

Working Together
for a Healthy Texas



March 2007
Texas Department of Insurance
State Planning Grant Project

Texas State Planning Grant

Insure Houston Pilot Project Plan Summary Report to

**U.S. Department of Health and Human Services
Health Resources and Services Administration
March 2007**

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A. Executive Summary

Texas has a lengthy history of legislative and regulatory attempts to address the problems encountered by citizens who have no health insurance. The reform efforts range from wide-reaching, comprehensive projects that addressed the statewide uninsured population to more limited private and public programs intended to focus on a specific group of uninsured people. The success of these programs has varied considerably over the years, depending on competing needs, budget and political priorities, and other complex factors which have in some cases prevented large-scale expansion programs, particularly when cost estimates and funding resources are difficult to predict. State budget challenges, economic uncertainties, and significant growth in health care expenses within both public and private programs have limited the state's ability to significantly fund or expand new programs. Despite these obstacles, Texas has made progress. Some of the more notable achievements in recent years include: the Blue Ribbon Task Force on Uninsured Texans (1999 -2001); the Texas Children's Health Insurance Plan (CHIP); the Texas Healthy Kids Corporation; the Texas State Center for Rural Health Initiatives; small employer insurance market reforms; the Texas Health Insurance Risk Pool; and the Texas Health Policy Task Force.

While each of these programs has had a positive impact on the uninsured, Texas continues to struggle with a large and growing uninsured population. A variety of factors contribute to the state's high uninsured rate, including: a high percentage of small businesses and lower than average participation in employment-based insurance plans; a high percentage of low wage workers; a higher-than-average population of both legal and illegal immigrants; and a large number of part time, contract and seasonal workers who do not have access to employment based coverage. Though numerous programs for coverage expansion have been considered and, in some cases, implemented, the state continues to face a growing number of uninsured citizens.

Prior State Planning Grant Activities

The State Planning Grant (SPG) program provided a unique opportunity for Texas to develop a new plan for reaching the uninsured in an informed, constructive approach using research and data collected specifically for this purpose. Texas was fortunate to be selected as one of the early SPG recipients, receiving \$1.3 million in 2001 to begin an ambitious study of the uninsured population. The work was continued under a supplemental grant of \$175,000 received in 2003. Working with a diverse and proactive group of stakeholders who served on the SPG Oversight and Implementation Working Group, staff completed a variety of qualitative and quantitative research activities. The information was used to guide the focus towards specific recommendations for coverage expansions, including the Insure Houston Pilot Project. Following is a brief summary of the major components of the completed SPG work:

Small Employer Health Insurance Surveys

One of the most useful components of the State Planning Grant research work, the small employer health insurance surveys conducted in 2001 and 2004 provided valuable information that was used to guide many of the decisions made regarding coverage expansions. The two surveys collected information on small business owners' attitudes and perceptions regarding insurance, their ability and willingness to purchase private coverage, and their preferences with

regard to benefit plan design. The results of the survey have been widely used by interest groups, state agencies, and legislative committees in the discussion about health care and health insurance expansion options.

Survey of Households above 200 Percent of Federal Poverty Level

A telephone survey of uninsured households above 200% of federal poverty level provided detailed analysis 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.

Survey of Health Insurance Carriers and HMOs

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

Focus Group Activities

Focus group meetings played a key role throughout the SPG process and provided extensive information on uninsured employers, employees and individuals throughout the state. A total of 59 sessions were held in all major regions of Texas, providing an excellent overview of the unique challenges faced in different areas of the state. The personal experiences expressed at these focus group sessions were both informative and disturbing, and underscored the importance of continuing this effort to expand insurance to include all Texans. The discussions pointed out the challenges faced by the uninsured, their willingness and desire to pay for coverage if affordable options are provided, and their frustration with a system that they view as overwhelmingly complicated.

Carrier Telephone Survey

During the first year of the SPG study, carriers repeatedly expressed concern with the small employer market, but many of the comments were anecdotal or lacking in detail. To obtain more qualitative information, actuarial consultants conducted a series of discussions with the six largest carriers representing approximately 68% of the small group health insurance market. Insurers/HMOs offered numerous recommendations for improving the market.

Agents Survey

Insurance agents were surveyed for information on company practices that some agents complained were designed to discourage agents from issuing coverage to certain small groups. In addition to providing information on specific carrier activities, agents also answered questions

regarding the small employer market and offered specific suggestions for improvements.

Small Employer Health Insurance Fairs

To obtain additional information from agents, carriers and small business owners, nine health insurance fairs were held in towns across the state. The endeavor was a unique public/private partnership opportunity involving the insurance industry, local chambers of commerce, business associations, and hundreds of small businesses and allowed SPG staff to collect additional information on local market conditions and small employers' concerns with regard to providing affordable coverage.

University-Sponsored Student Health Insurance Study

Young adults ages 18-34 represent more than 40 percent of the total uninsured population in Texas. Many of these young adults attend more than 100 colleges and universities in Texas and have access to relatively inexpensive health insurance coverage, but few are enrolled in these student plans. TDI/SPG staff conducted an extensive study of these plans and the reasons why so few students participate, and outlined several options for expanding coverage through these programs.

Expansion Options for the Texas Health Insurance Risk Pool

The Texas Health Insurance Risk Pool (THIRP) provides coverage for more than 26,000 individuals who have pre-existing health conditions that preclude them from obtaining private health insurance. SPG staff and consultants evaluated several expansion options and submitted a report to the Legislature in January 2005. Although options for expanding the pool were not enacted, several significant changes were made with the goal of providing more affordable coverage.

Consumer Choice Benefit Plans

Throughout the course of the initial SPG study, focus group and survey participants expressed an interest in a less expensive health benefit plan, even if some benefits had to be reduced or eliminated. In response, the Texas Legislature in 2003 abolished the two standard small employer plans and enacted legislation allowing insurers to market "Consumer Choice Benefit Plans", which may exclude or reduce coverage of certain mandated benefits. The plans also offer new flexibility for higher deductible and coinsurance requirements, which can produce significant cost savings.

Pilot Project Planning Grant

The SPG research and data analysis described above provided a wealth of information that clearly indicated a new strategy is needed to increase coverage among small business owners and their workers. The Houston/Harris County area was selected for this pilot because of the high number of small businesses, an estimated uninsured population of 1.3 million residents, and a highly motivated business community that is looking for affordable insurance options. The primary goals of the program are to increase the number of small business owners who provide health insurance and to decrease the number of uninsured residents by providing an affordable,

sustainable benefit plan that covers the majority of health care expenses incurred by a typical person. The benefit plan can then be expanded to other areas of the state, eventually providing a new insurance option for approximately two-thirds of Texas' uninsured population. The ultimate goal is to significantly reduce the number of uninsured Texans by offering an affordable option that will enable small employers throughout the state to offer their workers the insurance protection they need and want.

Using data collected through the small employer survey, focus group sessions and in discussions with insurance carriers, TDI staff worked with the Harris County Healthcare Alliance (the "Alliance"), the Greater Houston Partnership, insurers, providers, and employer and employee representatives to develop a unique, affordable small employer insurance program. Initial requirements for the plan were an average cost of no more than \$150 per month per employee, the inclusion of preventative/primary benefits as well as some limited protection from catastrophic injuries/illnesses, a simplified enrollment and rating process that would reduce the amount of time and effort required for employees to shop for coverage, and that the plan be appealing to both employers and employees to encourage higher employee participation.

Working with consulting actuaries, two benefit plans were developed by the grant staff and the Working Group. One plan focuses on primary and preventative care with limited out of pocket costs and a low annual deductible, but includes length-of-stay limits for hospital care and limits on the number of services for other types of care. The second plan includes a high deductible and limited coverage for primary and preventative care, but provides more extensive coverage for catastrophic care. Under this proposed program, both plans will be offered side-by-side to employers and employees.

To simplify the application process for employers, agents and carriers, the two benefit plans were priced using a modified community rating process, which is a distinct and significant departure from the complex rating system commonly used by carriers in the small group market in Texas. A simple rate chart will be available to employers and agents to immediately calculate the group rate for their workers without going through a lengthy medical underwriting process. The reduced cost, the simplified application and enrollment process, and the carefully designed benefit package are tailored to reflect the specific needs of the small business owners to whom it will be marketed. Each of the design elements included in this proposal are intended to work together to maximize the potential success of the new small employer plan.

After completing the initial plan design, SPG staff conducted 25 focus groups with employers and employees throughout the Houston area. The plans were presented in detail at each focus group, and participants then provided comments and suggestions on how the plans could be improved. At the conclusion of each focus group, employers were asked to indicate in an anonymous survey if they would purchase this benefit plan as it was presented. An overwhelming 88 percent of the employers responded with a definite "yes", even without the minor plan adjustments they suggested. The unique feature of modified community rating was a primary factor in the high approval rating given by focus group participants. Based on participants' survey input and other comments, the consulting actuaries made slight modifications to the plan designs and finalize cost estimates.

For the purpose of providing this health benefit plan, the Alliance intends to create a healthcare purchasing cooperative (the “Cooperative”) as authorized under Chapter 15, Subchapter B of the Texas Insurance Code. The targeted membership will consist of qualified small employers with 2 to 50 eligible employees, and the Cooperative will elect to be legally treated as a large employer. Although the Cooperative will primarily be marketed to uninsured small employers, state law prohibits membership from being restricted solely to this group. Also, membership in the Cooperative will initially be limited to employers whose primary place of business is within Harris County.

On February 21, 2007, the Alliance released a request for proposal (RFP) to select an insurer for the proposed benefit plan. Respondents were encouraged to provide suggestions and/or preferences regarding certain provisions, requirements and duties of both the Cooperative and the successful carrier. Among the most important of these provisions relate to initial and open enrollment periods and administrative services to be preformed by the Cooperative. The carrier, which will perform services under a contract with the Cooperative, must be licensed by the Texas Department of Insurance and must comply with all applicable statutes and regulations. The carrier will serve as the insurance provider of group benefit plans offered to eligible members of the Cooperative. Required services will include enrolling eligible applicants in a timely manner once eligibility for coverage is confirmed; issuing policy forms, member identification cards, summary benefit information and related forms for new members in a timely manner; performing services associated with premium billing and collection; processing and adjudication of claims; providing customer assistance to enrollees and potential enrollees; performing utilization management and quality assurance activities; developing and managing the provider network; and other services as agreed to by the respondent and the Cooperative.

The current deadline for RFP responses is March 30th, after which the Alliance will evaluate each proposal and select the winning carrier. Though implementation will depend on the selected carrier and their negotiations with the Harris County Healthcare Alliance, enrollment is targeted to begin in the summer of 2007. If the plan is successful, TDI will work with carriers and other communities to expand the program throughout the state.

Recommendations to the Federal Government

As a participant in the State Planning Grant Program since 2001, TDI has identified three primary suggestions that the federal government may wish to implement. First, the federal government should consider providing funds for states to develop survey activities on the uninsured on an on-going basis, with certain data requirements that would provide some base-line comparison across states. Second, the federal government should consider conducting a comprehensive study of the effects of ERISA (the Employee Retirement Income Security Act of 1974) on the regulated insurance market and the employers who obtain fully-insured coverage, including an analysis of the impact of lost revenue to states due to the inability to collect premium taxes on self-funded plans. Finally, HRSA should consider a grant program that would allow states to create a program to promote the importance of health insurance as an effective tool for promoting personal responsibility with regard to health insurance and health care.

B. Background and Previous HRSA SPG Accomplishments

For the past 25 years, Texas leaders have struggled to extend health insurance to millions of uninsured residents. Virtually every Governor, Lt. Governor and Speaker in recent history have initiated studies of the problem and debated options for improving access to both health care and health insurance. The success of these attempts has varied depending on budgetary and economic conditions, program logistics and feasibility, and varying levels of support among the affected constituencies. Other factors, such as the vast geographic size of the state, the large number of uninsured citizens, a large population of illegal immigrants, wide variations in local community health care conditions, an emphasis on local control of both money and programs, and the autonomy of many competing interest groups create a difficult environment for reaching consensus on any significant expansion idea.

The State Planning Grant staff, as well as other groups described below, have studied efforts in other states and, in some cases, have used other state models as a guideline for developing ideas for Texas. For example, the Texas Healthy Kids Corporation was developed based in large part on a similar program in Florida. Several of the final recommendations that were included in the Blue Ribbon Task Force report also were based on other states' programs. A number of Texas' Medicaid waiver concepts have used other states' successful waiver programs as a starting point, and the State Planning Grant Working Group considered extensively several concepts implemented in other areas, such as three-share plans and state-wide purchasing cooperatives. However, reaching consensus on any significant change is a time-consuming, labor-intensive and expensive process involving literally thousands of stakeholders who often have different priorities. While the activities across the country have certainly paved the way for some changes and have served as useful resources, duplicating the process is a challenge at best, and impossible in many cases.

1) Previous State Efforts to Address the Uninsured

Though Texas continues to struggle with providing coverage for a large uninsured population, the state has a number of successes to its credit. The following summaries highlight some of the more notable efforts in recent years.

A) Blue Ribbon Task Force on Uninsured Texans: 1999-2000

Senate Concurrent Resolution 6 passed by the 76th Texas Legislature (1999) and signed by Governor Bush authorized creation of the Blue Ribbon Task Force on Uninsured Texans. The members were appointed by Governor Bush, Lieutenant Governor Perry and Speaker Laney in September, 1999 and the Task Force was directed to perform targeted studies of the unique problems of the uninsured; review demographic trends; examine other states' programs; evaluate existing programs in Texas and how they address indigent health care needs; and develop recommendations to ensure all Texans have access to affordable health care coverage.

Beginning in September 1999, the Task Force held hearings throughout the state to hear first-hand testimony regarding problems of the uninsured and the providers that serve them, and to invite suggestions for improving insurance access and affordability. Much of the testimony focused on the problems of the uninsured and the financial difficulties local communities

experience in caring for this growing population. Local health care officials and stakeholders offered data and suggestions, which helped formulate the Task Force's recommendations. Proposals were also solicited from the business community, consumers, insurers, academicians, health care providers, and others with expertise and interest in the Texas health care delivery system. The Task Force issued a report in 2001, and included a number of recommendations. While a few of the concepts were eventually enacted, others were not due primarily to a lack of consensus and budget concerns.

B) Children's Health Insurance Plan

Enactment of the Texas Children's Health Insurance Plan (CHIP) represents a significant milestone for Texas policymakers in reaching consensus on how to assist one of the largest segments of uninsured: children. Due to Texas' biennial legislative schedule, CHIP coverage could not be implemented in Texas as early as in other states. To encourage maximum participation, an aggressive marketing and outreach campaign was implemented in both English and Spanish. Marketing was coordinated with area state agencies, through school districts, local public health offices, health care providers, various human services offices, non-profit service organizations and other community groups. The TexCare Partnership, a public-private entity, was established for the purpose of coordinating enrollment in CHIP, Medicaid and the Texas Healthy Kids Corporation and to assist parents with any questions or problems related to enrollment. After just three months, a total of 36,164 children enrolled. Enrollment continued to grow significantly during the first three years, and more than 500,000 children were enrolled by March 2003.

