guidebook would be printed only annually, with quarterly updates provided through the web.

Logistical Requirements: TDI will need to develop a format and process for collecting and reporting the rate information. Legislation may be necessary to require insurers to submit the information to TDI and to authorize publication of the data in the form of a rate guide.

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

Small employers in particular wanted an opportunity to meet with representatives from the Texas Department of Insurance to discuss questions about their insurance or to get advice about how to shop for coverage. While TDI does provide consumer assistance through a toll-free telephone and provides brochures by mail and through the agency's web-site, employers want something more personal that provides a face-to-face meeting. One way of providing this service is to hold local "health insurance fairs" in cities across the state where staff from TDI and the Office of Public Insurance Council (OPIC) could provide informational sessions on various insurance topics. Following group "lectures", staff would be available to meet one-on-one to answer specific questions from attendees.

Staff from the Texas Health and Human Services Commission has indicated that they would also like to participate in these insurance fairs in order to provide information to employers about the state Medicaid Health Insurance Premium Payment program (HIPP), the new CHIP employer premium program that is currently being developed, and the availability of tax credits for Temporary Assistance for Needy Families (TANF) clients that receive group health insurance. Other information could also be provided on both Medicaid and CHIP for employers to share with employees who may qualify for the programs.

This option also provides another excellent opportunity for the state to collaborate with the business community and insurance industry. To cover the costs associated with organizing the insurance fairs, insurance companies and agents could pay a fee to operate an informational booth at the fair. Employers would then have an opportunity to obtain information from a variety of insurance companies in one setting and meet with agents who are specifically interested in working with small employers. Fair organizers would work with the local chamber of commerce to advertise and make arrangements for the fairs. Depending on the success of the fairs, they could easily be expanded to include Texans shopping for individual coverage.

Target Population: Small employers with the possibility of expanding to individual consumers.

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

Logistical Requirements: Although Legislation may not be required, TDI and OPIC would need legislative authorization to hold such fairs, and spend state money for that purpose. Both offices also would need appropriations to cover the costs of staff who would organize and operate the fairs.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

Small Employer Reforms

Since the beginning of the SPG project, much attention was focused on opportunities to expand coverage in the private market. Financing was a significant consideration since most of the small employer reforms being considered require little if any state funding. In addition, focus group feedback and information obtained from the small employer survey also strongly supported reforms that would strengthen the private market and assist employers who want to provide insurance for their uninsured employees. While some reforms may require legislation, they are relatively simple to implement from an administrative perspective.

CHIP Buy-In to Expand Coverage to Adults

Because the Legislature had already expressed interest in expanding CHIP coverage to adults with the enactment of HB 835, it was a natural function of the SPG program to work with HHSC to evaluate the feasibility of buy-in options. Legislative members and HHSC representatives on the Working Group supported the coordination between HHSC and the SPG staff, and welcomed the opportunity for a detailed actuarial analysis that might not have otherwise been affordable without the grant funds. In addition, at the time the study began, the economic outlook for the state was more optimistic and an expansion of CHIP was more economically feasible than today. Although support for expanding CHIP may not be as widespread today as it was 12 months ago, interest does still exist in pursuing this option in some form in the future.

Insurance Education and Information for Small Businesses and Individuals

The options for enacting programs aimed at educating and providing information for small employers and individuals were based primarily on responses of focus group participants and survey results. Like the small employer reforms, these options are relatively low cost and easy to administer for the most part. In general, they enjoy widespread support among the working group members, and, to a lesser degree, the insurance industry.

These reforms also provide opportunities for public/private collaboration between the Texas Department of Insurance, the Health and Human Services Commission, and the insurance industry. At a time when the state faces limited financial resources for expanding insurance coverage, these reforms may provide alternatives that could make a significant contribution without costing the state considerable resources.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

Because a decision has not been made yet as to which options will be adopted, no steps have been made towards implementation.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

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

Several primary factors contributed to the decision not to pursue these options. Restructuring Medicaid and CHIP and the option to expand the programs in counties that agreed to leverage funds presented significant administrative and political challenges. Texas is currently in the process of significant reorganization activities in the Medicaid program, and most people agreed that this is not an ideal time for attempting additional changes within that program. There also was concern that a restructuring of Medicaid/CHIP benefits would meet significant resistance from providers and consumer advocates due to fears that important benefits could be eliminated or reduced. Providers also have expressed objection to an expansion of Medicaid managed care due to concerns that reimbursement rates will not be adequate.

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

4.19 How will your State address the eligible but not enrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

Texas has engaged in an extensive outreach effort to enroll individuals eligible for but not enrolled in both CHIP and Medicaid. The TexCare Partnership program has developed an extremely popular advertising and outreach program that works with local communities to reach families that may be eligible for enrollment. The campaign includes television and radio advertising, posters, brochures distributed through public schools, as well as local outreach efforts through churches, county health departments, shopping centers, physician offices, and other public locations. The state has also worked with members of the Texas CHIP Coalition to coordinate outreach with a large number of stakeholder groups interested in promoting the program. The outreach campaign has received high praise for its success as is evidenced by the steady increased enrollment in CHIP. Enrollment and renewal rates have continued to outpace projections with more than 530,000 children currently enrolled. An additional 296,000 children have been referred to Medicaid for enrollment assessment based on income information that indicates they may be eligible for Medicaid.

However, while the state is proud of its success in CHIP enrollment, the increase in enrollment coupled with increased medical costs has resulted in a projected budget shortfall of more than $29 million by the end of the current budget cycle. At this time, Texas is not considering actions to freeze or limit enrollment, but the state has reduced to some extent its advertising campaign for the program. Should the budget situation improve, the state will use the existing infrastructure and local community support to resume a more aggressive outreach strategy.

