A VISION FOR CHANGE:
Policy Solutions for Increasing Health Coverage in Texas
Preface

In 1996, the Institute of Medicine (IOM) began an initiative to assess and determine how to improve the nation’s healthcare system. Initial findings concluded that the national system is in need of a complete transformation. Texas' healthcare system has serious obstacles to improvement.

Our state’s demographics and increasing challenges in healthcare access, for example, create daunting healthcare issues that will extend well into the future. Accordingly, the delivery of healthcare has to change to reflect the fact that there will be intense competition for financial and workforce resources.

Current policies to address some of the individual issues we face, such as the uninsured rate, workforce shortages, obesity epidemic, poverty and various other problems will not be enough to meet the needs of our growing population. We need an overarching shared vision for healthcare in Texas.

On May 25, 1961, President John F. Kennedy told members of Congress he wanted to land a man on the moon. The vision of a moon walk became reality in 1969 because it was a shared vision, supported by the stakeholders involved, who committed themselves to see the vision become reality. Sharing a vision, even a very lofty one, can catalyze dramatic achievement.

Addressing the myriad healthcare issues in a state as geographically, ethnically and socio-economically diverse as ours may seem like reaching for the moon, yet a shared vision for healthcare can lead us to improved access, effectiveness and efficiency. Recognizing the need to develop such a vision, Texas Health Institute (THI), formerly the Texas Institute for Health Policy Research, launched the Shared Vision for Healthcare Project (Project) in 2003. Today, the implementation of THI's Shared Vision for Healthcare Project focuses on three major areas: Access/Uninsured, Public Health/Prevention (obesity and mental health) and Long Term Care.

Entering our fourth year of the Project, THI is launching A Vision for Change: Policy Solutions for Increasing Health Coverage in Texas, a major educational initiative to increase health coverage for the uninsured in Texas by almost 50 percent and to measure the economic and fiscal impact of increasing Texans’ access to health coverage. The following report offers cost-effective and workable policy solutions to the uninsured issue that policymakers at state, regional and local levels can deploy.

Special thanks to Methodist Healthcare Ministries for supporting the research and public education outreach for this initiative. We also thank Houston Endowment, Rockwell Fund, Friends of the Institute and the Trull Foundation for their financial commitment and support to the Shared Vision Project. For a complete list of sponsors, please go to the back of this report.

Over the next few months, we will be moving quickly to educate the public as well as policymakers. THI will be doing what we do best. We will be providing non-partisan, evidence-based solutions to make a difference in improving the health of Texans. We will be convening diverse stakeholders to provide on going dialogue on how to improve
the status of health in Texas. We will be educating policymakers on what they can do to reduce the uninsured at a community, regional, and state level.

The success of the Shared Vision Project and the release of this report are directly attributable to the input and support of the THI board members, the Shared Vision panel and workgroup members, a myriad of stakeholders who have provided input, and the financial sponsors of our work.

We would also like to thank shared vision partners: Betty Sue Flowers; the LBJ Library and Foundation; Taylor Willingham with Texas Forums; Earl Grinols, Ph.D, Distinguished Professor, Economics, Baylor University; James Henderson, Ph.D., Ben Williams Professor, Economics, Baylor University. Thank you to leadership offices’ liaisons since 2003: Office of Governor Rick Perry – Victoria Ford, former Deputy Legislative Director / Senior Advisor for Health and Human Services and Nora Cox, Assistant Director, Budget Planning and Policy; Office of Lt. Governor David Dewhurst – Julia Rathgeber, Director of Policy, Jared Wolfe, former Senior Policy Analyst, and Jamie Dudensing, Senior Policy Analyst; Office of Speaker Craddick – Troy Alexander, Senior Policy Analyst; Office of Comptroller Strayhorn – Ruth V. Ford, former Special Assistant for Expenditure Analysis, Phyllis Coombes, Sr. Research Analyst, and Linda Gibson, Senior Health and Human Services Analyst.

There have been hundreds of volunteers working with THI on this report. We are thankful for each and every person who has supported us. THI is committed to providing the leadership and education so that solutions to increase health coverage of the uninsured by almost 50 percent can be achieved.

To learn more about Texas Health Institute and our work, please go to our website at www.texashealthinstitute.org or contact us at 512-279-3910.

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A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS

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Executive Summary

Texas has the highest rate of uninsured in the nation. More than 5.59 million Texans—nearly 25 percent of the state’s total population—lacks basic health coverage.

Of the $65 billion in healthcare delivered to the uninsured in the U.S., one-third of the cost is paid for by the uninsured. Of the remaining two-thirds, the government pays one-third and the rest is paid for by people with insurance—*we all already pay for the uninsured*.

We pay directly through higher insurance premiums and indirectly through property taxes and other taxes in cities and counties that have hospital districts and indigent healthcare programs. In fact, according to a study by Families USA in 2005, annual health insurance premiums for Texas families were about $1,551 higher than they would otherwise have been due to the cost of caring for uninsured patients.