At the same time, the Texas Legislature faced a \$10 billion budget shortfall, and, like other states, was forced to implement significant budget cuts. In March 2003, under the existing benefit and eligibility provisions, cost projections for the state's contribution for FY 2003 CHIP benefits were estimated at \$201.6 million and were expected to increase to \$212.3 million in FY 2004 and \$230 million in 2005. Faced with equally significant cost increases under Medicaid, a depressed economy and reduced general revenue, the Legislature made the difficult decision to amend both the CHIP and Medicaid programs to reduce costs. Eligibility changes and benefit reductions were adopted to save an estimated \$1.6 billion. Largely as a result of these changes, CHIP enrollment declined to 330,393 as of February 2005. Since those changes were adopted nearly two years ago, the Texas economy has improved and the Texas Legislature has restored some of the benefit reductions adopted in 2003.

C) Texas Healthy Kids Corporation

The Texas Healthy Kids Corporation (THKC) was created by the Legislature prior to passage of the federal SCHIP legislation. Established in 1997 to facilitate access to affordable health insurance for children, THKC was a non-profit corporation that administered a program through which families could purchase health insurance from several participating health insurers and HMOs. Coverage was available statewide through a variety of benefit plans and delivery systems. The plan benefits were designed to cover the needs of children between the ages of 2 and 17 who had no other insurance.

During the first year of coverage, premiums under THKC ranged from approximately \$40 to \$80

a month per child depending on the health care plan selected and the location of the insurers. However, losses exceeded health plan expectations, and rates were increased to an average of about \$92 per child statewide in July 1, 2000. This increase, along with a dramatic decrease in enrollees due to the transition of eligible children to the CHIP program, resulted in the discontinuation of the program in 2002.

D) Texas State Center for Rural Health Initiatives

The Center for Rural Health Initiatives is continually involved in a variety of activities involving both state agency resources and private partnerships that focus on improving access to health care within rural communities. One of the primary goals is to increase the number of rural Texans with health insurance. The Center has coordinated statewide “health care summits,” as well as several local summits, for the purpose of promoting cooperation among various state agency representatives, providers, and local residents. The summit participants have discussed local problems regarding access to health care, concerns about HMO practices that discourage providers from serving rural communities, affordability of health insurance, and a variety of other issues that are specific to rural areas. Ongoing working groups have been developed within the communities to develop public-private solutions to these and other local health care problems. The Center continues to coordinate working group sessions and discussions that hopefully will lead to specific recommendations.

E) Small Employer Insurance Reforms: 1993-2003

Of the four million uninsured adults in Texas, more than two-thirds are employed. An estimated 80 percent of uninsured children reside in families where at least one parent works. These statistics indicate that providing access to affordable coverage for employees without insurance would significantly reduce the number of uninsured Texans. Focusing on that fact, the Texas Legislature in 1993 adopted the Small Employer Health Insurance Availability Act for the purpose of improving availability and affordability of health insurance for small employers. The Act was subsequently amended in 1995, and minor revisions were adopted in 1997 to comply with the federal Health Insurance Portability and Accessibility Act requirements. The reforms apply to all small employers with 2 to 50 employees, and include the following provisions:

- Guaranteed issuance of health insurance, regardless of health status;
- Portability and continuation of coverage options for employees who want to keep their coverage when they leave a job;
- Limitations on pre-existing condition requirements;
- Availability of reduced-benefit plans (basic and catastrophic standard plans) designed to provide more affordable coverage;
- Rate restrictions and premium increase limitations; and
- Mandatory reporting of certain information to monitor compliance and effectiveness of reforms.

Since the first reforms were implemented in September 1993, the number of small employers with health insurance has nearly tripled from 36,952 in 1993 to 86,106 in 2005. Whereas in 1993 only 10.6 percent of small employers offered health care benefits, 24 percent did so in 2005. While these increases are significant, they still fall far short of the intended goal. During

the past few years, the Texas Department of Insurance (TDI) has worked continuously with legislators, employers, insurers and providers to determine how the reforms can be more successful and to consider additional changes that could further improve the small employer market. The State Planning Grant work has focused largely on small employer options, and has served as the impetus for several recent changes including: development of the small employer rate guide; changes in regulations addressing marketing activities related to small employer plans; revisions in statutes and regulations enabling the creation of small employer purchasing cooperatives; and changes in the benefit plans that are required to be offered to all small employers. Additional reforms are under consideration and discussions with legislative leaders, insurers, health care providers, agents and other stakeholders are ongoing.

F) Texas Health Insurance Risk Pool

The Texas Health Insurance Risk Pool (THIRP) became operational in 1997 to meet requirements of federal law which required states to guarantee access to health insurance for certain eligible individuals. Texas chose to extend pool coverage to any state resident under the age of 65 who: 1) has been unable to obtain insurance due to health reasons; 2) can only obtain coverage that limits or excludes coverage for a pre-existing condition; or 3) can only obtain coverage at a premium rate greater than the current Texas Health Insurance Risk Pool rate. State law stipulates that THIRP's premium costs for individuals cannot exceed 200% of the standard rate for comparable individual health insurance. Losses to the pool in excess of premiums collected are paid through assessments on insurers and HMOs in Texas. Premium rates for the first year were set at 137% of the standard rate, but they have since increased to the current maximum level of 200 percent after several years of relatively high claims experience and increasing assessments.

The Legislature's goal in creating the THIRP was to provide access to quality health care for those individuals who could afford insurance but could not obtain coverage, while minimizing the cost to the public and protecting the availability of traditional health insurance for consumers in the voluntary commercial market. Currently there are more 26,000 Texans enrolled in the Pool. Changes were recently adopted by the THIRP governing board in an attempt to keep premium costs as low as possible, enabling more Texans to enroll. Despite the relatively high costs, the Pool continues to grow each month, providing a viable alternative for residents who cannot obtain health insurance through any other mechanism.

G) Texas Health Policy Task Force

Ten years ago, the Texas Legislature authorized an independent task force to conduct a comprehensive study that would provide recommendations for providing all Texans access to health care. The 29-member task force included six Senators, six Representatives, 13 public members representing a diverse group of stakeholders, and four state-agency directors involved in the provision or regulation of health care. Following a twelve-month study involving hundreds of various participants, the Texas Health Policy Task Force issued a lengthy report that included more than 80 specific recommendations. Over the next few years, many of the recommendations were adopted in the form of legislation or regulatory changes. As the Task Force acknowledged, some recommendations stood little chance of success given the difficulty of drastically changing health care policy direction, and the reality of budget restrictions that

discourage adoption of new programs with many “unknown” cost factors. However, despite the philosophical differences that existed among members of the task force, the final report provided a very comprehensive, though not unanimously supported, list of ideas, some of which are being reconsidered at this time.

2) HRSA State Planning Grant Activities

Because Texas has a large, diverse group of uninsured citizens, the stakeholders who participated in the initial State Planning Grant study determined early on that an effective approach to the state’s uninsured problem would require a multi-faceted, incremental plan. Texas, like other states, faced an uncertain economy and the state Legislature struggled with a \$10 billion budget deficit. As such, after preliminary discussions about the focus of the program, the Working Group acknowledged that a significant expansion of public programs (Medicaid or SCHIP) was an unreasonable goal and chose instead to focus on private market expansion options. After collecting and analyzing initial demographic data, certain population characteristics were apparent that directed the focus of additional research and program development activities:

- Most uninsured Texans are employed or live in a family with at least one full-time employee, but they often work for small businesses that do not offer insurance.
- While the majority of uninsured are from low-income families, approximately two million uninsured Texans have incomes above 200% of the federal poverty level and would likely be able to afford the employee’s insurance contribution if their employer offered coverage.
- More than two million of the uninsured (40 percent) are young adults ages 18-34, who are generally healthy, and may choose to go without insurance even if they can afford it, suggesting that education is an important factor in encouraging young adults to purchase coverage.

Based on these factors and other information, most SPG activities focused primarily on ideas for expanding private insurance coverage among small employers and young adults. Following is a discussion of the various grant activities. Full reports on all the research and survey activities are available at <http://www.tdi.state.tx.us/company/spg.html>.

A) Small Employer Health Insurance Survey

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

Despite the accomplishments under the original grant study and subsequent action by Texas Legislature and other stakeholders, small employers continue to face problems when shopping for affordable health insurance. To evaluate the effectiveness of previous efforts and determine what changes have occurred within this particular population, small employers were re-surveyed in March 2004. Though some new questions were added to the survey to address changes that have since occurred, many questions remained the same. Due to a more limited budget, only 20,000 surveys were mailed. A total of 4,303 usable survey responses were received, which represents a response rate of over 21 percent. Significant survey findings that contributed to the development of the Insure Houston Pilot Project include:

- The primary reason employers do not offer insurance is still because it is unaffordable; 54 percent of employers reported they can afford \$100 a month or less per employee for health insurance premiums; 34 percent can pay \$50 or less, and 14 percent would not purchase insurance at any cost.
- The majority of employers (81 percent) believe employers should provide insurance if they can afford to do so. In a separate question, however, only seven percent indicated they believe employers are *primarily* responsible for assuring people have coverage. Forty-one percent believe individuals are themselves responsible; 32 percent said the federal government is responsible, and 12 percent believe state governments are responsible.
- Of those employers who currently offer insurance, 18 percent are very likely to discontinue coverage within the next five years; 24 percent report they are somewhat likely to do so.
- The majority of employers (69 percent) said it is more important for government to focus on improving access to affordable health insurance than improving access to affordable health care (26 percent).
- When small businesses do offer coverage, employees often are unable to afford their contribution. This is particularly true of “family coverage.” Workers in small businesses often must pay a higher share of the premium cost. The average cost of family coverage for small businesses is more than \$10,000 a year per-employee, and many workers must pay 50 percent or more of the cost. For low-wage workers, this expense is truly unaffordable. A significant decrease in cost would be necessary in order for many of these workers to “take up” the health insurance that is available to them.

B) 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 because 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 was 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.
- Most of the non-poor uninsured are employed in small firms; 39 percent work in firms with less than five employees and 20 percent in firms with no more than 30 employees.

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 fully-insured health insurance market in Texas. Companies provided information on health insurance premium rates and how those costs vary by group size; claims cost information; data regarding small employer plans required to be offered under Texas law; the prevalence of stop-loss coverage and administrative-services-only (ASO) contracts; the extent to which managed care plans are offered; and other information. Survey results include:

- For HMOs, the average annual premium costs-per-person for small employers ranged from \$1,866 to \$10,188, with an overall average of \$3,748 in 2004. Average annual premium costs-per-person for large employers ranged from \$1,136 to \$3,713, with an overall average of \$2,777.
- For insurance carriers, the average annual premium costs-per-person for small employers ranged from \$2,223 to \$9,294, with an overall average of \$3,679 in 2004. Average annual premium costs-per-person for large employers ranged from \$1,238 to \$3,903, with an overall average of \$2,829.
- Total claims paid for 20 mandated benefits for group coverage represented 4.92 percent of all claims paid in 2005. Each of the mandated benefits represented less than one percent of total claims paid, and 17 of the benefits represented less than one half of one percent of all claims paid. The three most expensive mandated benefits were diabetes education and supplies (0.74 percent of all claims), reconstructive breast surgery following a mastectomy (0.66 percent of claims), and serious mental illness (0.54 percent of claims).
- The number of small employers with health insurance has increased significantly since

1993, but the numbers have declined slowly since 2000 when more than 1.4 million individuals were covered under small employer benefit plans. In 2005, carriers reported 86,106 small firms provided health insurance covering 1,102,135 people.

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 very important and often discouraging, 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.

E) Carrier Telephone Survey

During the first year of the SPG study, carriers repeatedly expressed concern with the small employer market, but many of the comments were anecdotal or lacking in detail. To obtain more qualitative information, the actuarial consulting firm Milliman USA conducted a series of discussions with six of the largest carriers representing approximately 68% of the small group health insurance market based on the percentage of premiums written. Milliman worked with SPG staff to develop a survey form which was mailed to the carriers in advance of the phone interview. Milliman spent several hours speaking with representatives from each company to discuss the survey questions and obtain input from the carriers on various issues related to improving the insurance market for small businesses. Major findings from the survey include:

- Carriers believe the standard basic and catastrophic insurance plans are outdated and do not fulfill their intended purpose to guarantee availability of a lower cost plan.
- Carriers indicated that several provisions of the current small group statutory and regulatory requirements contribute to higher premium costs. They specifically mentioned mandated benefit requirements, clean claims legislation that requires timely payment of

insurance claims, and rate band restrictions as contributing factors.

- Carriers expressed no interest in participating in purchasing alliances, despite the high interest expressed by small employers. Carriers do not believe alliances will result in lower premium rates for small employers.

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

F) Agents Survey

In 2002, SPG staff conducted a survey of group health insurance agents to obtain information related primarily to the small employer group market. During several focus group meetings and in discussions with agents attending the small employer insurance fairs, insurance agents repeatedly complained about carrier activities that penalized agents for writing certain types of small businesses, and appear to be in violation of legislative and regulatory requirements. However, very few agents were willing to go "on record" with a formal complaint due to concerns that the company would retaliate against the agent since closed complaint records are not confidential under Texas law. Carriers that participated in the survey mentioned above also acknowledged that agents were reluctant to identify specific companies, and suggested that TDI conduct an anonymous survey to protect agents' identities.

The agent survey was initially sent to approximately 350 active agents. Due to a low response rate, an additional 300 surveys were distributed. Agents were encouraged to return the surveys anonymously, though many agents voluntarily included their name and contact information in case staff needed additional information. Where possible, agents were asked to include supporting documentation of certain activities, and were instructed to delete any information that would identify either the agent or the client. At the end of six weeks, SPG had received 94 completed surveys. Though the response rate was lower than expected, the agents that participated provided excellent information and frequently attached supporting documentation. Information on specific claims against various carriers has been provided to staff at the Texas Department of Insurance for appropriate investigation.

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

- Develop cost-effective plans that provide employers with less comprehensive coverage and more affordable rates;
- Reduce participation and contribution requirements to allow more small businesses to meet carriers' requirements;
- Allow carriers to offer a benefit plan that does not include the mandated benefits required by law;
- Increase oversight of carriers' activities that are in violation of state law and are designed

- to discourage agents from submitting higher risk groups; and
- Assist and protect agents through better enforcement of laws and regulations related to agent commission payments that are intended to encourage agents to write more small businesses.

Several of these recommendations have already been implemented by TDI, and legislation on others has been considered. The Insure Houston Pilot Project focuses on the primary recommendation of developing reduced cost benefit plans for small businesses, which we believe will be strongly promoted by agents in Houston and throughout the state.

G) Small Employer Health Insurance Fairs

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

H) University-Sponsored Student Health Insurance Study and Survey

Nearly one million young adults ages 18-24 are uninsured, representing 17.2 percent of the total uninsured population in Texas. Also uninsured are an additional 1,222,205 adults ages 25-34, representing 22 percent of the uninsured. Many of these young adults attend more than 100 colleges and universities in Texas. While many of these schools offer student health insurance, most only require certain foreign students and students participating in health services education programs to have insurance. Other schools do offer coverage, but no study has been conducted to determine which schools offer coverage, the number of students who participate, the benefits provided, premium costs, or claim experience. Because this population is generally healthy and often less costly to insure, a plan for providing insurance options through student health insurance plans (SHIP) may be a viable, cost-effective option that targets this large population group.