Texas SPG Policy Options:

Levels of Interest by Working Group Members, October 2001

(Options Sorted by TOTAL SCORE)

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

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

Section 5 - Consensus Building Strategy

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g. providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

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

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

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

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

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

At the time Texas was notified of its grant award, a press release was sent to hundreds of newspapers and periodicals throughout the state announcing the grant and inviting interested parties to either contact TDI for information or follow the project through our web-site. Throughout the SPG study, all working group meetings were officially posted and publicized through the Texas Secretary of State's Office as open meetings, and notices were provided to all individuals who had attended previous meetings. Meeting information was posted on the SPG

web-site, and e-mail notices were sent to anyone who requested to be informed. The SPG web-site also requested comments and feedback, and a process was implemented to assure that a response or acknowledgement was sent to all commenters. All surveys mailed also included information on how respondents could participate in the project.

Input was also obtained through focus group sessions held with small employers and uninsured Texans in 16 different cities across the state. Focus group sessions were publicized through a variety of means, including newspaper stories and advertisements, posters, mailings, and contacts with local providers of health services for the uninsured. Two separate surveys also were used to obtain significant input from small employers and uninsured individuals.

Finally, a statewide conference was held on January 31 - February 1 that was widely advertised across the state. More than 200 people attended the conference, which provided detailed information on the SPG research, focus group and survey results, and the policy options under review. Nine breakout sessions were held to discuss the different options and obtain feedback from attendees.

5.3 What other activities were conducted to build awareness and support (e.g., advertising, brochures, web-site development)?

Because Texas is an extremely large and geographically diverse state covering more than 250,000 square miles, the SPG staff relied greatly on the project web-site and information distributed by working group members to build awareness across the state. In addition, at the time focus group sessions were held, local press releases were issued that provided information on both the focus groups and the SPG project. To distribute information regarding the conference, a brochure was sent to stakeholder groups across the state, and invitations to the conference were sent to thousands of potential attendees via the mail and the internet.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

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

While the policy environment is very receptive to recommendations for expanding insurance coverage, the reality of the economic limitations faced by the state indicate that any expansion of public programs is unlikely at this time. However, options that do not require large sources of revenue from the state, and those that encourage the expansion of private coverage, are likely to be well received and given serious consideration by policymakers and state leaders.

Section 6: Lessons Learned and Recommendations to States

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

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

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

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

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

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

The Texas project conducted all the original data collection activities that were proposed. While the focus group sessions were more expensive than anticipated and required extensive amounts of staff time, they also provided some of the most useful information.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

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

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

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

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

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

A third area for potential research activity is large employers. While uninsured individuals are much more likely to work for small firms than large firms, nearly 500,000 uninsured Texans work at firms with 1,000 or more employees. Though many of these individuals may be seasonal or contract workers, little is known about their income, why they are uninsured, or the firms' policies towards part-time or temporary workers. This information would be useful to determine

how to best assist this population of uninsured workers. Again, however, due to lack of funding, the State does not plan to conduct this research.

Texas has also identified questions that could be addressed with a survey of insurance agents. As a result of the information obtained in the small employer survey and through focus group meetings with small employers, a number of issues relating to insurance agents and marketing activities were raised that cannot be answered. Texas is considering conducting an agent survey during the next twelve months as part of the grant extension activities, but that will largely depend on the expense involved and whether adequate funds remain in the grant budget.

Finally, a follow-up survey of small employers would also provide some very useful information. Several of the policy options that are being considered require more detailed information than what was obtained through the original survey of small employers. Within the next few months, SPG staff plan to identify the specific information that is needed and will evaluate whether a follow-up survey is possible within the remaining budget. Without adequate SPG funds, however, the survey will not be conducted.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

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

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

One of the most beneficial aspects of the SPG activities has been the opportunity to bring many stakeholders together to address the problems of the uninsured. While both the insurance industry and employers have strong feelings about what should and should not be done, both groups expressed a willingness to consider the problem with an open mind. The exchange of information between the two groups and other stakeholders who participated in the process was both educational and encouraging. However, the stakeholders who participated in this process may not be representative of the employers and insurers across the state. One of the questions

that remains unanswered is how others who were not involved in this process and who do not have the benefit of the survey and research data will respond to the options under consideration.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

- Begin the data collection activities as early as possible. Do not underestimate the amount of time that is required to complete large survey activities and allow plenty of time to complete your analysis so the data can be used to influence policy options.
- Use the experiences of other states to help you in your project. Talk to states about their experiences with surveys and focus groups to assist you in planning your own research activities. Learn from their mistakes and successes.
- Involve legislators to the greatest extent possible. Provide them with regular updates, invite them to your meetings, send them copies of your research reports, and encourage them to keep up with the activities of your group. They will appreciate your efforts to keep them informed and will generally be more aware of the uninsured issue and the challenges of expanding coverage.
- Focus group activities require extensive amounts of time and effort that are difficult to anticipate. If possible, work with a contractor to assist in your efforts.

6.9 How did your State's political and economic environment change during the course of your grant?

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

Changes in the economic environment have certainly had an impact on this project. Although the project focused considerable attention on expanding coverage through the private market from the beginning, the economic downturn and projections of budget shortfalls after September 11th required an even greater focus on options that do not involve large outlays of state funds. Texas also realizes that the economic outlook will improve and has not, therefore, entirely excluded options involving expansion of public programs. However, the realities of the current budget limitations have certainly impacted the discussion of options and likely discouraged consideration of some options that might have generated more interest under a different economic environment.

6.10 How did your project goals change during the grant period?

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

6.11 What will be the next steps of this effort once the grant comes to a close?

Texas has received a 12-month extension to continue the work begun this past year. As such, the staff plans to continue to develop and refine the options that are under consideration. Specific activities that will be pursued include:

- Additional actuarial development of plan benefit provisions and cost estimates based on recommendations made at the statewide conference that was held on January 31 and February 1, 2002;
- Collecting updated cost data from insurers and HMOs, enrollment information and participation data in the small employer market, and other information that is necessary to evaluate the feasibility of specific expansion plan options;
- Surveying insurance agents in Texas to obtain comments and identify areas of concern regarding specific insurance recommendations, and to determine the extent to which agents support and will participate in specific insurance expansion plans;
- Working with the appropriate Legislators and legislative staff (many of whom will be newly elected following the November elections) to inform them of the SPG study results and recommendations for expanding health insurance, and to provide assistance in developing any legislation that may be required;
- Continue meeting with Oversight and Implementation Working Group members to further develop options and plans for implementation; and
- Evaluating how changes in the economy may impact certain options for expanding coverage to determine if revisions in policy options are necessary.