A nationwide poll conducted by Americans for Health Care reported 86 percent of Americans support providing affordable healthcare for all Americans. An April 2006 Texas Hospital Association poll found nearly nine out of 10 Texans agreed with the statement “Texas should find a way to increase health insurance among those who need it so that the portion paid by those with health benefits does not continue to increase.”

The economic benefits resulting from increased healthcare coverage can be broadly categorized as increased labor force participation, greater worker productivity, and reduced sick days. In addition, increased access to healthcare coverage is associated with decreased mortality and an enhanced quality of life. With a growing consensus that something needs to be done and Texas’ forecasted $14.3 billion plus budget surplus, Texas is well-positioned to adopt a plan of action for increasing health coverage for Texans.

With that in mind, the Texas Health Institute, an independent, non-partisan think-tank, undertook a study to develop public policy solutions that, when combined together, could cut the number of Texans without health coverage almost in half. The study also examines the corresponding economic impact of increasing the number of Texans with health coverage.

Some of the report’s finding may surprise readers.

- *The uninsured work* - At least 72 percent of Texas’ uninsured live in households where one or more family members work full-time; another 10 percent live in households with a family member who works part-time. Most of these individuals work in one of Texas’ small businesses – those with 2-50 employees.

- *The uninsured are young* – Twenty-three percent of our uninsured are children younger than 18 years of age. An additional 36 percent are between the ages of 18 and 34 years of age.
The uninsured are not all poor – Forty percent of families without health coverage have incomes of $40,000 a year or more. However, in 2004 the cost of health coverage for a family of four would have been more than $11,000 or 25 percent of their annual income.

Geography matters – Every county in Texas has uninsured, but almost half live in Texas’ five largest urban counties: Bexar, Dallas, El Paso, Harris, and Tarrant. The counties whose populations have the highest percent of uninsured however, are along the Texas-Mexico border where between 29 to 34 percent of the residents are uninsured.

Ethnicity matters – Hispanics – a dramatically growing segment of the population – are three times more likely, and Blacks twice as likely, as Anglos to be uninsured.

How Covering the Uninsured Can Help the Texas Economy

Although the negative consequences of the uninsured have been carefully documented by many studies, the economic and fiscal benefits that may result from increasing the number of covered lives has rarely been examined. To help bridge this critical information gap, the Texas Health Institute commissioned an economist to answer the question: What are the economic impacts of cutting the number of uninsured Texans in half?

The economist determined that reducing the state’s uninsured by one half would be beneficial economically. Specifically, the analysis showed that in 2005:

- The Texas economy would have seen a total increase in annual economic activity of just over $9.4 billion.
- Direct healthcare expenditures in the economy would have increased by an additional $3.7 billion.
- Nearly 90,000 new jobs would have been created in all sectors of the economy.
- Total income (compensation to employees and employers) would have grown by more than $3.2 billion.
- Texas state government would have received more than $162 million in new revenues.

Health Coverage Affordability

Most uninsured Texans lack coverage because their employer does not offer health insurance, they cannot afford the coverage offered, or they are ineligible for employer supported insurance or publicly-funded programs such as the Children’s Health Insurance Program (CHIP) or Medicaid. Currently, only 24 percent of Texas’ small businesses offer health coverage.

Small employers and individuals tend to pose a higher risk for insurers than large employers, therefore health insurance premiums for small employers’ employees and individuals are higher than those for employees of large firms. Affordability is the number one reason cited by small businesses for not providing health insurance for their employees.

However, there are people who can afford the average individual health insurance policy premium, but their risk – due to health conditions – makes coverage inaccessible. For these people, lack of coverage is both an affordability and availability issue. For others, the issue is
not necessarily affordability, but whether they see the value of health coverage. For some people – most of them young – they do not believe they need health coverage.

**Policy Solutions**

Covering the uninsured will require solutions that address affordability and availability of health coverage as well as an outreach effort to educate the public about the importance of having coverage. This report contains a dozen policy solutions for creating a vision for change that will ultimately reduce the number of uninsured by almost half.

This vision includes addressing the high cost of premiums for small employers with ideas that lower insurers’ risks, encourage employer participation by reducing premium costs, make coverage more available for individuals with health conditions and low-income children and adults, and persuade young adults to obtain health coverage through colleges and universities.

These policy solutions are presented briefly below with the estimated numbers of Texans who would be covered. Together, they could help nearly 2.7 million Texans obtain health coverage for an annual cost to the state of about $1.6 billion. Additionally, these recommendations would bring more than $1.7 billion in federal funds to the state.