After conducting some initial research and interviewing several of the state's largest universities' insurance administrators, SPG staff developed three separate surveys to collect information related to student coverage: 1) a comprehensive survey was mailed to more than 150 colleges and universities to obtain information on the availability of and details regarding school-sponsored health insurance options; 2) a survey of insurers who provide school-sponsored insurance was sent to the carriers identified by the schools as providing coverage; and 3) a student survey was completed by more than 1,000 students, providing information on students' perspective regarding college-sponsored coverage. Primary findings from the study include:

- The average cost for student-only coverage in a SHIP ranges from \$718 to \$786 per year.
- Students at the highest risk of being uninsured include non-traditional aged students, single parents, Hispanic students, students not in good health, students not required to have coverage by their college, students whose education is primarily financed by the military, and students in their senior year.
- Seventy-eight percent of surveyed college students said that health insurance coverage is very important, 20 percent said it is somewhat important, and only two percent reported thinking that coverage is not important.
- Only 12 percent of Texas colleges require all students to have health insurance.
- Average enrollment in student health insurance plans was 11 percent in 2003.
- The ability to pay for insurance coverage as part of tuition and fees and the requirement that students must accept or reject coverage during registration are both linked to significantly higher enrollment rates.

The final report included recommendations on options for expanding coverage through student insurance plans and was provided to state leaders and members of the Legislature.

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

The Texas Health Insurance Risk Pool is a statewide insurance program for uninsured individuals who have pre-existing health conditions that preclude them from obtaining private health insurance. The Pool serves as the state's mechanism to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) provision which requires states to provide guaranteed access to health insurance for certain individuals. The Pool provides comprehensive insurance benefits with a range of deductible and coinsurance options. Although premiums are not cheap, the pool is generally considered very successful with a current enrollment of 28,075 people.

Due in part to the Pool's success, there is considerable legislative interest in expanding it to include more individuals and, perhaps, some groups (such as small businesses). As part of the grant activities, staff directed a study of alternatives for expanding THIRP enrollment. The final report was submitted to the Legislature in January 2005, and several related legislative proposals were introduced. Legislative changes finally enacted focus primarily on the assessment methodology used to providing funding that subsidizes THIRP losses.

J) Consumer Choice of Benefit Plans

Throughout the course of the initial SPG study, focus group and survey participants expressed an interest in a less expensive health benefit plan, even if some benefits had to be reduced or eliminated. Insurers also advocated for lower cost benefit plans and freedom to eliminate certain mandated benefits. In response, the Texas Legislature in 2003 abolished the two standard small employer plans and enacted legislation allowing insurers to market "Consumer Choice Health Benefit Plans" to small and large employer groups, and individual insurance applicants. These new plans provide comprehensive benefits, but insurers may eliminate or reduce coverage of specific mandated benefits such as contraceptive drugs and devices, home health care services, and treatment for chemical dependency. The plans also offer new flexibility for higher

deductible and coinsurance requirements, which can produce significant cost savings. An evaluation of the plans by SPG staff and consulting actuaries show that savings estimates vary widely among carriers, and most premium reductions are due primarily to increases in coinsurance requirements. The plans have been relatively successful in reaching people who previously had no coverage. In 2005, a total of 87,675 Texans were covered under the plans, including 7,325 who previously were uninsured.

K) Statewide Symposium and Conference

In May, 2004, a symposium was held in Austin to provide a forum for various stakeholders to discuss the uninsured problem in Texas and exchange information on local initiatives. Due to the size limitations of the facilities, attendance was limited to 120 people. The one-day working forum was attended by legislative staff as well as representatives of the insurance industry, physicians, hospitals, consumer advocates, public health officials, employers and other stakeholders. Separate break-out sessions were held to discuss topics including: public programs and options for expanding coverage; employer sponsored insurance; the Texas Health Insurance Risk Pool and options for better meeting the needs of the “uninsurable;” and health care access, education and improvement. The symposium included a “poll the audience” activity using an electronic voting system that allowed the audience to express their response to a variety of questions related to uninsured Texans. A complete report on the polling responses is available on the Texas SPG website at <http://www.tdi.state.tx.us/company/spg.html>.

Under the original grant, the SPG staff also hosted a statewide conference on January 31 - February 1, 2002. The focus was to review all survey and research activities, present the results 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.

3) Options for Expanding Coverage

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

Throughout the course of this project, SPG staff and Working Group members remained keenly aware of the diverse interests and needs of uninsured individuals and political subdivisions across the state and the importance of developing realistic options in a changing political environment. To add to the challenge, Texas, like other states, experienced significant economic

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

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

However, recognizing that we could not wait for finalized data to begin discussions about insurance expansion options due to time constraints, the SPG staff and Working Group members began researching other states' programs and developing background information on a wide range of options early in the process with the understanding that the viability of the options might be affected by the survey results. Initially, any and all ideas for expanding coverage were open for discussion. Working Group members were provided a notebook with extensive information on all options prior to the first meeting at which they were discussed, and materials were placed on the SPG website for others to review. In addition, public meetings were held to present and discuss information on more than 20 different policy options that included a wide range of ideas. These included: creation of a state-supported purchasing alliance for small businesses; Medicaid and CHIP expansions to include low-income parents; restructuring of Medicaid benefits to expand coverage to additional people; establishment of a CHIP "buy-in" program; opening enrollment in the state employees' insurance plan to small businesses and/or individuals; creation of small employer tax incentives; mandating insurance coverage for businesses and individuals under contract with the state; providing subsidies for enrollment in the Texas Health Insurance Risk Pool; low-wage worker subsidies for small businesses; development of an insurance education and information program for small businesses; development of a two-tiered premium system for the Texas Health Insurance Risk Pool to encourage enrollment of healthy family members; and revising the small group standard insurance policies to increase interest and affordability. (Note: an employer buy-in program

under SCHIP was not considered by this group since the 77th Legislature directed that such a program be implemented by the state Health and Human Services Commission. Texas already has an employer buy-in program under the state Medicaid program.)

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

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

Throughout the following 18 months, the SPG staff continued working with stakeholders to refine and focus on specific options. Though the Working Group officially ended, several key members and legislative staff have continued to work with SPG staff and TDI on several of the concepts. Additional research was completed under the Supplemental State Planning Grant, and several options were implemented. Others were more fully developed and defined, including the Insure Houston Pilot Project, so that implementation could be seriously considered. The following is a brief overview of the small employer insurance market reforms, insurance education and outreach approaches, and CHIP buy-in options that received extensive evaluation and widespread support.

A) Small Employer Insurance Market Reforms

The majority of people with health insurance in Texas and throughout the United States obtain coverage as a benefit provided by their employer. In 2004, an estimated 53.2 percent of Texans were insured under employment-based plans. However, many working Texans are employed at firms that do not offer insurance, and many of these businesses are small firms with 50 or fewer employees. Small business employees and their families are about twice as likely to be uninsured as workers employed by large firms, and firms with 25 or fewer workers are even less likely to offer coverage than those with 25 to 50 employees. In 2005, approximately 40 percent of employees working in firms with less than 25 employees were uninsured, and these workers

represented 44 percent of the state's total uninsured employees.

Numerous studies have examined the reasons why small employers do not offer health insurance. Factors most often cited include: unaffordable premium costs; the presence of pre-existing health conditions which make the group uninsurable; a high number of low-income workers; high employee turnover; and lack of interest among employees. While some of these problems are inherent in the nature of a small business, Congress partially addressed these issues in the Health Insurance Portability and Accountability Act 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. Some of 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 86,106 small employers provided health insurance benefits for their employees in the year 2005. Though this number is up significantly from 36,952 in 1993, it still represents only 26 percent of all small firms in Texas. Most small employers continue to not offer health insurance.

The small employer surveys conducted in 2001 and 2004 by the State Planning Grant helped provide a better understanding of the reasons why small firms in Texas do not offer coverage. The survey requested information on why employers do not provide insurance and what type of changes they would like to see implemented to make insurance more affordable and attractive to small business owners. This information, along with suggestions provided by focus group participants and ideas from other states, directed the development of several options designed to address the low number of small employers with health insurance, which are summarized below.

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

The basic and catastrophic benefit plans introduced in 1996 were extremely unpopular. Although these plans were intended by the Legislature to provide employers with a lower cost, limited benefit plan, rate information collected by TDI suggests that the plans were not significantly less expensive than the traditional comprehensive plans sold by carriers. Insurers reported that employers were not interested in the plans, but data collected in the SPG small employer survey indicates that 80 percent were not even aware the plans existed. Employers who participated in the focus group sessions also were not familiar with the plans. At the same time, numerous employers specifically suggested that the state should adopt a standard benefit plan to make it easier for small employers to shop for and compare insurance policies. As such,

it is not clear whether the policies were truly undesirable, or if other factors were to blame for their failure. Some agents indicated that companies discouraged them from selling the standard plans, while others reported that they were unable to even obtain quotes when requests are submitted to the carriers. Other anecdotal information suggested that agents received lower commissions when selling the plans and, therefore, had no incentive to actively market them to their clients.

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

Data collected in calendar year 2004 shows that 17,445 Texans were covered under the new Consumer Choice plans, including 4,283 people who were previously uninsured. In 2005, the plans covered 87,675 people, 7,325 of whom were previously uninsured. Cost savings reported by carriers vary widely. Most savings are attributed to increases in consumer coinsurance requirements rather than changes in mandated benefit coverages. Generally, carriers reported less than three percent savings due to mandated benefit exclusions/reductions.

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, under state law carriers develop rate calculations based on several standard factors, including applicants' age and gender, health status, the location and size of the group, and type of industry. Based on these different characteristics, insurers determine how much risk a particular group represents and calculate a rate accordingly. As a result, any one of these characteristics may result in a significant increase or decrease in a particular person's rate, even when they are part of a group. For example, in general, the older a person is, the higher the insurance rate for that person. Therefore, a 24 year old healthy male will pay considerably lower premiums than an equally healthy 50 year old male. Because of the ability to rate group members as individuals, insurance costs for small firms vary significantly based on the characteristics of the group members. As such, it is possible that a business with only eight employees may pay significantly higher insurance costs than a larger firm with 15 employees if the smaller business has employees who are older and/or less healthy than the employees at the larger firm.

These disparities have led many states, including Texas, to enact rate reforms designed to limit wide rate differences within the small employer market. New York implemented a true "community rating" system that basically requires all insured people to pay the same rate, regardless of age, sex, health status, location, etc. Community rating generally lowers rates for high-risk individuals, while increasing rates for young, healthy applicants who are considered low-risk. For example, a 25-year-old healthy male pays the same premium as a 50-year-old unhealthy male. By spreading the risk equally across all people, the objective is to provide lower rates overall for more people so more people will purchase insurance. While this concept is appealing in theory, true community rating may not produce the desired affect. Because younger, healthy people will immediately experience significant rate increases, some will drop coverage rather than pay the higher rates required to subsidize the older, less healthy people. Over time, if additional young, healthy people opt out of the system, rates will continue to increase, possibly causing still more people drop coverage. Eventually, rates may become unaffordable for everyone due to the "adverse selection spiral."

States have implemented an assortment of rating reforms and experienced varying degrees of success. Texas law is generally considered to be less restrictive than many other states, as it allows small employer carriers to adjust premium rates based on age, gender, area, industry, and group size. Rates can also be increased up to 67 percent on the basis of health status. Before the reforms of 1993 and 1995, carriers had few restrictions on both underwriting and rating of small groups. While the reforms have lowered rates for some groups that previously were not subject to any limitations and faced much higher costs, some employers would like to see the rate bands limited even more. There is also some support for further restricting or eliminating the ability to use health status factors in calculating rates, a practice that is already effective in some other states. Others believe the rating reforms have already gone too far and support broadening or eliminating the rate band restrictions.

To evaluate how these different approaches might affect rates over a long period of time, Milliman USA examined the potential impact of four rating options. These options included community rating, modified community rating (which does not allow rating for health status), an allowed rate band of +/-10 percent, and the current allowed rate band of +/-25 percent. For each rating option, Milliman examined four different consumer groups: 1) young low risk; 2) young high risk; 3) older low risk; and 4) older high risk. To isolate the impact of the rating options, Milliman assumed that the expected cost of each group stayed the same for all three rating years (i.e. no medical trend). Assuming the groups that pay the greatest subsidy are the most likely to lapse, Milliman assumed that the young low risk group lapsed at the end of year one and the older low risk group lapsed at the end of year two. The community rated and modified community rated plans provided combined two-year rate increases of 40 percent. As discussed earlier, this can create an "adverse selection spiral." 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. A more detailed discussion of this analysis is provided in materials on the SPG website at <http://www.tdi.state.tx.us/company/spg.html>.

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

A change in the rating methodology would require legislative action. Though some groups have supported changes in recent years, no legislation has been enacted.

3) Create a small employer purchasing alliance

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

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

In 2003, the Texas Legislature addressed some of the questions and concerns about the laws allowing purchasing alliances and clarified language to enable more employers to participate. They also authorized the formation of “coalitions” which are available only to small employers. While there are important distinctions between “cooperatives” and “coalitions” under Texas law, both allow multiple employers to join together to purchase insurance. As of August 2006, 33 cooperatives and coalitions were registered with TDI. Though some carriers have been reluctant to provide coverage to these groups, participation appears to be increasing as more actuarial experience becomes available and agents become more informed on how the process works.

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

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

B) Insurance Education and Information for Individuals and Small Businesses

Among the most common issues raised by focus group participants in 2001 and again in 2005 was the difficulty of purchasing insurance and a general lack of information available to assist them in understanding the choices available to them. Uninsured individuals and small business owners specifically requested that the state provide more consumer oriented information to help shop for health care coverage, and employers in particular wanted a rate guide to serve as a resource for comparing prices. Several options were developed to respond to these specific requests for assistance.

1) Publish a small employer rate guide

Both individuals and small employers complain about the inability to compare health insurance premium rates due to the extensive variation in benefits and plan designs. Participants in focus group sessions expressed overwhelming need for a rate guide that would allow them to compare insurance prices. Several specifically referred to the Medicare supplement rate guide published by TDI and suggested that the state publish a similar guide for both individual and small group health insurance. Employers stated they find it difficult and intimidating to shop for insurance, and would like to have a “non-biased” resource that would provide 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 consensus among focus group participants was that agents are primarily motivated by commissions. Without some means of comparison, employers have no way to evaluate premium prices and have no choice but to rely on the information provided by their agent. Employers also pointed out that the amount of time they can afford to spend shopping for insurance is much more limited than for a large company with a human resources department, and they welcome anything that can be done to simplify the process.

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 a detailed health application for each employee and dependent seeking coverage. The agent provides a basic rate quote based on selected group characteristics, but the final quote is not available until after the underwriting department has reviewed the application of each group member. Numerous employers even felt that some agents deliberately underestimate the initial premium quote by excluding detrimental information the employer has

told them about the group. However, in order to get the final premium rate, the employer is often 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 this lengthy and time-consuming process with one company, many employers do not have the time to start the process over again and are reluctant to terminate the coverage they already have. As a result, employers and their employees often remain uninsured despite the significant time and effort they have invested in shopping for coverage.