Some additional survey work may also be conducted depending on costs and whether adequate funds exist. As Texas draws closer to the next legislative session in January 2003, grant staff will work with interested legislators and committees to present the findings of this study and discuss the various options for Texas. All legislators will be provided copies of this report and encouraged to request additional information. Key stakeholders will continue to remain very supportive of this project.

Section 7: Recommendations to the Federal Government

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

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

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

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

Texas focused almost exclusively on state level program options, particularly in the expansion of private insurance coverage. None of the options that were under consideration early in the process would have required changes in Federal law.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

On several occasions during the course of this study, the SPG staff and working group noted that a lack of data discouraged an in-depth review of some options. This was particularly true with private market reforms. While the Medical Expenditure Panel Survey (MEPS) data did provide some useful information, the data would be more useful if provided in a more timely manner. In addition, restrictions on the ability of states to access the data due to privacy concerns severely limits the extent to which detailed reports can be created. As such, the Federal government should review the process by which MEPS data is provided to states to determine if this resource can be shared with states in a more productive manner.

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

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

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

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

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

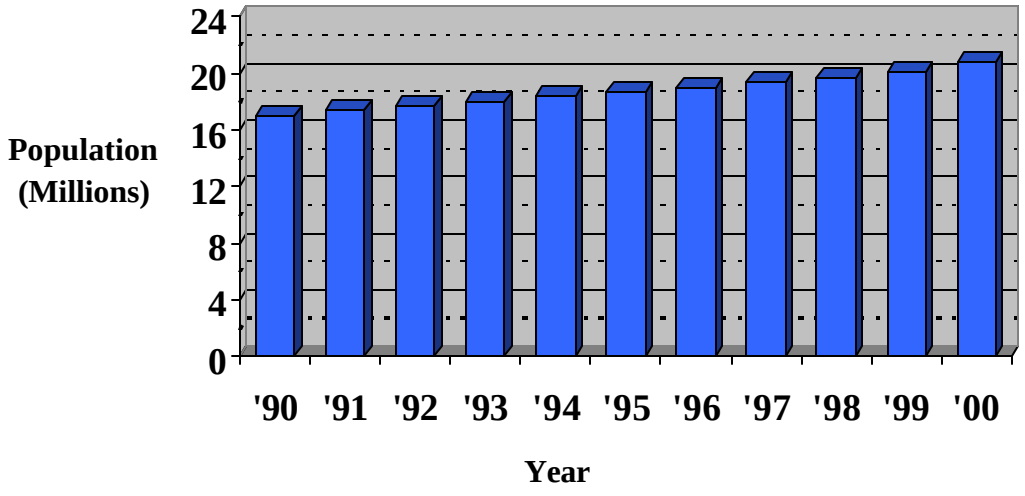
Appendix I: Baseline Information

Population

Table A1: Official Texas Statewide Population and Growth Rate Estimates: 1990-2000

Year	Population	Growth Rate
2000	20,851,820	4.03%
1999	20,044,141	1.68%
1998	19,712,389	1.84%
1997	19,355,427	1.84%
1996	19,006,240	1.75%
1995	18,679,706	1.86%
1994	18,338,319	1.90%
1993	17,996,764	1.96%
1992	17,650,479	1.79%
1991	17,339,904	1.73%
1990	17,044,714	-

Chart A1:Texas Statewide Population Growth: 1990-2000



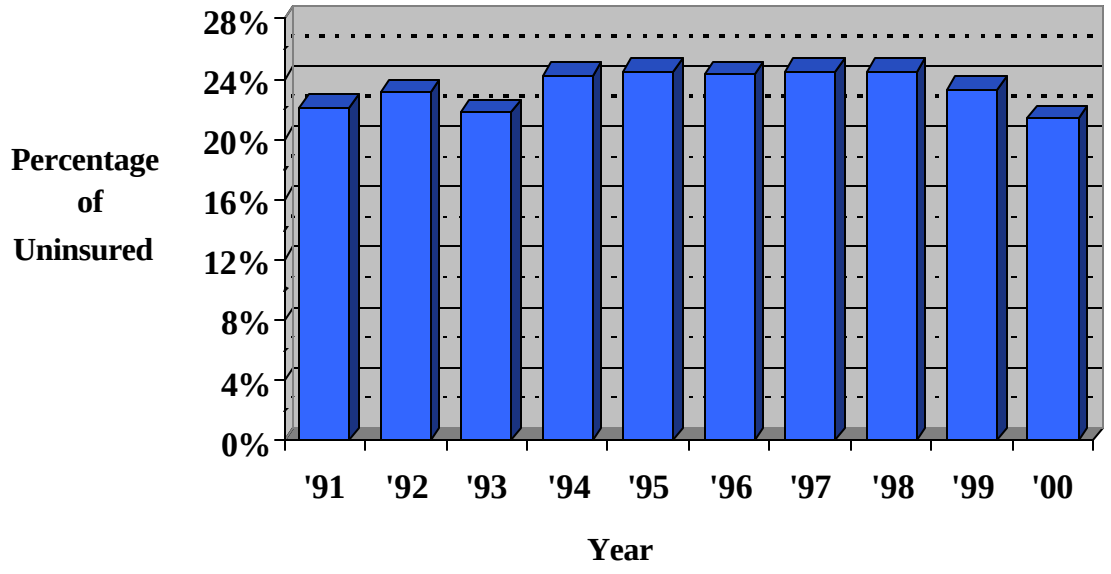
SOURCES: 1) State Population Estimates: Annual Time Series, July 1, 1990 to July 1, 1999. ST-99-3. Release date December 29, 1999. 2) Census 2000 Data for the State of Texas. Release Date March 12, 2001.

Number and Percentage of Uninsured

Table A2: Number and Percentage of Texans Without Health Insurance: 1994-2000

Year	Uninsured Rate	Number Uninsured
1991	22.1%	3,755,000
1992	23.1%	4,144,000
1993	21.8%	3,981,000
1994	24.2%	4,580,000
1995	24.5%	4,615,000
1996	24.3%	4,680 000
1997	24.5%	4,836,000
1998	24.5%	4,880,000
1999	23.3%	4,664,000
2000	21.4%	4,500,000

Chart A2: Percentage of Uninsured in Texas: 1994-2000



Source: United States Census Bureau, Current Population Survey

Average Age of Population

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

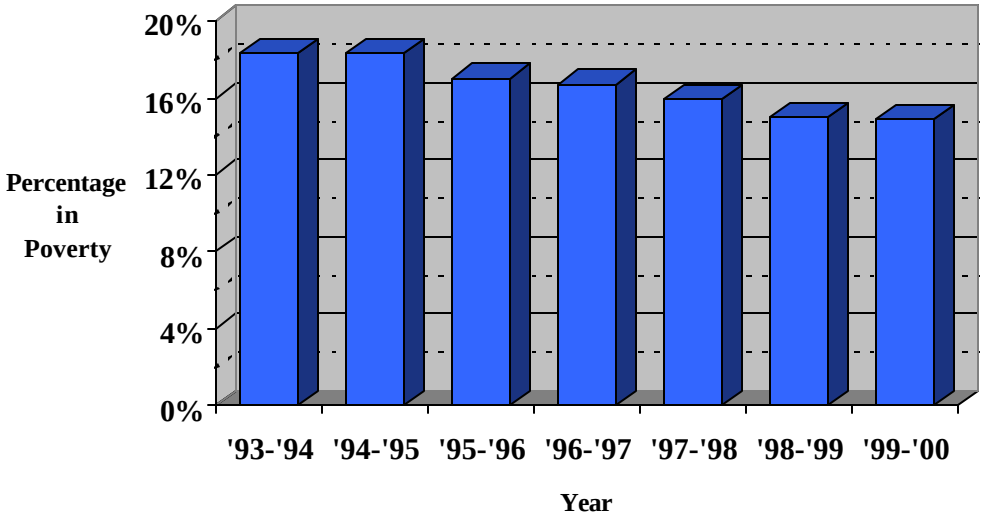
Percent of Population Living in Poverty

Table A3: Texas Uninsurance Rates by Poverty Range

Income/Poverty Level	Number Insured	Number Uninsured	Percent Uninsured within Income Category	Percent of Total Uninsured
Under 50%	739,187	466,670	38.7%	10.4%
51% to 99%	1,134,862	744,113	39.6%	16.6%
100% to 149%	1,322,318	787,617	37.3%	17.6%
150% to 199%	1,534,302	647,229	29.7%	14.4%
200% to 249%	1,569,169	551,402	26.0%	12.3%
250% +	10,225,826	1,289,019	11.2%	28.7%
Total	16,525,665	4,486,051	21.4%	100.0%

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS, Research and Forecasting Department, Texas Health and Human Services Commission

Chart A3: Rate of Poverty in Texas: 1994-2000



Source: United States Census Bureau, Current Population Survey

Primary Industries and Number and Percent of Employers Offering Coverage

Table A4: Texas State Employment Estimates by Industry, 2000-2001 (Numbers in 1000's)

Industry	September 2001 Employment Estimate	September 2000 Employment Estimate	Percent Change from 1999 to 2000
Mining	160.1	151.3	5.8%
Construction	582.8	564.5	3.2%
Durable Goods Mfg.	653.7	665.7	-1.8%
Non-durable Mfg.	415.9	420.7	-1.1%
Trans. & Public Utilities	620.1	597.8	3.7%
Wholesale Trade	556.3	550.4	1.1%
Retail Trade	1,738.1	1,705.6	1.9%
Fire	535.1	526.3	1.7%
Services	2,823.6	2,751.9	2.6%
Government	1,598.9	1,567.4	2.0%
Total Nonagricultural	9,684.6	9,501.6	1.9%

Source: Labor Market Information Department, Texas Workforce Commission

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

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

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

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

Industry	Companies Offering Insurance	Companies Not Offering Insurance	Percent Not Offering Ins. Within Industry	Percent of Total Not Offering Ins.
Agriculture, forestry, fishing	144	206	58.9%	4.1%
Construction	463	523	53.0%	10.4%
Food service	72	273	79.1%	5.4%
Manufacturing	479	242	33.6%	4.8%
Retail	555	702	55.8%	13.9%
Services	2,806	2,204	44.0%	43.8%
Wholesale	304	147	32.6%	2.9%
Other	1,050	701	40.0%	13.9%
No Response	45	39	46.4%	0.8%
Total	5,918	5,037	46.0%	100.0%

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

Table A7: MEPS Survey Data for All Private-Sector Employees (1998)

Category	All Employers	Small Employers	Large Employers
Total Employees	7,906,500	2,231,600	5,674,900
Accepted Coverage	4,477,300 56.63%	784,900 35.17%	3,692,400 65.07%
Declined Coverage	693,500 8.77%	141,800 6.35%	551,700 9.72%
Ineligible Employees	1,594,700 20.17%	334,100 14.97%	1,260,600 22.21%
Not Offered Coverage	1,141,000 14.43%	970,800 43.50%	170,200 3.00%

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Table A8: MEPS Survey Data for All Private-Sector Employees (1998)

Firm Size (Number of Employees)	Percent of Employees Not Covered	Percent of Employees Covered
Less than 50	64.8%	35.2%
More than 50	34.9%	65.1%
Less than 10	71.1%	28.9%
10-24	61.9%	38.1%
25-99	54.0%	46.0%
100-999	35.5%	64.5%
1000+	32.9%	67.1%