While developing a rate guide poses some challenges because of the lack of uniformity among policies, several states have successfully developed guides using hypothetical individual and group applicants. Based on a review of those guides and using recommendations developed by Milliman USA, TDI developed a Texas small employer rate guide in the fall of 2002. The rate guide provides basic rate estimates for typical HMO, PPO and indemnity plans offered by small employer carriers, and it also includes cost estimates for the new Consumer Choice Plans. Insurers are provided guidelines for rate submissions using age, sex and geographic rating factors. Employers using the guide are also provided instructions on how to use the rate quotes and informed of the limitations of the standard premium estimates. Most importantly, the information provided to employers stresses that the quoted rates represent estimates and that final rates will vary from the sample rates quoted in the rate guide. Despite these limitations, the rate guide is a valuable tool that allows employers to both become aware of the approximate cost of coverage in their area and compare rates using standard factors. The small employer rate guide is available for 11 separate Texas cities, and it is updated regularly on the TDI website at <http://www.tdi.state.tx.us/consumer/serg01.html>.

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

Throughout the SPG project, small employers in particular have expressed interest in meeting with representatives from the Texas Department of Insurance to discuss questions about health insurance and to receive advice about how to shop for coverage. While TDI does provide consumer assistance through a toll-free telephone line and provides brochures by mail and through the agency’s website, employers want something more personal that provides an opportunity to interact with TDI technical staff who can answer questions and discuss in detail the many questions they have about health insurance.

During the fall of 2002 and summer of 2005, the SPG staff had an opportunity to host small business health insurance fairs as requested by employers. In conjunction with a separate SPG initiative to examine certain aspects of the local small employer health insurance market, SPG staff organized nine health insurance fairs across the state. The primary purpose of the health fairs was to provide a forum for small employers to meet with TDI staff and obtain information on health insurance options. The fairs also provided an opportunity to facilitate personal visits with local agents and insurance company representatives to discuss local market concerns impacting the ability of employers to obtain coverage, as well as expansion and reform options for small employers. In addition to SPG and TDI staff, representatives from the local chambers of commerce, state CHIP program and the U. S. Department of Labor and the Small Business Administration also attended to provide information to employers. All health insurance carriers

and HMOs licensed to offer small employer coverage in Texas were invited to provide information packets and answer questions on their companies' insurance products for small employers.

Although the fairs required a significant amount of planning and time, employers, agents and company representatives expressed overwhelming support. Many employers commented to SPG staff that they had been struggling to get information on health insurance options, and the fair provided them the chance to easily obtain the information they needed in one setting, without contacting several different carriers or agents. In most locations, agents and insurance carriers indicated they would like to work with TDI to organize and fund such fairs on an annual basis. The fairs provided an excellent opportunity for the state to collaborate with the business community and insurance industry, while providing a significant service for local employers. They also provided SPG staff with important information that was used to facilitate development of the agent survey. Conversations with agents provided a unique perspective on the local insurance market that frequently differed from information provided by insurance carriers. The opportunity to meet with agents was critical in identifying items of concern that were subsequently addressed in the agent survey.

3) Provide information to help consumers shop for coverage

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

C) CHIP Buy-In Options to Expand Coverage to Parents

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

Early in the SPG review process, a majority of stakeholders and Working Group members supported expanding insurance coverage to low-income adults through a CHIP “buy-in” program. Through administrative efficiencies and the purchasing power generated from pooling with subsidized programs, CHIP buy-in programs have the potential to provide coverage to thousands of adults who cannot afford coverage in the commercial market. However, the success of a buy-in program and the extent to which it can increase affordability depends largely

on how the program is designed.

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

The Texas SPG Working Group discussed the benefits and disadvantages of both a full-cost buy-in and a subsidized buy-in using both state and federal funds, as well as a state-only subsidized program. The buy-in option was also presented at the state conference and was the subject of three separate break-out sessions. While there was a great deal of interesting discussion and debate about how such a program could be implemented in Texas, there were also a number of concerns raised. For example, numerous participants pointed out that the state has encountered some difficulties negotiating rates with current providers in order keep them in the program. If the program was expanded to include adults, whether on a subsidized or full-cost basis, the state may have problems finding enough providers to serve the added population without significant reimbursement rate increases. Several people also commented that CHIP is already growing at such a rapid pace that it is premature to consider adding adults. Others felt that Texas should focus more on locating and enrolling uninsured children who are eligible for but not enrolled in CHIP before we consider expanding the program to adults.

The most difficult problem identified, however, was how to fund the state’s contribution required for a state/federal subsidized buy-in. While there were many who strongly advocate maximizing our ability to use federal money, the fiscal outlook at that time was not conducive to expanding coverage in any way that required additional state funds. Despite high interest, budget deficits in the subsequent legislative sessions precluded any consideration of a CHIP expansion proposal.

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

During the 2001 Texas legislative session, the Legislature directed that a study be conducted to determine the feasibility of expanding CHIP to include adults. The SPG staff coordinated efforts

with the Health and Human Services Commission to develop the necessary information. Under SPG contract, the actuarial firm Milliman USA developed extensive data and program design alternatives. The detailed information is included in the report to the Legislature, “Family Buy-In Option for the Children’s Health Insurance Program”, November 1, 2002, which is available at http://www.hhsc.state.tx.us/chip/reports/02-11_HB835_CHIP.html.

C. Pilot Project Activities

The Insure Houston Pilot Project concept is the culmination of four years of State Planning Grant research and planning activities that have included collaboration with a large group of stakeholders and interested parties, and it builds upon data collected specifically for this purpose. Throughout this study, the primary focus has been expansion of employment-based insurance, with particular emphasis on small employer coverage. At the same time, the Houston Partnership and Public Health Task Force also identified small employer coverage as a primary target for their continued efforts to expand health care and health insurance access in the Houston/Harris County metroplex. As such, the coordination of the State Planning Grant activities with the Houston Partnership is an ideal collaborative opportunity that combines the local knowledge and commitment of the Houston Partnership members and community stakeholders with the state insurance policy expertise, experience and uninsured research data of the State Planning Grant program and staff.

There are more than 5 million uninsured residents throughout the state of Texas. One of the more significant challenges to expanding any insurance initiative is the sheer size of the state; with more than 261,000 square miles and more than 23 million residents, involving the many communities and local stakeholders with competing interests requires significant time and money. While all earlier SPG work addressed the uninsured problem on a statewide basis, the Insure Houston Pilot Project focuses on a limited area of the state due to several critical factors that make initial statewide implementation unrealistic and unaffordable:

- The 12 month time period and budget limitations of the grant program made it impossible to effectively organize, meet and collaborate with stakeholders in all regions of the state and then complete the level of detailed work required for successful implementation of this proposal.
- While virtually all communities in Texas are interested in providing health insurance for their uninsured citizens, local public health control, competing interests and unique community programs make it difficult if not impossible to create and implement a successful pilot plan that deals with the many intricacies and variations across the state. Once the project is finalized, the program can be easily adapted to accommodate local conditions.
- For health insurance purposes, the state is divided into numerous geographical regions that have considerable differences in provider networks, health care costs, insurance premiums, and health care and insurance utilization patterns. The actuarial analysis that was critical to this project requires local data in order to provide accurate projections. Due to time and budget limitations, it was impossible to collect similar data and provide the actuarial analysis required for insurers to implement this project initially on a statewide basis.
- Insurance collaboration is critical to the success of this project. While Texas is fortunate to have a healthy, competitive health insurance market with more than 50 small business health insurance carriers, development of new insurance products requires working with a significant number of industry representatives, agents and interest groups. While we expect this project to be welcomed by insurers and to quickly expand across the state, working with a limited group of stakeholders within a defined geographic area is more

manageable and significantly increases the chances of success. Also, this will provide insurers a sufficient amount of time to evaluate the program and make any necessary revisions before going statewide.

While all cities in Texas are facing the challenge of providing care for the uninsured, Houston has the largest share of the state's uninsured population. Out of the 3.5 million area residents, an estimated 1.1 million people are without health insurance, including 25 percent of all children. Most uninsured citizens are either employed or live in a family with at least one working adult. However, many of the uninsured either work for employers that do not offer insurance benefits or cannot afford the premium contribution required to participate. In an effort to address this growing problem, Houston and Harris County business and community leaders created the Greater Houston Partnership Public Health Care Task Force to collect information and provide recommendations for providing health care and health insurance in the area. A key recommendation from their year-long effort was the development of a new affordable small business insurance option for employers who cannot afford existing plans. Because of this ongoing commitment of local stakeholders as well as state leaders, collaboration with the Greater Houston Partnership was a both a perfect match for the State Planning Grant pilot project and an excellent opportunity to significantly expand insurance coverage. Several of the participants in the Partnership also worked with the State Planning Grant staff in previous efforts, enabling the groups to share information and work towards a common goal.

Other factors also made Houston an excellent candidate for the pilot project. Houston is the world's largest medical center, with access to the highest quality of health care and virtually any type of medical treatment or service available. The community enjoys an expansive public health system that provides vital services for low-income and uninsured residents, but it is struggling to keep up with increased demand and a growing uninsured population. Local public health care agencies spend approximately \$1.5 billion per year serving the uninsured, and private providers spend an additional \$450 million per year serving the safety net population. These costs, though necessary, are growing and cannot be sustained indefinitely. Both public and private health care representatives and providers are anxious to work together to address this problem and want to do so in a logical, data-driven, sustainable manner that will enable residents to access the care they need in the most effective and cost efficient manner possible.

Houston also has a diverse population that includes a large and growing Hispanic component. The Hispanic population has a much higher than average uninsured rate throughout the state, and 51.7 percent of Houston-area Hispanic residents are currently uninsured. Demographic projections indicate that the Hispanic population is expected to rise from the current 27.3 percent to 48 percent by 2015. As a border state, this situation is true in many other Texas communities with high uninsured rates. Developing a Houston-area pilot program that addresses the cultural, language and communication issues unique to the Hispanic population will be particularly useful for other areas of the state that face similar challenges.

The primary purpose of the Insure Houston Pilot Project is to develop a carefully-designed small employer benefit plan that will provide an acceptable, affordable option for small businesses that cannot afford coverage in the current insurance market. An employer-based plan is important since most employers are willing and able to assist with the cost of insurance. By including

employers' contributions in this attempt to expand coverage, more uninsured workers will be able to afford coverage, thus achieving our ultimate goal of significantly reducing the number of uninsured Texans. Developing the prototype model based on local-area market and provider conditions further enhances the success of the program and increases the likelihood that insurers and HMOs will offer the new benefit plan. Once implemented, the plan can easily be expanded throughout the state with applicable adjustments, further increasing the number of Texans with coverage.

Reaching consensus on an option that is widely supported by policymakers, legislators, and the many stakeholders has been a challenging process. A number of program ideas have been considered during the past four years, and many received widespread, though not unanimous, support. However, the concept of expanding coverage through the existing private market is a concept that was widely endorsed by a majority of Working Group participants and other stakeholders. The concept also is strongly supported by the Governor, Lt. Governor, Speaker of the House, and Legislators who are looking for new alternatives that are sustainable without depending on state funds.

To ensure the success of this program and maximize support among competing interest groups, significant consideration was given to the following program objectives:

- Develop a small employer plan that is affordable for a majority of uninsured employers and their employees;
- Involve stakeholders in the development phase to maximize support and participation;
- Ensure that the plan is sustainable and affordable by using actuarial expertise to develop the plan, and include insurers in the developmental phase;
- Obtain feedback and suggestions from employers and employees to create a benefit plan that meets the needs of this specific population and provides the coverage they value;
- Develop a marketing plan that will enhance the ability to immediately implement the benefit plan once it is developed;
- Encourage widespread participation of employers through town hall meetings that will provide an opportunity to promote the pilot project to the local business community; and
- Enhance implementation success by involving the agent community in the planning process and including them in the implementation plans.

The Insure Houston Pilot Project complements both the qualitative and quantitative research activities conducted as part of the Texas SPG program. From the beginning, grant activities have focused on small businesses as providing the most potential for significantly increasing the number of insured Texans. Using data collected by the Greater Houston Partnership and the Texas Department of Insurance, we estimate that nearly 900,000 Houston-area residents could obtain insurance as a result of this project. Providing an alternative for these workers and their families is a high priority for legislative leaders and is a primary goal of this project. As demonstrated in the letters of support submitted with TDI's grant application, several key legislators are closely following the progress of this program and are looking at additional ways to build on its success.

Although initial work under the project began as planned, some of the early activities were

delayed due to the challenges posed by hurricanes Katrina and Rita. Both storms significantly affected critical health care services in the Houston/Harris County area, and virtually all Working Group members were involved in addressing the health care needs of hurricane victims. The sudden influx of new citizens – many of whom were uninsured – posed numerous problems for local providers and officials, who had little time to devote to the Houston pilot. As a result, the work plan was adjusted to accommodate this unavoidable delay. Some deadlines were simply altered, while a few other planned activities were either eliminated or revised. However, the major components of the program and all significant design elements were retained and have been completed or were near completion at the conclusion of the six-month extension granted by HRSA.

The Insure Houston Pilot Project began with an organizational meeting of the SPG staff, Houston Partnership members, other Working Group participants and contractors. After a review and discussion of the program objectives and project matrix, the initial development began on the benefit plan that would be the basis of this program. Using a prototype already developed under previous grant activities, the actuarial consultants proposed a low-cost benefit plan that was within the targeted cost range of an average \$150 per month per employee. The plan design took into account the preferences and needs described by employers in previous SPG surveys. The consultants presented the proposal to the Working Group, along with an explanation of the process used to design the benefit plans and the assumptions used to develop the cost estimates.

After a lengthy discussion about the plan design, suggestions were made for improvements and revisions. Eventually, it was decided that two plan designs should be offered; the first plan would focus on primary and preventative health care with relatively low out-of-pocket costs, and the second would focus on providing more comprehensive catastrophic coverage with higher cost sharing requirements. The actuarial consultants responded with two separate benefit plans.

To simplify the application process for employers, both benefit plans were priced using a modified community rating process, which is a distinct and significant departure from the rating methodology used in the small group market in Texas. Under the existing system, carriers are allowed to adjust small group premium rates based on the group size, the industry classification, the geographical location of the business, the age and gender of each enrollee, and the health status of enrollees. If a carrier requests medical records for the purpose of determining the rating factor for health status, employers can face delays of several weeks or longer before receiving final price quotes. In addition, the application process is often further delayed when employees are required to complete lengthy application forms for each family member. Small business owners therefore often find the process of applying for insurance to be extremely time-consuming for themselves as well as their employees. By eliminating the health status rating factor from the project proposal, the administrative effort required by employers, carriers and agents will decrease significantly. The only two factors that will affect a group's rates under the proposed plan are the age and gender of the enrollees, and a simple rate chart will enable employers and agents to immediately calculate premium rates for the entire group.