Source: Analysis of the 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Eligibility for Existing Coverage Programs

Chart A4: Texas Medicaid Eligibility Requirements

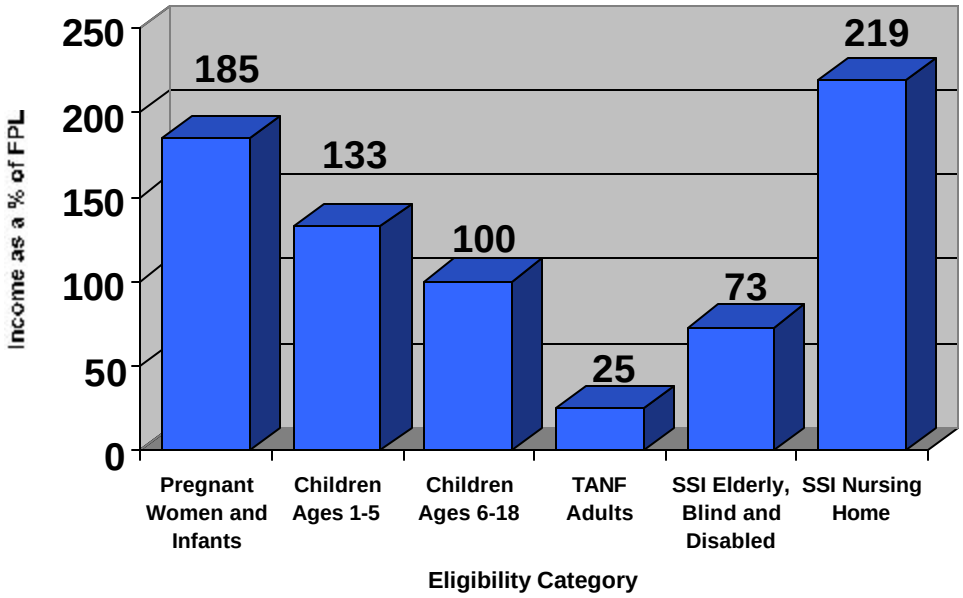
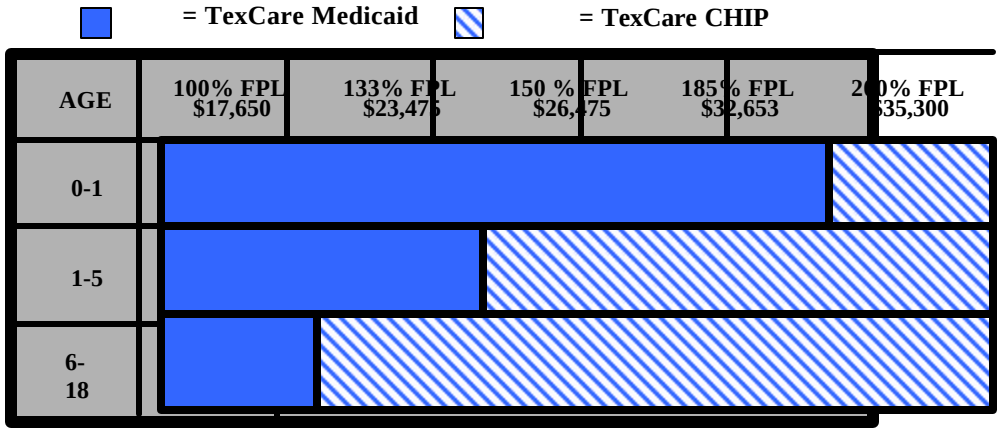


Chart 1.2: FPL Guidelines for TexCare Medicaid and TexCare CHIP



NOTES: 1) Income amounts reflect 2001 federal poverty guidelines for a family of four.
2) Children may be added or excluded, however, based on income deductions and asset tests.

Use of Federal Waivers

Table A9: Description of 1915 (c) Medicaid Waivers in Texas

`	Population Served and Age Group	Effective Date of last waiver modification	Responsible Agency	Average Individual Served per Month (August 2001)	Total Unduplicated Individuals Served per Year (August 2001)	Total Expenditures (August 2001)	Average Per Capita Cost Approved for Individuals (August 2001)
1915 (c) Waivers – Home and community-based waivers (1915(c)) are tools used by states to obtain federal Medicaid matching funds to provide long-term care to patients in settings other than institutions. Waivers must be approved by HCFA and are good for three years, after which they may be renewed every five years. Home and community-based care is increasingly being viewed as a preferable alternative to long-term institutional care, not only for the individual who may remain among friends and family, but also for the state, because services may be provided for less than the cost of institutional care.							
HCS (Home and Community-based Waiver Services) - This Medicaid expansion provides case management, day habilitation, supported employment, dental treatment, respite, nursing, minor home mods., adaptive aids, counseling & therapeutic services, residential assistance service components of supported home living, HC foster/companion care and residential support to MR children and adults. 0110	People with MR who qualify for ICF-MR care.	09/01/98 (last modification effective date)	Texas Department of Mental Health and Mental Retardation	381 people	4,574 people	$189,977, 938	$45,114
MDCP (Medically Dependant Children's Program) – This Medicaid expansion provides respite, environmental accessibility adapts., adaptive aids and adjunct supports for medically dependent children. 0181	Children under 21 who qualify for nursing facility care	9/01/1997 (last modification effective date) *expired 6/08/2001	Texas Department of Health	883	NA	$14515,150	$16,436

Table A9: Description of 1915 (c) Medicaid Waivers in Texas (Page 2)