In July 2006, the two benefit plans were presented in 25 focus groups with small business owners throughout the Harris County area. Employers and employees were both invited to

attend. SPG staff provided an overview of the two plans and pointed out other significant features, such as the modified community rating provision and simplified application process. Following the presentation, participants provided feedback on features they liked and disliked about the plans and suggested ways in which the plans could be amended to make them more attractive. Some of the most significant findings that emerged from these discussions include:

- Employers were generally much more knowledgeable than employees about the health insurance market, and they already have strong opinions about what they want in a benefit plan.
- Employers as a rule preferred the comprehensive/catastrophic plan but believed their employees would prefer the preventive and primary care benefit plan. They strongly felt that it was important to be able to offer both plans in order to improve employee participation levels.
- The majority of employers (60%) confirmed earlier research indicating that they can afford to pay no more than \$100 a month per-employee for insurance coverage.
- All but three employers said they would purchase this plan if it were available to them at the rates provided.

A detailed summary of the focus group responses and suggestions is included in a separate report available at <http://www.tdi.state.tx.us/company/spg.html>.

Upon conclusion of the focus groups, the Working Group discussed the findings and made decisions to adjust the prototypes based on the comments and suggestions provided by employers and employees. The most significant changes under the catastrophic care plan (“Plan A”) were an increase in the annual maximum limit from \$100,000 to \$300,000 and the addition of two office visits for children under age two at a co-pay of \$25. Changes to the basic benefit and preventative care plan (“Plan B”) include the addition of two office visits at a co-pay of \$25 and an increase in prescription drug coverage from an annual limit of \$500 to \$1,000. Other minor changes were also included, such as including ambulance coverage in Plan B. The table below provides a summary of the major components of the two revised prototype plans.

	Plan A Revised Prototype: Catastrophic Care Plan	Plan B Revised Prototype: Basic Benefit and Preventive Care Plan
Plan Basics		
Approximate Monthly Premium Cost Per Adult	\$156	\$129
Approximate Monthly Premium Cost Per Child	\$72	\$59
Annual Deductible	\$1,000	\$250
Coinsurance	30%	20%
Out-of-pocket Maximum (Including deductible)	\$11,000	\$1,250
Annual Maximum Benefit	\$300,000	No specified dollar limit
Hospital Benefits		
Inpatient Hospital Stay	Covered	Five days covered annually
Outpatient Hospital Surgery	Covered	Two visits covered annually
Hospital Outpatient Radiology, Pathology, and Diagnostic Tests	Covered	Two surgeries covered annually
Emergency Room Visits	Covered	Two visits covered annually
Physician Benefits		
Inpatient Hospital Care	Covered	Five days covered annually
Outpatient Hospital Care	Covered	Two visits covered annually
Doctor Office Visits and Preventive Care	The first two visits have a \$25 co-pay for adults, and the first four visits have a \$25 co-pay for children under age two; all other visits are subject to the deductible and coinsurance requirement	Six visits covered annually; the first two visits have a \$25 co-pay
Doctor Office Visits for Substance Abuse and Psychiatric Care	First two visits have a \$40 co-pay; all other visits are subject to the deductible and coinsurance requirement	Not covered
Radiology and Pathology	Covered	Two visits covered annually
Prescription Drug Benefits		
Deductible	\$500	None
Coinsurance	30%	None
Co-payments	None	\$10 for generic drugs, \$20 for formulary brand name drugs, and \$30 for non-formulary brand name drugs
Annual Maximum Benefit	None	\$1,000

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

TDI held a conference in December 2006 to present the State Planning Grant program research, revised prototype benefit plan designs and marketing plan to high-level officials from several of the largest insurers and HMOs in Texas. Invitation letters were sent to the Chief Executive Officers of all 51 insurers and HMOs licensed to write small employer coverage in Texas, and 22 of those companies were represented at the conference. Attendees were provided data explaining the reasoning behind the benefit plan designs, how employers and employees responded to the focus group presentations, and the rating methodology and underlying actuarial assumptions used to develop the premium rates for the benefit plans.

After the conference, attendees were allowed a two-week comment period during which they could submit any questions or concerns before the official release of the RFP. A total of 38 questions were received, and official responses to these questions were released in conjunction with the RFP on February 21, 2007. The current deadline for RFP responses is March 30th, after which the Alliance will evaluate each proposal and select the winning carrier.

For the purpose of providing this health benefit plan, the RFP detailed the Alliance's intention to create a healthcare purchasing cooperative as authorized under Chapter 15, Subchapter B of the Texas Insurance Code. The targeted membership of the Cooperative will consist of qualified small employers with 2 to 50 eligible employees, and the Cooperative will elect to be legally treated as a large employer. Although the Cooperative will primarily be marketed to uninsured small employers, state law prohibits membership from being restricted solely to this group. Also, membership in the Cooperative will initially be limited to employers whose primary place

of business is within Harris County.

In the RFP, respondents were also encouraged to provide suggestions and/or preferences regarding certain provisions, requirements and duties of both the Cooperative and the successful carrier. Among the most important of these provisions relate to initial and open enrollment periods and administrative services to be performed by the Cooperative. The carrier, which will perform services under a contract with the Cooperative, must be licensed by the Texas Department of Insurance and must comply with all applicable statutes and regulations. The carrier will serve as the insurance provider of group benefit plans offered to eligible members of the Cooperative. Required services will include enrolling eligible applicants in a timely manner once eligibility for coverage is confirmed; issuing policy forms, member identification cards, summary benefit information and related forms for new members in a timely manner; performing services associated with premium billing and collection; processing and adjudication of claims; providing customer assistance to enrollees and potential enrollees; performing utilization management and quality assurance activities; developing and managing the provider network; and other services as agreed to by the respondent and the Cooperative.

The next and final steps in this program will be to select a carrier that will work with the Harris County Healthcare Alliance to offer this plan to eligible employers in Harris County. The carrier that wins the contract to offer this program will benefit from a professionally designed marketing proposal prepared for the Insure Houston Pilot Project by S&C Advertising and Public Relations that includes a campaign logo, character, draft website, and memorable English and Spanish slogans. Because so many small employers assume they cannot afford health insurance, an effective marketing approach is critical to encourage employers to consider this new plan that is significantly different from all other small group plans in Texas. The marketing campaign will both provide employers with information about this particular benefit plan and educate employers and employees about the value of health insurance. The campaign is directed to both employers *and employees* to maximize interest in the program and address concerns about inadequate employee participation. Cost-effective marketing options already explored by S&C include pin point emails, press releases, op-ed pieces, brochures and postcards. Additional marketing options include providing articles and advertisements through local business publications, meetings with business groups and associations, promotion through local chambers of commerce and other organizations, and internet opportunities through local government, business and community groups.

Though implementation will depend on the selected carrier and their negotiations with the Harris County Healthcare Alliance, enrollment is targeted to begin in the summer of 2007. If the plan is successful, TDI will work with carriers and other communities to expand the program throughout the state.

D. Implementation Status

As described in the previous section, the pilot project RFP has been published to select a carrier that will offer the benefit program designed under the pilot program. Enrollment is expected to begin in the summer of 2007. In addition to the pilot project, several other expansion activities have already been enacted or are still under consideration. Following is a brief summary of the status of those options.

Consumer Choice Benefit Plans

Early in the SPG process, the working group evaluated options within the existing small employer market and made several recommendations for benefit plan design changes. In 2003, the Texas Legislature authorized creation of the Consumer Choice Benefit Plans, which may exclude or reduce coverage for certain mandated benefit provisions. The plans also generally provide higher cost sharing requirements and reduced out-of-network coverage as a mechanism for reducing the premium cost. In 2005, a total of 87,675 Texans were insured under these new benefit plan.

Health Insurance Premium Payment Assistance for CHIP Eligibles

The SPG working group recommended that the state provide private insurance payment assistance for families of children eligible for CHIP, which would facilitate enrollment of parents who otherwise may remain uninsured. The Texas Health and Human Services Commission has applied for a waiver that would allow the state to create a health insurance premium assistance (HIPP) program for such families, and is awaiting approval from CMS.

Insurance Coverage for University Students

SPG staff conducted a comprehensive evaluation of student health insurance programs offered by universities in Texas and offered several recommendations for enhancing enrollment in those programs. The Texas Legislature is currently considering legislation that would enact several of the options included in the SPG study, including mandatory participation and improved marketing and coordination through the Department of Insurance.

Subsidies for Low-Wage Workers

Several of the options developed through the SPG study included subsidy programs for qualified low-wage workers. The Texas Legislature is currently considering several different proposals that would create programs to provide subsidies for eligible small businesses with low-wage workers. Though it is too early to determine whether the proposals will be enacted, several have already received public hearings in legislative committees, and others are scheduled for hearings within the coming weeks. The specific provisions vary, but most provide subsidies that range from \$50 per-month-per-worker to full-cost subsidies based on income eligibility.

Information Assistance for Small Employers

One of the problems identified early in the SPG study was availability of information and technical assistance for small employers. In response, the Texas Legislature created the Health

Coverage Awareness and Education Task Force in 2005 to develop a comprehensive plan for providing current information to consumers shopping for health insurance. A separate website at the Department of Insurance – www.TexasHealthOptions.com – was also developed to assist consumers. The Texas Legislature is currently considering legislation that would expand this program by providing more comprehensive assistance and additional staff at the Department of Insurance to focus exclusively on education and information programs for uninsured individuals and small business owners. The legislation also would create a unique “certification” program for insurance agents and brokers who specialize in working with small business owners. The certification would also require agents/brokers to agree to accept businesses of any size, which would address the difficulty some of the smallest businesses have described when trying to find an agent that would agree to assist them.

Challenges and Barriers to Implementation

Throughout the SPG process, flexibility has been a key requirement in adapting to a constantly changing environment. Budgetary uncertainty and constraints have provided the most significant challenge, both at the state and federal level. Economic concerns throughout the process have restricted serious consideration of many options that were appealing in concept, but could not realistically be funded. For example, the SPG working group considered early in the process the benefits that could be achieved with expansion of CHIP and Medicaid, as well as a variety of subsidy options for low-income residents. However, implementation of any expansion option was dependent on additional revenue, which in most cases was not viable at the time.

Several of the provisions under consideration also depend on decisions at the federal level. The premium assistance program for CHIP, for example, was submitted to CMS and has been reviewed but never approved. Ongoing changes and opportunities within Medicaid and provisions of the Deficit Reduction Act also have created a level of uncertainty and, at times, confusion regarding what approach the state could and/or should take with regard to expansion options. At this time, the Texas Legislature is considering several comprehensive Medicaid reform options that could result in a significant expansion of coverage, but depends largely on decisions of and guidance from CMS.

Implementation of the Pilot Project also posed some unexpected challenges with regard to existing state law. Several statutory provisions that were enacted to protect small businesses and improve access to health insurance also prohibit some flexibility that might be desirable for a limited pilot project. For example, a provision that all employers have access to all small group plans prohibits the pilot project from limiting coverage to include only those firms that are uninsured. While the statutory protections are important and have certainly improved availability of coverage for small groups, some exceptions for limited pilots may be appropriate in order to test new innovations that could provide coverage for thousands of uninsured Texans. The Legislature is currently considering legislation that would, in limited circumstances, provide exceptions from existing insurance provisions, but it is unknown at this time if the legislation will be enacted.

Finally, expansion options within the private insurance market are often dependent on acceptance and support of the insurance industry. In several cases, insurance carriers and/or agents have expressed concerns or reluctance regarding new requirements or provisions that

were considered. One example is the recommendation to use a modified community rating approach within the pilot project. Despite assurances from consulting actuaries that the risk of adverse selection was mitigated by both the benefit plan design and limitations in coverage and was considered in developing the rate tables, insurers were reluctant to deviate so significantly from the existing rating process due to concerns that the pilot project group would attract a disproportionate share of unhealthy groups since they would not be rated based on health status.

Because Texas is a large state with more than 50 small group carriers, considerable competition exists within that segment of the market. Both agents and carriers are usually opposed to any provisions that may restrict their freedom, and generally do not support standardization of products, despite employers' continued interest in standardization. While competition usually provides more opportunities and options for consumers, balancing the needs and interests of consumers with those of the insurance industry is a continuing challenge that must be considered when implementing any changes.

Effects of SPG Program Discontinuance

The SPG program has provided enormous opportunities and information for Texas. During the past five years, the data obtained from surveys and focus groups has been used by countless research and public policy organizations and is used frequently to provide information to the Governor, Lt. Governor, Speaker and various legislative committees and state agencies. Several independent studies of Texas' uninsured population have relied heavily on the data obtained from the SPG work. While some of the SPG data collection activities may be repeated in the coming years using existing funds, most of those activities will end unless additional funding is provided.

The Department of Insurance will continue to work with the Legislature and other state agencies and organizations to address the problems of uninsured Texans and will continue with many of the activities that were begun as a direct result of the SPG work. For example, TDI will continue to collect data and publish the small employer rate guide, and will expand education and awareness activities under the Task Force created for that purpose. Other activities may be added if the Legislature enacts legislation currently under consideration. However, research opportunities associated with focus groups and health insurance information fairs will be discontinued unless additional revenue is provided. While the Department hopes to continue to work with communities that are interested in local expansion opportunities similar to the Pilot Project with Harris County, the extent to which we may assist will be limited based on available funds.

E. Recommendations to the Federal Government and HRSA

Through the five years TDI has participated in the State Planning Grant program, several suggestions for the federal government were identified:

- While one-time surveys are useful for a specific point in time, most surveys need to be repeated to be of any long-term value. Because the need for data varies by state, the federal government should consider providing funds for states to develop survey activities on the uninsured on an on-going basis, with certain data requirements that would provide some base-line comparison across states.
- The federal government should conduct a comprehensive study of the effects of ERISA (the Employee Retirement Income Security Act of 1974) on the regulated insurance market and the employers who obtain fully-insured coverage. The study should include an analysis of the impact of lost revenue to states due to the inability to collect premium taxes on self-funded plans. Insurers are particularly concerned with their inability to compete with self-funded plans as they are exempt from all state regulations and tax requirements. Self-funded plans are also generally exempt from paying assessments to fund state high-risk pools, which forces smaller employers who provide fully-insured plans to bear a disproportionate share of the cost of subsidizing state risk pools.
- HRSA should consider a grant program that would allow states to create a program to promote the importance of health insurance. Consumers who can afford health insurance but choose not to purchase it often do so because they do not understand the value of having medical coverage. An education campaign similar to the Medicare prescription drug promotion campaign would be an effective tool for promoting personal responsibility with regard to health insurance and health care.