Waiver Description	Population Served and Age Group	Effective Date of last waiver modification	Responsible Agency	Average Individual Served per Month (August 2001)	Total Unduplicated Individuals Served per Year (August 2001)	Total Expenditures (August 2001)	Average Per Capita Cost Approved for Individuals (August 2001)
HCS-OBRA (Home and Community-based Waiver Services) – The Medicaid expansion provides case management, habilitation, nursing, physical therapy, occupational therapy, speech therapy, psychology, respite, social work, dietary, adaptive aids and minor home mods. One modification to reduce number of counties served by 22, effective 3/1/01 0240	A specific group of individuals with MR and other DDs who were inappropriately placed in nursing facilities	3/01/2000 (last modification effective date)	The Texas Department of Mental Health and Mental Retardation	14 people	170 people	$7,156,721	$49,541
CBA (Community Based Alternatives) – This Medicaid expansion provides personal assistance, nursing services, physical therapy, occupational therapy, speech therapy, respite (in and out of home), adaptive aids, minor home modifications, prescriptions, medical supplies, adult foster care, residential care, and emergency response services to the aged and disabled. 0266	Adults age 21 and over who qualify for nursing facility care.	8/01/1999 (last modification effective date)	The Texas Department of Human Services	26,750 people		$359,855,940	$13,454

Table A9: Description of 1915 (c) Medicaid Waivers in Texas (Page 3)

Waiver Description	Population Served and Age Group	Effective Date of last waiver modification	Responsible Agency	Average Individual Served per Month (August 2001)	Total Unduplicated Individuals Served per Year (August 2001)	Total Expenditures (August 2001)	Average Per Capita Cost Approved for Individuals (June 2001)
DBMD (Deaf, Blind, Multiply Disabled) - This Medicaid expansion provides case management, respite, residential habilitation, day habilitation, skilled nursing, special medical equipment and supplies, chore services, assisted living, intervenor services, dietary services, behavior communications orientation and mobility training, occupational therapy, speech therapy, physical therapy and prescription drugs to individuals having deafness and blindness with multiple disabilities needing care in an ICF-MR. 281	Adults age 18 and over with multi-sensory disabling conditions incurred before age 22 who qualify for ICF-MR-DD care	3/01/1998 (last modification effective date)	The Texas Department of Human Services	98	NA	$3,933,544	40,138
CLASS (Community Living Assistance and Support Services) – This Medicaid expansion provides case management, respite, habilitation, skilled nursing, specialized medical equipment and supplies, extended state plan services , including physical therapy, occupational therapy, speech therapy and prescription drugs, as well as other services including specialized therapies. 0221	People with develop-mental disabilities (incurred before age 22) who qualify for ICF-MR care.	1/01/1998 (last modification effective date) *Additional information received on 2/22/2001 and pending approval	The Texas Department of Human Services	1398 people	NA	$39,825,533	$26,428

Table A9: Description of 1915 (c) Medicaid Waivers in Texas (Page 4)

Waiver Description	Population Served and Age Group	Effective Date of last waiver modification	Responsible Agency	Average Individual Served per Month (August 2001)	Total Unduplicated Individuals Served per Year (August 2001)	Total Expenditures (August 2001)	Average Per Capita Cost Approved for Individuals (August 2001)
CBA – STAR+PLUS (State of Texas Access Reform PLUS Long Term Care Pilot Project) – This Medicaid expansion provides respite, case management, skilled nursing, PERS, prescription drugs, personal assist, adult foster care, assisted living/residential care, adaptive aids and medical supplies, physical therapy, occupational therapy, and speech therapy to the aged and disabled who are 21 years old and over. 0325	CBA clients are included in the STAR PLUS program, which provides managed care, acute and long-term care services		The Texas Department of Human Services	1,643	NA	$32,084,405	$19,527
MRLA (Mental Retardation Local-Authority Pilot Project) – Behavioral Health Organization in Dallas 0330	People with MR-DD are served in a pilot project in 7 counties in which the local mental retardation authority develops service plans and provides case management.	3/01/2001 (last modification effective date) *4/01/2001 waiver modification pending approval)	Texas Department of Mental Health and Mental Retardation	63 people	754 people	$22,552,417	$32,056

Table A10: Description of 1915 (b) Medicaid Waivers in Texas

Waiver Program Name	Program Type	Population Served	Effective Date	Renewal Information	Responsible Agency	Total Number Enrolled as of 7/1/01
1915 (b) Waivers* – Section 1915(b) of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain portions of the Medicaid statute that prevent a state from mandating Medicaid beneficiaries obtain their care from a single provider or health plan. Waivers must be approved by the Center for Medicaid and Medicare Services (CMS) - formerly known as HCFA - and are good for two years with the option to renew for successive two-year periods. As managed care plans have grown in importance over the past decade, more and more states have sought 1915(b) waivers to limit a beneficiary's freedom of choice.						
Status of Medicaid Managed Care – Improvements have been made towards achieving all of the original State's goals except for improved satisfaction of providers. Overall, access has improved, program savings have incurred, inappropriate utilization of services has decreased and processes to monitor and assure quality improvement are in place. However, administrative complexity in the program has increased. Providers are generally dissatisfied with Medicaid managed care, citing administrative complexity, more paperwork, and inadequate reimbursement. Like other managed care programs nationally, Texas has encountered implementation and operational issues. Texas is working to achieve all of the potential managed care benefits while struggling with the obstacles of the transition to value purchasing.						
STAR – Southeast Service Area	PCCM	Requires TANF and TANF-related Medicaid clients to enroll into a managed care health care delivery system. The waiver operates in the following Counties: Chambers, Jefferson, Liberty, Hardin, and Orange.	12/01/93	Approval-04/01/99 Expiration-03/31/01 (operating under extension)	Texas Department of Health	25,846
STAR – Travis County Service Area	HMO	Requires TANF and TANF-related Medicaid clients to enroll into a managed care health care delivery system. SSI and SSI-related clients may voluntarily enroll in managed care. The waiver operates in the following Counties: Travis, Burnet, Blanco, Bastrop, Caldwell, Hays, Lee and Williamson.	Pilot (1 County): 08/01/93 Expansion (8 counties): 09/01/96	Approval – 09/01/99 Expiration-09/31/01	Texas Department of Health	34,273

Table A10: Description of 1915 (b) Medicaid Waivers in Texas (Page 2)