Appendix I: Summary of Policy Options

Option Considered	Target Population	Estimated Number of People Served	Status of Approval	Status of Implementation	If Implemented, Number of People Served
Revise the small employer benefit plans to increase participation	Small business owners, employees and family members	100,000	Legislation enacted by the Texas Legislature; Rules adopted by TDI	Implementation completed January 2004	87,675 enrollees in 2005
Organize insurance information events to provide current information on insurance options for small employers	Small business owners	1,500	Completed in 2003 and 2005	Completed	1,500 in FY 2005;
Creation of purchasing alliances and cooperatives	Small and Large Employers	Unknown	Legislation enacted in 2003. Rules adopted by TDI; implementation effective January 2004	Completed	Unknown; estimated between 5,000 - 10,000 in FY 2005
CHIP Buy-In program for parents of children enrolled in Medicaid or CHIP	Low-income parents of children enrolled in CHIP / Medicaid	Not applicable	On – Hold; requires legislation	On-Hold until Legislature takes future action	Not applicable
Insure Houston Pilot Project	Small Employers in Harris County and their workers and dependents	Up to 900,000 potentially eligible when implemented	Plan design approved and finalized by Working Group	Awaiting selection of a carrier through RFP process	

Appendix II: Project Management Matrix

Task / Step	Timetable	Responsible Agency/Person	Anticipated Results	Evaluation/Measurement
Task 1: Organize and oversee Insure Houston Coalition meetings				
Step 1 - Inform coalition of grant award and arrange organizational meeting	Sept 2005	Project Director	Participants are informed of grant of meeting date	Grant implementation begins in a timely manner
Step 2 - Hold meeting; provide project overview, appnt subcommittees, make assignments, schedule future mtgs.	Nov 2005	Project Director	Participants are informed of work schedule; meeting dates are confirmed	Grant activities proceed on schedule and conflicts with future meeting dates are minimized with early scheduling
Step 3 - Follow-up with attendees, other stakeholders; inform legislature of activities	Dec 2005	Project Director and Staff	Information is distributed to inform all stakeholders	Continued involvement and interest in the project and knowledge of progress
Step 4 - Make arrangements for future meetings; provide materials in advance	Oct 2005 - Feb 2006	SPG Staff	Members are informed of and prepared for upcoming events	Progress of coalition members in meeting deadlines, providing necessary input, and maintaining involvement in the process
Task 2: Hire Grant staff and contractors; finalize timeline				
Step 1 - Organize staff, finalize timeline and workload assignments	Sept - Oct 2005	Project Director and Staff	Work distributed and timeline finalized	Progress of staff and development of detailed work-plan
Step 2 - Finalize contractual agreement with university assisting with focus groups	March 2006	Project Director and Staff	Contract issued and work plan Developed	Timely arrangements and plans for focus group meeting
Step 3 - Following state contractual requirements, negotiate and finalize actuarial contract	Nov 2005	Project Director	Contractor selected and initial meeting scheduled	Date of signed contract and actuarial services provided

Task / Step	Timetable	Responsible Agency/Person	Anticipated Results	Evaluation/Measurement
Task 3: Develop Prototype Benefit Plan				
Step 1 –Distribute prototype plan draft developed by actuarial consultant under earlier grant activities	Nov 2005	Project Director	Work on prototype is initiated	Review of draft prototype by subcommittee
Step 2 – Review small employer survey data, utilization data, focus group information; use information to adjust prototype plan	Jan 2005 – March 2006	SPG Staff, subcommittee, actuarial consultant	Prototype plan is revised	Progress on prototype plan continues on schedule
Step 3 – Work with insurers and actuarial consultant to provide financial input and cost estimates	April – May 2006	SPG Staff, subcommittee, actuarial consultant	Prototype plan cost estimates are provided	Affordability of prototype plan
Step 4 – Adjust plan design as necessary; present plan to full Working Group	May 2006	Subcommittee, actuarial consultant, SPG staff	Completion of first prototype draft	Development of plan that is supported and approved by full Working Group
Step 5 – Present plan to employers/employee focus group attendees; obtain feedback	June - July 2006	SPG Staff, focus group contractor	Focus groups are held	Comments on prototype and their impact on plan
Step 6 – Evaluate focus group comments; make adjustments to plan and finalize	August 2006	SPG Staff, focus group, actuary contractor, subcommittee	Final plan is developed for full committee	Development of prototype plan that will appeal to employers, employees
Step 7 – Present final recommendation	September 2006	SPG Staff, subcommittee	Final plan is approved by Working Group	Prototype final plan is ready for marketing, implementation
Task 4: Organize and hold focus group sessions with employers/employees				
Step 1 – Work with contractor to plan focus groups	March – June 2006	SPG staff, focus group and contractors	Sites selected and arrangements made	Confirmation of dates, location for sessions
Step 2 – Solicit focus group participants	May – June 2006	SPG staff, contractor	Focus group participation is confirmed	Attendance at focus group meetings
Step 3 – Hold focus group sessions	June - July 2006	Contractor and SPG staff	Comments on prototype plan are received	Evaluation of prototype plan and necessary changes

Task / Step	Timetable	Responsible Agency/Person	Anticipated Results	Evaluation/Measurement
Task 5: Develop Marketing and Education Plan				
Step 1 – Develop contract RFP; review bids and award contract	April - May 2006	Project Director and SPG Staff	Contract is awarded	Date of contract finalization and timely initialization of contract services
Step 2 – Work with contractor to develop marketing plan	June - Nov 2006	Contractor, Project Director, and Staff	Working Group agrees on plan	Successful development of a detailed education and marketing plan
Step 3 – Meet with carriers, insurance agents, Working Group	Sept - Nov 2006	Contractor, Project Director, Staff	Plan will reflect local community participation	Consensus in approach to marketing and education plan
Step 4 – Present final proposal to full committee; discuss implementation plans	Nov 2006	Project Director and Contractor	Comments on plan received; final proposal is completed	Stakeholder support and participation in future implementation is maximized
Task 6: Determine employer eligibility criteria and insurer participation conditions				
Step 1 – Review other states' programs	Dec – Jan 2006	SPG Staff	Information provided to subcommittee	Consideration of other state's experience informs decisions
Step 2 – Develop options; discuss w/insurers, actuarial contractor	March - May 2006	SPG Staff, actuarial contractor, Working Group	Initial list of options is developed	Analysis of options and their potential impact on participation
Step 3 – Finalize options	July – Aug 2006	SPG Staff, Working Group	Options are finalized	Participation & sustainability is maximized
Task 7: Finalize pilot project proposal and implementation plans				
Step 1 – Meet with carriers, agents, stakeholders to explain plan design	Nov – Dec 2006	Project Director, Staff and Working Group	Program design and research will be distributed	Decisions on benefit plan and implementation finalization
Step 2 – Work with appropriate parties to develop and initiate implementation activities	Dec 2006 – Feb 2007	Project Director and Staff	Plans for implementing project are developed	Successful implementation of pilot project is initiated
Task 8: Complete and submit final grant pilot project report for HRSA				
Step 1 – Using template provided by HRSA, finalize report on project activities; submit to HRSA by required deadline	Dec 2006 – Feb 2007	Project Director	Report is finalized and delivered to HRSA	Timely completion of final report that includes project proposal and implementation plans

Appendix III: Profile of Uninsured Texans – 2005 CPS Data

The uninsured data below was extracted from the “Demographic Profile of Uninsured Texans in 2005” which was released by the Texas Health and Human Services Commission’s Research and Evaluation Department - Center for Strategic Decision Support. The original source of this information was the March 2006 Current Population Survey (CPS) from the U.S. Census Bureau.

Texas Uninsured Statistics Ages 0 through 64: 1995-2005

Year	Uninsured Rate	Number Uninsured
1995	24.5%	4,615,000
1996	24.3%	4,680,000
1997	24.5%	4,836,000
1998	24.5%	4,880,000
1999	23.3%	4,664,000
2000	21.4%	4,500,000
2001	23.5%	4,960,000
2002	25.8%	5,556,000
2003	24.6%	5,374,000
2004	25.0%	5,583,000
2005	24.2%	5,516,000

Texas Uninsured by Gender

Gender	Percent Uninsured	Percent Uninsured within Gender Category
Male	25.4%	51.8%
Female	23.0%	48.2%
Total	24.2%	100.0%

Texas Uninsured by Race / Ethnicity

Race / Ethnicity	Percent Uninsured	Percent Uninsured within Race / Ethnicity Category
Anglo	15.0%	29.7%
Black / African American	23.2%	11.0%
Hispanic	37.0%	55.9%
All Other	19.2%	3.3%
Total	24.2%	100.0%

Texas Uninsured by Age Group

Age Group	Percent Uninsured	Percent Uninsured within Age Group Category
Ages 6 and Younger	18.9%	8.8%
Ages 7 - 17	19.4%	13.7%
Ages 18 - 24	45.1%	17.6%
Ages 25 - 34	36.6%	21.8%
Ages 35 - 44	26.4%	16.1%
Ages 45 - 64	22.9%	21.1%
Ages 65 +	1.8%	0.8%
Total	24.2%	100.0%

Texas Uninsured by Percent of Poverty Category

Percent of Poverty Category	Percent Uninsured	Percent Uninsured within Percent of Poverty Category
Under 50%	44.4%	13.2%
51% to 99%	40.3%	15.0%
100% to 149%	38.7%	18.4%
150% to 199%	36.2%	16.6%
200% to 249%	28.1%	11.2%
250% or Higher	12.0%	25.6%
Total	24.1%	100.0%

Texas Uninsured by U.S. Citizen Status

U.S. Citizen Status	Percent Uninsured	Percent Uninsured within U.S. Citizen Status Category
U.S. Citizen (Native)	20.2%	71.7%
U.S. Citizen (Naturalized)	28.9%	4.6%
Not a U.S. Citizen	54.5%	23.7%
Total	24.2%	100.0%

Texas Uninsured by Area of Residence

Area of Residence	Percent Uninsured	Percent Uninsured within Area of Residence Category
In Metropolitan Area	24.4%	89.1%
Outside Metropolitan Area	22.6%	10.9%
Total	24.2%	100.0%

Texas Uninsured by Educational Attainment (Persons 18 and older)

Educational Attainment	Percent Uninsured	Percent Uninsured within Educational Attainment Category
Less than High School	43.0%	36.2%
High School	31.0%	32.9%
Some College or Associate Degree	21.9%	23.0%
College or Higher	9.1%	7.9%
Total	26.1%	100.0%

Texas Uninsured by Labor Force Status (Non-retired persons 18 and older)

Labor Force Status	Percent Uninsured	Percent Uninsured within Labor Force Status Category
Employed	26.1%	65.6%
Unemployed	53.4%	7.0%
Not in Labor Force	36.3%	27.5%
Total	29.4%	100.0%

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

Company Size	Percent Uninsured	Percent Uninsured within Company Size Category
Not Reported	54.7%	6.8%
Fewer than 10 Employees	40.9%	31.8%
10 through 24 Employees	37.5%	12.6%
25 through 99 Employees	27.3%	12.9%
100 through 499 Employees	22.1%	9.1%
500 through 999 Employees	17.0%	3.4%
1,000 or More Employees	15.4%	23.4%
Total	26.1%	100.0%

Texas Uninsured By Marital Status
(Persons 18 and older)

Marital Status	Percent Uninsured	Percent Uninsured within Marital Status Category
Married	21.7%	48.7%
Widowed	9.6%	2.1%
Divorced or Separated	32.5%	16.0%
Single, Never Married	38.1%	33.1%
Total	26.1%	100.0%

Texas Uninsured Dependent Children under 18
by Family Type

Family Type	Percent Uninsured	Percent Uninsured within Family Type Category
In Husband-Wife Family	20.5%	60.9%
In Single Parent Family	23.6%	39.1%
Total	23.6%	100.0%

**Texas Uninsured Dependent / Related Children under Age 18
by Percent of Poverty Category**

Percent of Poverty Category	Percent Uninsured	Percent Uninsured within Percent of Poverty Category
Under 50%	25.0%	13.5%
51% to 99%	25.4%	15.6%
100% to 149%	30.6%	22.1%
150% to 199%	28.8%	18.2%
200% to 249%	19.9%	10.2%
250% or Higher	9.2%	20.4%
Total	19.1%	100.0%

**Texas Uninsured Dependent / Related Children under Age 19
by Percent of Poverty Category**

Percent of Poverty Category	Percent Uninsured	Percent Uninsured within Percent of Poverty Category
Under 50%	25.6%	13.9%
51% to 99%	25.9%	15.6%
100% to 149%	31.0%	21.8%
150% to 199%	29.0%	18.2%
200% to 249%	20.4%	10.5%
250% or Higher	9.1%	20.0%
Total	19.2%	100.0%

Appendix IV: Houston Small Employer Focus Group Summary Report

WorkingTogether
for a Healthy Texas



**Houston Small Employer
Focus Group Summary Report**



October 2006
Texas Department of Insurance
State Planning Grant Project

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Section I: Background Information

Since 2001, the Texas Department of Insurance (TDI) has conducted extensive research of the issues affecting Texans who have no health insurance as part of the federal State Planning Grant (SPG) program funded by the Health Resources and Services Administration (HRSA). Under the grant program, TDI collected qualitative and quantitative data through a variety of survey and research activities and used this data to develop options for expanding health insurance to the uninsured. TDI then received a supplemental grant from HRSA in 2003 to continue the evaluation and development of several expansion options considered under the original grant that needed additional research. The supplemental grant also allowed TDI to evaluate several options that were implemented after the original grant to determine whether or not they have been effective in reducing the uninsured rate in Texas.

The research under the grant program provided a wealth of information and data indicating, in part, that small employers with 2-50 employees face considerable administrative and educational hurdles in evaluating their insurance options and finding quality, affordable insurance coverage. Among TDI's key findings were:

- The primary reason small employers do not offer insurance is because it is unaffordable; 62 percent of uninsured small employers reported they can afford \$150 or less per month for employee health insurance premiums, 34 percent can pay \$50 or less, and 14 percent would not purchase insurance at any cost.
- Approximately three-fourths of uninsured individuals in Texas either work for a small business or are a spouse or dependent of a small business employee.
- Approximately 80 percent of employers believe they *should* provide insurance if they can afford to do so.
- Of those employers who currently offer insurance, 18 percent are very likely to discontinue coverage within the next five years and 24 percent report they are somewhat likely to do so.
- Approximately 70 percent of employers said it is more important for government to focus on improving access to affordable health insurance than improving access to affordable health care.
- When small employers do offer coverage, employees often are unable to afford their required contribution. This is particularly true of family coverage since the average cost for small businesses is more than \$11,000 a year per employee. Many workers are required to pay 50 percent or more of this cost.
- Approximately three-fourths of insured small employers have experienced rate increases of 25 percent or more over the past three years.

Using this and other relevant data, TDI concluded that a simplified, low-cost health insurance alternative was needed to significantly improve the availability and affordability of health coverage for small employers in Texas. When given the opportunity in 2005, TDI applied for and received a second supplemental grant from HRSA to develop a "pilot project" small employer health insurance plan that would meet these criteria. Sufficient funds were not yet available to develop a statewide program, so

TDI elected to first target the Harris County/Houston metroplex area with this new plan. Houston was selected because it has both a high uninsured population and a high concentration of uninsured small employers, and it is also one of the most expensive areas of the state in which to access healthcare. Once implemented, the plan will provide a new alternative for approximately 1.3 million Houston workers and their families.

Two prototype low-cost small employer health insurance plans were developed by TDI staff with the guidance of a leading actuarial firm, Milliman, and several participating stakeholders, including the Greater Houston Partnership, insurance company representatives, health care providers, and employer and employee representatives. Actuarial experience data and information collected and analyzed under the grant were used to identify services most commonly utilized by the uninsured in the Houston area, and the benefit plans were tailored to satisfy those needs. After the prototype benefit plans were developed, TDI held 25 focus group sessions with Houston-area small employers to evaluate the benefit plans and their appropriateness. During these sessions, TDI employees provided an overview of the two benefit plans and asked the participants to discuss what they liked about the plans, what they disliked, and how they would modify the plans to make them more appealing. Also, TDI asked participants to complete a written survey in which they provided demographic information, described the plan types they would prefer, rated the importance of certain benefits, and rated the adequacy of several prescription drug plans.

Using information from the focus group participants, TDI has worked with Milliman actuarial consultants to adjust the prototype plans to more accurately reflect the preferences expressed by small business owners. A marketing campaign will be designed specifically to promote this unique product, which may be offered in early 2007 through a sole provider contract negotiated with an insurance carrier. Following is a description of the original prototype plans presented at the focus groups, an analysis of the focus group findings, and a summary of how the plans were amended based on recommendations of employers and employees.

Section II: Original Prototype Benefit Plans

Working with Milliman actuarial consultants and the Houston State Planning Grant Small Employer Benefit Plan Working Group, TDI developed two prototype benefit plans that were presented at the July 2006 focus groups. Both plans are priced using a “modified community rating” system, which determines premiums based solely on the age and gender of each company’s employees. Other rating factors currently used to underwrite small employer insurance plans (including health status, group size, and type of business) do not apply to this prototype proposal. Using only age and gender, older employees generally will pay relatively higher premiums while younger employees pay relatively lower premiums under the modified community rating system.

The proposed plans will create a large pool of Harris county small employers, distributing the risk among thousands of covered lives. The target premium for each plan was an average of \$150 per employee per month, as previous research indicated that nearly three-fourths of uninsured small business owners interested in purchasing health insurance are able to pay no more than this amount for employee-only health coverage. The first plan, “Plan A,” provides broader coverage for more costly injuries and illnesses and less “first dollar” coverage for routine expenses. The plan is frequently described as a “catastrophic coverage” benefit plan and has an average annual premium of approximately \$148 for adults and \$68 for children. “Plan B” focuses more on routine medical expenses and preventive care and limits coverage of costly illnesses and injuries, and has an average annual premium of approximately \$117 for adults and \$55 for children.

The characteristics of the two plans vary considerably and limit covered services using different approaches. Plan A has a \$1,000 annual deductible, a 70/30 coinsurance requirement, and an \$11,000 annual out-of-pocket maximum (including the deductible). It also includes a maximum annual benefit of \$100,000 per covered individual, but it is not restrictive in terms of the number of inpatient or outpatient hospital days, outpatient surgeries, radiological/pathological procedures, physician office visits, or emergency room visits allowed in a given year. The first two doctor visits under this plan would be available for a \$25 co-payment rather than being subject to the deductible and coinsurance requirements, and the first two office visits for psychiatric care or substance abuse would require a \$40 co-payment rather than being subject to the deductible and coinsurance. The prescription drug plan includes a separate \$500 deductible, and then the same 70/30 coinsurance requirement applies.

Plan A also has a variety of additional covered services, including ambulance transportation, private duty nursing, home health care, durable medical equipment and prosthetics. It does not provide coverage for vision exams or glasses/contacts, but it does offer two annual preventive dentist visits that are covered at 100 percent after a \$25 co-payment. These dental visits cover an oral exam, prophylaxis, fluoride treatment, x-rays, and lab and other needed tests, and the plans may provide discounts on common dental procedures such as fillings, crowns and root canals.

Plan B includes a \$250 annual deductible, an 80/20 coinsurance requirement, and a \$1,250 annual out-of-pocket maximum (including the deductible). The plan does not have a maximum annual dollar limit, but it does restrict services in other ways. The plan provides only five days of inpatient hospital care, two outpatient surgeries, two radiological/pathological procedures, two emergency room visits, and six physician office visits annually. If these limits are exceeded, the insured would be responsible for 100 percent of the cost of care. It is anticipated that even with these restrictions, Plan B would provide more than enough coverage for the average individual in any given year. Statistics show that the average adult visits the doctor twice a year. Statistics also show that only seven percent of the population will be hospitalized in any given year, with an average length-of-stay of less than 5 days.

Plan B also covers up to \$500 in prescription drugs annually, and while it has no prescription drug deductible, it requires co-payments of \$10 for generic drugs, \$20 for formulary brand-name drugs, and \$30 for non-formulary brand-name drugs. It does not include coverage for glasses or contacts, but it does include one vision exam and the same dental benefits that were included in Plan A. Finally, Plan B does not offer inpatient psychiatric abuse coverage, ambulance transportation, private duty nursing, home health care, or coverage of durable medical equipment or prosthetics.

The following table provides a side-by-side comparison of the covered benefits under the original prototype Plan A and Plan B.

	Plan A Original Prototype: Catastrophic Care Plan	Plan B Original Prototype: Basic Benefit and Preventive Care Plan
Plan Basics		
Approximate Monthly Premium Cost Per Adult	\$148	\$117
Approximate Monthly Premium Cost Per Child	\$68	\$55
Annual Deductible	\$1,000	\$250
Coinsurance	30%	20%
Out-of-pocket Maximum (Including deductible)	\$11,000	\$1,250
Annual Maximum Benefit	\$100,000	No specified dollar limit
Hospital Benefits		
Inpatient Hospital Stay	Covered	Five days covered annually
Outpatient Hospital Surgery	Covered	Two visits covered annually
Hospital Outpatient Radiology, Pathology, and Diagnostic Tests	Covered	Two surgeries covered annually
Emergency Room Visits	Covered	Two visits covered annually

	Plan A Original Prototype: Catastrophic Care Plan	Plan B Original Prototype: Basic Benefit and Preventive Care Plan
Physician Benefits		
Inpatient Hospital Care	Covered	Five days covered annually
Outpatient Hospital Care	Covered	Two visits covered annually
Doctor Office Visits and Preventive Care	The first two visits have a \$25 co-pay; all other visits are subject to the deductible and coinsurance requirement	Six visits covered annually
Doctor Office Visits for Substance Abuse and Psychiatric Care	The first two visits have a \$40 co-pay; all other visits are subject to the deductible and coinsurance requirement	Not covered
Radiology and Pathology	Covered	Two visits covered annually
Prescription Drug Benefits		
Deductible	\$500	None
Coinsurance	30%	None
Co-payments	None	\$10 for generic drugs, \$20 for formulary brand name drugs, and \$30 for non-formulary brand name drugs
Annual Maximum Benefit	None	\$500
Additional Covered Services		
Ambulance	Covered	Not Covered
Private Duty Nursing	Covered	Not Covered
Home Health Care	Covered	Not Covered
Durable Medical Equipment	Covered	Not Covered
Prosthetics	Covered	Not Covered
Maternity Care	Covered	Covered
Psychiatric Care	Covered	Not Covered
Substance Abuse Treatment	Covered	Not Covered
Vision Exam	Not Covered	Covered
Glasses or Contacts	Not Covered	Not Covered
Dental Coverage	Two annual preventive visits are covered at 100% after \$25 co-pay	Two annual preventive visits are covered at 100% after \$25 co-pay
Chiropractic Care	Not Covered	Not Covered
Podiatrist	Not Covered	Not Covered

Section III: Focus Group Participant Survey Feedback

To ensure the product designed for the program provided benefits that both employers and employees would find appealing, and to identify what changes should be made to improve the prototypes, TDI invited small business owners and their staff to participate in focus groups held throughout Harris County. A total of 40 uninsured small employers volunteered to participate, and appointments were scheduled individually with the first 30 of those respondents. TDI allowed companies to specify the dates and times they would be available and offered to meet company representatives either at their place of business or at a location provided by TDI.

A total of 25 focus groups were successfully completed in July (five employers cancelled their appointments), representing a broad cross section of businesses with a diverse group of employees. According to employer survey responses used to collect demographic data, the companies ranged in size from two to 26 employees. Average annual employee salaries varied widely from \$20,000 to \$110,000. As a group, the companies each averaged 5.5 full-time workers and one part-time worker, with an aggregate average annual salary of about \$40,000 per employee. The following table describes the primary type of industry of each participating business. Please note that four companies did not complete the employer survey.

Business Type	Number of Participants
Computer/Information Technology Services	3
Construction	2
Advertising/Marketing	2
Financial Services	2
Manufacturing	2
A/C Refrigeration Services	1
Auto Insurance Agency	1
Certified Public Accountant	1
Consulting	1
Corporate Communications	1
Fine Arts and Supplies	1
Fire Construction and Restoration	1
Landscaping Supplies	1
Janitorial Services	1
Medical Services	1
Real Estate Management	1
Specialized Technology	1
Wholesale/Retail Trade	1
Transporting	1
TOTAL	25

The employer survey included a variety of questions about health insurance coverage as it relates to themselves and their employees. Over three-fourths of the employers indicated that they personally had health insurance coverage, while they estimated that approximately 40 percent of their total workforce was insured. About one-half of the employers indicated that they had unsuccessfully attempted to purchase insurance coverage for their employees within the past year, and they most commonly cited cost as the primary barrier to coverage. Seventy-six percent of participating employers felt that a lack of insurance coverage is affecting their ability to attract and/or retain qualified employees, while one-third indicated that employees had actually left the company because insurance was not an offered benefit. Nearly 40 percent of employers also stated that they have personally observed health problems among their employees that were likely untreated because of a lack of health coverage.

In the current small employer health insurance market, carriers in Texas usually require 75 percent of eligible employees to participate in the health plan before coverage will be issued. Eligible employees are defined as permanent full-time employees who do not already have health coverage through other means, such as a spouse’s plan or a parent’s plan. Approximately 45 percent of participating small employers indicated that they believed they would have difficulty reaching this 75 percent participation requirement.

Focus group participants substantiated earlier SPG research indicating that the vast majority of employers (80.9 percent) can afford to contribute no more than \$150 per employee per month. In fact, almost sixty percent of participants indicated that they could pay only \$100 per employee per month or less. The following table provides a detailed breakdown of the maximum employer contribution levels indicated by focus group participants.

Maximum Monthly Contribution	Percent of Responses
\$50	23.8%
\$75	14.3%
\$100	19.0%
\$125	4.8%
\$150	19.0%
\$175	9.5%
\$200+	9.6%

Employers were also asked to identify all of the methods by which their uninsured employees access care when it is needed. Three-fourths of the participating employers indicated that some employees go to a physician and pay their own medical expenses. Almost 50 percent indicated that some employees go to free or low-income clinics, while 38 percent indicated that some employees use local emergency rooms. Cross-border health care was much less prevalent, as only 14 percent of employers indicated that some employees purchase prescription drugs in Mexico, and ten percent indicated that some employees seek medical care.

The focus group sessions were originally intended to be a forum in which employers and employees could discuss the proposed benefit plans together and provide input on them. The employee attendance at the focus groups was unfortunately very low, as only 12 employees were able to attend and complete an employee survey. Of those who were able to attend, the average age was 35.6 years, the average monthly take-home income was \$4,470 per family, and two-thirds were currently insured. The following table provides a more detailed demographic summary of the participating employees.

Demographic Feature	Response
Average age	35.6 years
Percent male	50.0%
Percent female	50.0%
Average number of children in family	0.5
Percent full-time workers	100.0%
Percent attending school	17%
Average monthly family take-home income	\$4,470
Percent currently insured	66.7%
Average annual doctor visits	2.33
Percent using emergency room in past two years because they were uninsured and had nowhere else to go for treatment	0.0%
Percent in support of allowing uninsured parents to purchase child-only coverage	58.3%

Participating employees were also asked to indicate how much they were able to contribute to the cost of insurance each month and how much they felt would be a reasonable amount for the employer to contribute toward their coverage. Nearly two-thirds of employees felt that their employer should contribute \$100-199 per month, while about one-fourth felt that their employer should contribute less than \$100. Their opinions on employee contribution requirements were surprisingly high; while the most common response was in the \$100-199 range, about 55 percent reported that they are able to contribute \$300 or more for coverage. Only 18 percent felt that an employee contribution of \$100 or less was appropriate. The following table provides a more detailed breakdown of these responses.

Contribution Level	Employer Contribution	Employee Contribution
\$0-99	27.3%	18.2%
\$100-199	63.6%	27.3%
\$200-299	9.1%	0.0%
\$300-399	0.0%	18.2%
\$400-499	0.0%	18.2%
\$500-599	0.0%	18.2%

On both the employer and employee surveys, respondents were also asked to rate the importance of selected benefit options on a scale of one to five, with a rating of one representing benefits that are “not at all important” and a rating of five representing benefits that are “extremely important.” This exercise was designed to give employers and employees the opportunity to specify which benefits they value the most, therefore allowing TDI to more effectively create a plan that best meets their needs. Respondents were asked to rate the following 12 benefits: dental coverage, vision coverage, maternity coverage, mental health treatment, doctor office visits when sick only, doctor office visits when sick and for annual well-person check-ups, visits to specialist physicians, in-patient hospital care, diagnostic tests such as lab work or x-rays, well-child care, preventive screenings such as mammograms or prostate cancer tests, and prescription drugs. The results were tallied and weighted on a scale with a maximum value of 100.

Employers most valued doctor office visits when sick and for annual well-person check-ups (with an overall score of 96), followed by in-patient hospital care (89), prescription drugs (85), preventive screenings (83) and well-child care (81). The least valued benefits for employers were dental coverage (58), vision coverage (55), maternity coverage (55), and mental health treatment (34).

Employees most valued in-patient hospital care (97), diagnostic tests (88), doctor office visits when sick and for annual well-person check-ups (87), preventive screenings (83), and visits to specialist physicians (83). Least-valued benefits included doctor office visits when sick only (63), dental coverage (60), vision coverage (48), and mental health treatment (38). A comprehensive analysis of both the employers’ ratings and the employees’ ratings can be found on pages 11-12.

Similarly, employers and employees were asked to rate the adequacy of 12 prescription drug plans on a scale of one to five, with a rating of one representing “not acceptable coverage” and a rating of five representing “more than enough coverage.” Respondents were instructed to rate the plans based on what they felt was a reasonable amount of coverage for their personal needs. The proposed prescription plans included the following: four, six, ten and twelve prescriptions per year; one, two, and four prescriptions per month; and up to \$500, \$1,000, \$2,000, \$2,500 and \$5,000 in coverage per year. The results were once again tallied and weighted on a scale with a maximum value of 100. On this scale, a value of 80 represents “very adequate” prescription drug coverage, which can be interpreted as being neither too much coverage nor too little coverage.

Employers reported that the most adequate prescription plan would cover four prescriptions per month (with a score of 81), while up to \$5,000 per year would provide slightly more than enough coverage (87), and \$2,500 per year would provide slightly less than enough coverage (74). Coverages ranked as not adequate included \$500 in coverage per year (40), one prescription per month (38), six prescriptions per year (36), and four prescriptions per year (27).

Employees felt that coverage up to \$2,500 per year would be most adequate (80), with

four prescriptions per month (87) and up to \$5,000 in coverage per year (93) providing slightly more than enough coverage. Employees felt that six prescriptions per year (56), \$500 in coverage per year (49), one prescription per month (47), and four prescriptions per year (42) would be the least adequate. A comprehensive analysis of the prescription drug plan ratings for both the employers and employees can be found on pages 13-14.