Waiver Program Name	Program Type	Population Served	Effective Date	Renewal Information	Responsible Agency	Total Number Enrolled as of 7/1/01
STAR – Bexar County Service Area	HMO and PCCM	Requires TANF and TANF-related Medicaid clients to enroll into a managed care health care delivery system. SSI and SSI-related clients may voluntarily enroll in managed care. The waiver operates in the following Counties: Bexar, Atascosa, Comal, Guadalupe, Kendall, Medina, and Wilson.	09/01/96	Approval-12/01/00 Expiration-11/10/02	Texas Department of Health	102,257
STAR – Lubbock County Service Area	HMO and PCCM	Requires TANF and TANF-related Medicaid clients to enroll into a managed care health care delivery system. SSI and SSI-related clients may voluntarily enroll in managed care. The waiver operates in the following Counties: Lubbock, Crosby, Floyd, Hale, Lamb, Hockley, Terry, Lynn, and Garza.	10/01/96	Approval-09/01/99 Expiration-08/31/01	Texas Department of Health	24,551
STAR – Tarrant County Service Area	HMO	Requires TANF and TANF-related Medicaid clients to enroll into a managed care health care delivery system. SSI and SSI-related clients may voluntarily enroll in managed care. The waiver operates in the following Counties: Tarrant, Denton, Hood, Johnson, Parker and Wise.	10/01/96	Approval-09/01/99 Expiration-08/31/01	Texas Department of Health	59,762
STAR – Harris County Service Area	HMO and PCCM	Requires TANF and TANF-related Medicaid clients to enroll into a managed care health care delivery system. The waiver operates in the following Counties: Harris, Brazoria, Fort Bend, Galveston, Montgomery and Waller.	12/01/97	Approval-02/01/01 Expiration-01/31/01	Texas Department of Health	174,026

Table A10: Description of 1915 (b) Medicaid Waivers in Texas (Page 3)

Waiver Program Name	Program Type	Population Served	Effective Date	Renewal Information	Responsible Agency	Total Number Enrolled as of 7/1/01
STAR – El Paso Service Area	HMO and PHP** and PCCM	The waiver operates in the following Counties: El Paso, Hudspeth and Culberson counties. The State seeks to enroll 66,499 members by the end of the second year of the waiver period.	12/01/99	Expiration – 11/30/01	Texas Department of Health	74,649
STAR – Dallas Service Area	HMO and PCCM	The waiver operates in the following Counties: Dallas, Collin, Ellis Hunt, Kaufman, Navarro and Rockwall. The State seeks to enroll 76,600 members by the end of the second year of the waiver period.	09/01/99	Expiration – 08/31/01	Texas Department of Health	97,960
LoneSTAR Select I Contracting Program	Inpatient Hospital Selective Contracting	Allows the State to selectively contract with hospitals for non-emergency inpatient services for Medicaid recipients (except dual eligibles and Medicaid managed care clients). Includes: general acute care hospitals and rehabilitation hospitals; "small" hospitals; children's hospitals.	07/01/94	Approval-09/31/00 Expiration-09/30/02	Texas Department of Health	

*Texas Human Services Commission and TDH have been working with CMS to consolidate the eight service area waivers into one waiver in order to simplify the waiver submission and renewal process. The consolidation of eight waivers into one was an administrative change only and did not reflect any substantive changes to the STAR Program. HHSC is expecting approval of the consolidated waiver by CMS by August 11.

**As of 09/01/01 there will be HMO and PCCM available in the El Paso Service Area

Additional Baseline Current Population Survey Data

The data appearing in Tables A11-A23 was extracted from "Analysis of the 2001 Current Population Survey," distributed by the Research and Forecasting Department of the Texas Health and Human Services Commission.

Table A11: Texas Uninsured by Gender

Gender	Percent Uninsured	Percent Insured
Male	51.8%	48.2%
Female	48.2%	51.8%

Table A12: Texas Uninsured by Race / Ethnicity

Race / Ethnicity	Percent Uninsured	Percent Insured
Anglo & Other	31.6%	68.4%
Black	10.8%	89.2%
Hispanic	57.6%	42.4%

Table A13: Texas Uninsured by Age

Age Group	Percent Uninsured	Percent Insured
0 - 6	10.4%	89.6%
7 - 17	19.5%	80.5%
18 - 24	16.5%	83.5%
25 - 34	17.3%	82.7%
35 - 44	16.7%	83.3%
45 - 64	19.0%	81.0%
65 +	0.5%	99.5%

Table A14: Texas Uninsured by Percent of Poverty Category

Percent of Poverty Category	Percent Uninsured	Percent Insured
Under 50%	10.4%	89.6%
51% to 99%	16.6%	83.4%
100% to 149%	17.6%	82.4%
150% to 199%	14.4%	85.6%
200% to 249%	12.3%	87.7%
250% or Higher	28.7%	71.3%

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

U.S. Citizen Status	Percent Uninsured	Percent Insured
U.S. Citizen (Native)	71.4%	28.6%
U.S. Citizen (Naturalized)	4.9%	95.1%
Not a U.S. Citizen	23.7%	76.3%

Table A16: Texas Uninsured by Area of Residence

Area of Residence	Percent Uninsured	Percent Insured
In Metropolitan Area	85.8%	14.2%
Outside Metropolitan Area	14.2%	85.8%

Table A17: Texas Uninsured by Educational Attainment
(Persons 18 and older)

Educational Attainment	Percent Uninsured	Percent Insured
Less than High School	42.5%	57.5%
High School	28.4%	71.6%
Some College or Associate Degree	21.2%	78.8%
College or Higher	7.8%	92.2%

Table A18: Texas Uninsured by Labor Force Status
(Non retired persons 18 and older)

Labor Force Status	Percent Uninsured	Percent Insured
Employed	68.7%	31.3%
Unemployed	7.4%	92.6%
Not in Labor Force	23.9%	76.1%

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

Uninsured Workers By Company Size	Percent Uninsured	Percent Insured
Fewer than 10 Employees	32.9%	67.1%
10 through 24 Employees	13.2%	86.8%
25 through 99 Employees	14.1%	85.9%
100 through 499 Employees	8.3%	91.7%
500 through 999 Employees	4.6%	95.4%
1,000 or More Employees	23.0%	77.0%
Not Reported	4.0%	96.0%

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

Marital Status	Percent Uninsured	Percent Insured
Married	47.9%	52.1%
Widowed	2.0%	98.0%
Divorced or Separated	16.5%	83.5%
Single, Never Married	33.6%	66.4%

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

Presence of Parent(s) at Home	Percent Uninsured	Percent Insured
Both Parents Present	61.8%	38.2%
Only Mother Present	25.1%	74.9%
Only Father Present	3.8%	96.2%
Neither Parent Present	9.3%	90.7%

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

Depende nt / Related Children Under Age 18 by Percent of Poverty Category	Percent Uninsured	Percent Insured
Under 50%	9.5%	90.5%
51% to 99%	22.3%	77.7%
100% to 149%	20.0%	80.0%
150% to 199%	15.9%	84.1%
200% to 249%	11.3%	88.7%
250% or Higher	20.9%	79.1%

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

All Children Under Age 19 by Percent of Poverty Category	Percent Uninsured	Percent Insured
Under 50%	11.1%	88.9%
51% to 99%	21.6%	78.4%
100% to 149%	19.1%	80.9%
150% to 199%	15.8%	84.2%
200% to 249%	11.6%	88.4%
250% or Higher	20.8%	79.2%

Table A24: Texas Counties with the Ten Largest Uninsured Populations

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

Source: Texas Health and Human Services Commission, 2000

Additional Baseline Employer Data

Table A25: Company Size and Health Insurance Status of Small Employers with 2-50 Employees

Company Offers Health Insurance	Number of Employees		
	Mean	Median	Mode
Yes	13.3	9	5
No	9.1	6	4

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

Table A26: Full-time Employees and Health Insurance Status of Small Employers with 2-50 Employees

Company Offers Health Insurance	Number of Full-time Employees		
	Mean	Median	Mode
Yes	11.8	8	5
No	6.8	4	3

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

Table A27: Part-time Employees and Health Insurance Status of Small Employers with 2-50 Employees

Company Offers Health Insurance	Number of Part-time Employees		
	Mean	Median	Mode
Yes	1.6	1	0
No	2.4	1	0

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

Table A28: Contract Employees and Health Insurance Status of Small Employers with 2-50 Employees

Company Offers Health Insurance	Number of Contract Employees		
	Mean	Median	Mode
Yes	0.6	0	0
No	1.0	0	0

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

Table A29: Percent of Companies Offering and Not Offering Employer-based Health Insurance by Industry Sector: Small Employers with 2-50 Employees

Industry	Percent of Companies Not Offering Insurance	Percent of Companies Offering Insurance
Food service	79.1%	20.90%
Agriculture, forestry, fishing	58.9%	41.10%
Retail	55.8%	44.20%
Construction	53.0%	47.00%
No Response	46.4%	53.60%
Services	44.0%	56.00%
Other	40.0%	60.00%
Manufacturing	33.6%	66.40%
Wholesale	32.6%	67.40%
Total	**46.0%**	**54.00%**

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

Table A30: Average Annual Salary of Small Businesses Employees: Small Employers with 2-50 Employees

Average Employee Salary	Percent of Companies Not Offering Insurance	Percent of Companies Offering Insurance
Less than $10,000	86.1%	13.90%
$10,001-$15,000	81.3%	18.70%
$15,001-$20,000	62.9%	37.10%
$20,001-$25,000	46.3%	53.70%
$25,001-$50,000	29.1%	70.90%
$50,001-$75,000	20.0%	80.00%
More than $75,000	27.5%	72.50%
No Response	54.6%	45.40%
Total	**46.0%**	**54.00%**

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

Table A.31: Predominant Wage Type of Employees: Small Employers with 2-50 Employees

Predominant Employee Wage Type	Percent of Companies Not Offering Insurance	Percent of Companies Offering Insurance
Minimum Wage	89.0%	11.00%
Hourly, More than Minimum Wage	55.5%	44.50%
Salaried	33.6%	66.40%
Independent Contractors	66.7%	33.30%
Mix	37.9%	62.10%
Hourly Plus Tips	68.4%	31.60%
No Response	54.5%	45.50%
Total	**46.0%**	54.00%

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

Table A.32: Monthly Employee Contribution for Employee-only Employer-based Insurance: Small Employers with 2-50 Employees

Amount of Monthly Employee Contribution	Number of Responses	Percent of Responses
$0	3,575	63.1%
Less than $50	775	13.7%
$50-75	523	9.2%
$76-$100	356	6.3%
More than $100	439	7.7%
Total	**5,668**	**100.0%**

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

Table A.33: Monthly Employee Contribution as a Percent of Total Premium for Employee-only Employer-based Insurance: Small Employers with 2-50 Employees

Monthly Employee Contribution as a Percent of Total Premium	Number of Responses	Percent of Responses
0%	3,593	62.9%
5%	149	2.6%
10%	159	2.8%
15%	94	1.6%
20%	229	4.0%
25%	490	8.6%
30%	103	1.8%
More than 30%	891	15.6%
Total	**5,708**	**100.0%**

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

Appendix II

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

http://spg.tdi.state.tx.us/conference/binder/index.html.

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

Endnotes

[i] "2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS," Research and Forecasting Department, Texas Health and Human Services Commission.

[ii] "1998 Texas Insurance Population Characteristics," Texas Department of Insurance. March 2000.

[iii] Report to the Blue Ribbon Task Force on the Uninsured by the Office of the Comptroller. May 10, 2000.

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

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

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

[vii] 1998 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality Analysis of Texas Data

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

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

[x] "Texas Health Care Spending," Carole Keeton Rylander, Texas Comptroller. March 2001, pg. 2.

[xi] "Texas Health Care Spending," pgs. 3-7.