Benefit	Importance of Benefit Options – Counts of Employer Responses					Overall Rating (100 Max.)
	Benefit is Not At All Important	Benefit is Not Very Important	Benefit is Somewhat Important	Benefit is Very Important	Benefit is Extremely Important	
Doctor Office visits when sick and for annual well-person check ups	0	0	0	4	15	96
In-patient hospital care (for surgery, emergencies, illnesses, etc.)	0	0	1	8	10	89
Prescription Drugs	0	2	1	6	10	85
Preventive screenings, such as mammograms or prostate cancer testing	1	0	4	4	10	83
Well-child care, including immunizations and routine check ups	1	2	2	4	10	81
Visits to a specialist physician such as a cardiologist or dermatologist	1	1	3	8	6	78
Doctor Office visits but only when sick	1	1	3	7	6	74
Diagnostic tests, such as blood work, x-rays or MRIs	0	2	5	7	4	71
Dental	3	2	10	2	2	58
Maternity coverage	2	4	7	4	1	55
Vision (eye exams and glasses)	3	5	8	0	3	55
Mental health treatment	6	8	2	1	0	34

Benefit	Importance of Benefit Options – Counts of Employee Responses					Overall Rating (100 Max.)
	Benefit is Not At All Important	Benefit is Not Very Important	Benefit is Somewhat Important	Benefit is Very Important	Benefit is Extremely Important	
In-patient hospital care (for surgery, emergencies, illnesses, etc.)	0	0	1	0	11	97
Diagnostic tests, such as blood work, x-rays or MRIs	0	0	1	5	6	88
Doctor Office visits when sick and for annual well-person check ups	0	0	2	4	6	87
Preventive screenings, such as mammograms or prostate cancer testing	0	0	4	2	6	83
Visits to a specialist physician such as a cardiologist or dermatologist	0	0	3	4	5	83
Prescription Drugs	0	2	1	7	2	75
Maternity coverage	3	0	1	1	7	75
Well-child care, including immunizations and routine check ups	3	0	2	1	6	72
Doctor Office visits but only when sick	1	2	5	2	2	63
Dental	3	0	4	4	1	60
Vision (eye exams and glasses)	3	3	4	2	0	48
Mental health treatment	7	1	2	2	0	38

	Adequacy of Prescription Drug Coverage – Counts of Employer Responses					Overall Rating (100 Max.)
	Not Acceptable Coverage	Not Very Adequate Coverage	Somewhat Adequate Coverage	Very Adequate Coverage	More than Enough Coverage	
Up to \$5,000 coverage per year	2	0	0	4	12	87
Four prescriptions per month	1	1	1	8	7	81
Up to \$2,500 coverage per year	1	0	5	4	7	74
Up to \$2,000 coverage per year	2	3	4	4	4	62
Twelve prescriptions per year	1	1	6	6	2	61
Two prescriptions per month	4	3	5	4	2	57
Up to \$1,000 coverage per year	3	5	6	3	1	53
Ten prescriptions per year	3	1	7	5	0	51
Up to \$500 coverage per year	8	3	3	2	1	40
One prescription per month	7	7	1	0	2	38
Six prescriptions per year	6	5	4	1	0	36
Four prescriptions per year	11	4	0	0	1	27

	Adequacy of Prescription Drug Coverage – Counts of Employee Responses					Overall Rating (100 Max.)
	Not Acceptable Coverage	Not Very Adequate Coverage	Somewhat Adequate Coverage	Very Adequate Coverage	More than Enough Coverage	
Up to \$5,000 coverage per year	0	1	0	1	9	93
Four prescriptions per month	0	0	2	3	6	87
Up to \$2,500 coverage per year	1	0	1	5	4	80
Up to \$2,000 coverage per year	1	0	2	5	3	76
Twelve prescriptions per year	2	0	2	2	5	75
Two prescriptions per month	0	2	2	5	2	73
Ten prescriptions per year	2	2	1	3	3	65
Up to \$1,000 coverage per year	2	1	4	3	1	60
Six prescriptions per year	2	2	4	2	1	56
Up to \$500 coverage per year	3	2	5	0	1	49
One prescription per month	4	2	3	1	1	47
Four prescriptions per year	5	3	1	1	1	42

Section IV: Focus Group Participant Verbal Feedback

In addition to completing the written surveys, focus group participants were given the opportunity to provide verbal feedback on the prototype benefit plans and make suggestions on how they should be modified and improved. Specifically, TDI wanted to determine what was most appealing about the plans, what was least appealing, and how the plans could be changed to make them more desirable. Also, TDI asked the attending employers and employees to indicate if they would be interested in purchasing either of the plans if they were available.

Employer interest was overwhelmingly positive overall, as 22 of the 25 focus group participants indicated that they would be interested in purchasing at least one of the prototype plans. Eleven employers indicated that either of the prototype plans would be attractive, while four expressed interest only in Plan A and seven expressed interest only in Plan B. The final three employers indicated that they would not be interested in either of the plans; in those cases, the employers either wanted a more comprehensive benefit plan or a truly catastrophic plan with a higher deductible and a higher annual maximum benefit limit. Participants were generally most attracted to the plan premiums and the simplified enrollment process. Compared to the existing small employer market, the prototype plans significantly reduce the employer's administrative burdens through the use of a modified community rating approach that does not require lengthy employee/dependent applications, medical histories or medical record reviews.

Several interesting dichotomies existed among participants regarding which of the two benefit plans would be more attractive. Employers generally expressed significantly more interest in Plan A for themselves and in Plan B for most of their employees. The employers had often accumulated a more significant amount of personal assets, and their primary concern was generally protecting those assets in the event of a catastrophic injury or illness. This was also the case with experienced professionals and other white-collar workers on staff; they felt that they had sufficient funds to cover routine medical expenses, but they expressed concern over the large, unexpected catastrophic events that could occur. Lower-wage and blue-collar workers generally showed more interest in first-dollar medical expense coverage and preventive care coverage that Plan B provides. This was especially the case for employees with young children who make more frequent doctor visits for routine care or preventive care such as immunizations. These employees would most likely only agree to contribute to an insurance plan if they knew it would offer benefits that they would regularly utilize and need. Several participants also indicated that Plan A may be more attractive to people with known health conditions who anticipate higher health care costs, while Plan B would appeal more to healthy individuals who rarely visit the doctor and require very few prescription drugs.

Several characteristics of Plan A were also commonly cited as being especially appealing to participating employers and employees. The catastrophic nature of Plan A was especially attractive to about one-half of participants, as these individuals primarily desired security and peace of mind in the event of a serious accident or illness. Numerous participants also voiced approval for the co-payment system in place for the initial physician visits and psychiatric/substance abuse visits. Since the first two visits of each kind are not subject to the deductible and coinsurance requirements, participants felt that this would encourage plan enrollees to seek medical treatment sooner and more regularly when needed. Also, numerous

participants cited the comprehensiveness of Plan A as being especially attractive, as it covers physician visits, hospital care, mental health/substance abuse treatment, ambulance service, durable medical equipment, prosthetics, private duty nursing, maternity, dental and home health care. Finally, participants commonly cited the lack of a specific annual maximum benefit limit on prescription drugs as being particularly appealing. This was especially the case among participants who are currently taking maintenance drugs for one or more chronic health conditions.

Employers and employees also offered several common criticisms of Plan A, which are summarized as follows:

- Participants at 13 focus groups expressed concern about the annual maximum benefit of \$100,000 being too low to cover truly catastrophic illnesses or injuries. For example, they argued that medical expenses could quickly exceed this threshold if a person was involved in a serious car accident, contracted cancer or another serious disease, or required a lengthy hospital stay. Most felt that an annual maximum benefit of \$250,000 to \$500,000 would be much more desirable, and while they acknowledged that these additional benefits would rarely be used, they would allow for considerably more peace of mind.
- Participants at eight companies expressed concern that the annual out-of-pocket maximum of \$11,000 was cost prohibitive. Especially for many young or low-wage employees, obtaining this amount of money at once could prove to be extremely difficult or even impossible. While some respondents suggested an annual out-of-pocket maximum of around \$2,000 or less, the majority felt that reducing this amount to about \$5,000 would be much more appropriate.
- Participants at five companies voiced concern that the annual deductible of \$1,000 was too high. In their opinion, many healthy individuals would experience little or no benefit from a plan with such a high deductible provision. Common suggestions for revised deductibles ranged from \$250 to \$750.
- Participants at five focus groups suggested that more than two doctor's office visits should be allowed at the \$25 co-payment. They contended that many people, and especially people with young children, could easily exceed this visit allowance in any given year. The most common suggestions were for between four and six co-pay visits each year.
- Participants at four companies felt that the 70/30 coinsurance requirement was either undesirable or unacceptable. They suggested that an 80/20 split is more consistent with the industry standard, and this lower coinsurance requirement would be significantly preferable.
- Participants at three companies suggested that four to six psychiatric/substance abuse visits were needed at the \$40 co-payment, and three others recommended that a vision exam should be included in the plan.
- Other miscellaneous suggestions included eliminating the separate \$500 deductible for prescription drug coverage, expanding the dental coverage to include common dental procedures, and adding chiropractic and acupuncture benefits.

Plan B also had several characteristics that were commonly cited as being especially attractive.

The relatively low deductible, coinsurance and out-of-pocket maximum were almost unanimously viewed as being very appealing, especially for young, healthy, low-wage, or blue-collar workers. Numerous participants also cited the co-payment structure of the prescription drug coverage as being much preferable to the deductible and coinsurance configuration under Plan A. The average annual cost of \$120 was viewed as a tremendous selling point as well, and the plan was overall viewed as an excellent low-cost alternative for uninsured small employers. Several participants also especially liked the fact that an annual vision exam and maternity care were included in the covered services.

Participating employers and employees expressed several common criticisms and suggestions for Plan B as well:

- Thirteen participants expressed concern that the prescription drug coverage of \$500 per year was not adequate. They felt that individuals with one or two maintenance drugs could easily exhaust this allowance in a given year and suggested that this amount be raised to at least \$2,000.
- Nine respondents voiced the opinion that ambulance services should be included in the plan. They argued that ambulances regularly cost hundreds or even thousands of dollars, and are essential when a true health crisis occurs.
- Six respondents suggested that both additional doctor visits and hospital days should be allowed each year. They felt that the restrictions of six doctor visits and five hospital days sounded adequate in a normal year, but these limits should be raised to approximately eight office visits and eight hospital days in the event that a moderately severe illness or injury takes place.
- Four respondents expressed concern that psychiatric and substance abuse coverage was not included on Plan B. They felt that coverage similar to that provided under Plan A would be reasonable, but four to six visits would be preferable.
- Two participants also felt that durable medical equipment, private duty nursing and skilled nursing facilities should be included.
- Other participants suggested that the dental coverage should be expanded to include common dental procedures and that chiropractic care and acupuncture should be included as covered benefits.

Participants also made several other important observations and recommendations about the prototype benefit plans. For example, sixteen employers supported the concept of having multiple benefit plan options available for each participating company, even if this would result in a slight premium increase each month. Several of these participants even suggested that TDI should provide three to five different plan options, with a more comprehensive plan or a truly catastrophic plan being included. Two participants took this concept a step further by recommending that the members of a family should be able to individually select the plan that best meets their needs. Six employers stressed the importance of contracting with a carrier that could provide the most comprehensive coverage network for this project in addition to cost considerations, while two employers opposed having a provider network of any kind. Three employers suggested that an expanded dental rider be made available at an additional cost, while three others suggested that temporary, part-time and seasonal workers be allowed to participate in the plan. Other employers others suggested that the dental and/or vision benefits be removed

altogether in favor of additional medical and/or prescription drug coverage. Another employer suggested that the plans include a credit to encourage enrollees to exercise and generally promote healthy lifestyle habits, while another suggested that the State should assume a key role in promoting and educating the public about this pilot program. This participant contended that the State's official endorsement of the pilot project would likely bring legitimacy to the plans and that an educational campaign directed by TDI would be an extremely valuable outreach instrument. Finally, another employer suggested that premiums be paid through payroll deductions or some other reliable mechanism to help ensure that policies are not allowed to lapse.

Section V: Revised Prototype Benefit Plans

After completing the focus group sessions, TDI held a follow-up meeting with the Houston State Planning Grant Small Employer Benefit Plan Working Group to present the original prototype benefit plans and discuss the input received at the focus groups. At the meeting, Milliman's actuarial consultants also discussed the premium impacts of several benefit plan revisions commonly recommended by focus group participants. Each plan revision was considered in relation to its relative premium increase, and an extremely important consideration was maintaining a premium of approximately \$150 per employee per month.

For Plan A, Working Group participants supported increasing the annual maximum benefit of \$100,000 and including two additional office visits at the \$25 co-pay for small children under the age of two. Annual maximum benefits of \$250,000, \$300,000, and \$500,000 were considered as alternatives. For Plan B, participants most supported including ambulance coverage, allowing a \$25 co-pay for two of the six annual doctor's office visits, and increasing the annual maximum prescription drug benefit of \$500. Annual prescription maximums of \$1,000 and \$2,500 were considered as alternatives. In both cases, the revised annual benefit maximums will ultimately be determined during negotiations with the carrier contracted to sell the benefit plans.

The following table provides a side-by-side comparison of the covered benefits under the revised prototypes of Plan A and Plan B. In this example, a \$300,000 annual maximum benefit is considered under Plan A, and a \$1,000 annual maximum prescription drug benefit is considered under Plan B. Increasing the annual maximum benefit of Plan A to \$300,000 added an average of \$8 to the estimated monthly premium cost, while two additional office visits at the \$25 co-pay for children added approximately 40 cents per month to the child premium. For Plan B, increasing the annual prescription drug benefit to \$1,000 added an average of \$10 to the premium of the original prototype. Ambulance coverage added about one dollar, and two office visits at a \$25 co-pay added about 70 cents. Overall, these benefit plan changes resulted in a premium increase of approximately \$8 for adults and \$4 for children per month under Plan A, and premium increases of approximately \$12 for adults and \$4 for children per month under Plan B.

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

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

Section VI: Conclusion

Using grant funds received from the Health Resources and Services Administration and the expertise of experienced health actuaries, marketing consultants and local stakeholders, TDI developed two prototype small employer health insurance plans as part of a pilot project to provide affordable health insurance for uninsured workers in Harris County. One plan provides primarily catastrophic benefits, while the other plan focuses more on primary and preventive care coverage. The initial catastrophic benefit plan design was estimated to cost approximately \$150 for adults and \$70 for children each month, while the primary and preventive care plan was estimated to cost approximately \$120 for adults and \$55 for children.

Focus group discussions with small business owners in Harris County provided extensive feedback on these plans. Support for the program was overwhelmingly positive, as 22 of the 25 participating companies expressed interest in purchasing either one or both of the prototype plans when they become available. Participants also provided a significant amount of oral and written feedback, and many of their suggestions have been incorporated into re-designed prototypes. TDI will continue to work with the Houston SPG Small Employer Benefit Plan Working Group, the Greater Houston Partnership and other stakeholders to finalize the program design and negotiate with a licensed carrier to market this new program. Although a number of significant details still must be finalized, the goal is to begin offering coverage in early 2007.