◆ **Working Texans**

**Solution 1. Provide Technical Assistance and Seed Funding for 3-Share/Multi-Share Programs** – By providing a modest amount of state funding, the number of these public-private, cost-sharing arrangements can be increased, and ones already under development strengthened. (Texans To Be Covered - 150,000)

**Solution 2. Expand Use of Medicaid Health Insurance Premium Program (HIPP)** – By changing the rules for the HIPP premium assistance program, more Medicaid eligible workers who have access to – but can’t afford – employer supported insurance, should be able to obtain and retain access to this coverage. (Texans To Be Covered – 7,000)

**Solution 3. Enact Employer Tax Credits** – By creating financial incentives for small employers that lower the cost of offering employer-based health coverage, the number of small businesses providing coverage to their employees will increase. (Texans To Be Covered - 316,614)

**Solution 4. Replace State’s Existing Reinsurance Program** – By lowering insurers’ risk, state-funded reinsurance can lower premiums, making health coverage more affordable for businesses and individuals who previously could not afford it. (Texans To Be Covered - 200,000)

**Solution 5. Expand Eligibility for Texas’ Insurance Health Risk Pool (TIHRP)** – By changing eligibility criteria to permit individuals to combine plans and enroll in TIHRP before exhausting transition benefits available as result of a job loss or change in family status, Texans who are more difficult to insure will have access to health coverage. (Texans To Be Covered - 7,868)
Solution 6. Increase Access to Pre-paid Medical Plans – By encouraging the development of these low-cost primary care plans, low-income workers will be able to replace the emergency room as their de facto source of healthcare with a regular medical home such as a primary care physician. (Texans To Be Covered – 200,000)

◆ Young Adults

Solution 7. Require All Texas Higher Education Students to Have Health Coverage – By obliging young adults in school to take advantage of the low-cost, comprehensive coverage available to them, they would learn the value and appropriate use of health insurance and be more likely to purchase coverage after leaving school. (Texans To Be Covered - 400,000)

◆ Children

Solution 8. Allow CHIP Buy-In at Full Premium Cost – By allowing working parents whose employers do not offer dependent coverage to buy into the state’s Children’s Health Insurance Program (CHIP) (and pay all or a portion of the costs depending on their incomes), Texas will enable these parents to better protect their children’s health. (Texans To Be Covered - 405,452)

Solution 9. Fully Restore the Children’s Health Insurance Program (CHIP) – By removing barriers to CHIP enrollment, children who currently have little or no access to needed medical services, will be able to secure the care they need. (Texans To Be Covered - 152,615)

Solution 10. Align Medicaid and CHIP Renewal Policies – By allowing annual Medicaid and CHIP renewals, low-income children will be less likely to have gaps in coverage and more likely to maintain better overall health. (Texans To Be Covered - 609,164)

◆ Poor/Medically Needy Adults

Solution 11. Expand Access to Medicaid for Poor Parents – By increasing Texas’ income eligibility criteria for parents of Medicaid eligible children, the state would give adults who otherwise have little or no access to medical services an opportunity to have healthier, more productive lives. (Texans To Be Covered - 417,688)

Solution 12. Encourage Expansion of Federally Qualified Health Centers – By encouraging the expansion of community health centers, the state will promote access to medical care in medically underserved and rural areas of the state. (Texans To Be Covered - 60,000)

Once Texas has taken steps to reduce its uninsured, there will be one more thing to do – make sure that the solutions adopted actually succeed in increasing the number of Texans with health coverage. A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS uses recently released numbers on the uninsured by county and region in Texas developed by the Texas State Data Center. These numbers should be updated annually, giving decision-makers the ability to track annual progress made to increase covered lives in Texas.
Almost one in four Texans lacked healthcare coverage in 2005 making Texas the state with the highest percent of uninsured in the country with more than 5.59 million or 24.5 percent of our residents uninsured.\(^1\) If you only consider those Texans under 64 years of age, the percent increases to 27 percent.\(^1\) Individual Texans and Texas communities suffer from a lack of health insurance.\(^2\)

Publications like the Kaiser Family Foundations’ *Sicker and Poorer: The Consequences of Being Uninsured*, The Common Wealth Funds’ *The Costs and Consequences of Being Uninsured*, and *Code Red: The Critical Condition of Health in Texas* (Code Red Report), for example, discuss in detail the negative consequences of the uninsured and underinsured including the effects on individual health; worker productivity and absenteeism; increases in expensive, emergency room utilization; and levels of uncompensated care experienced by both physicians and hospitals.\(^3\) Families USA notes that of the $65 billion in healthcare delivered to the uninsured nationally, one-third of the cost is paid for by the uninsured. Of the remaining two-thirds, government pays one-third and two-thirds is paid by people with insurance – that is, *we all already pay for the uninsured*.\(^4\) We pay directly through higher insurance premiums and indirectly through property taxes in cities and counties that have hospital districts.

This report grew from the Texas Health Institute’s Shared Vision Project. The Texas Health Institute is a non-partisan, non-profit organization committed to finding feasible solutions to Texas' health policy problems. The Institute understood that only through consensus and shared vision could Texas rise to the healthcare challenges the state faces. Since the inception of the Shared Vision Project in 2003, the Institute has brought business, community leaders, insurance, government, providers and consumers together to develop innovative ideas to improve the state's quality of health care.

The Shared Vision panel believes that one of the most pressing issues confronting the state is covering the uninsured. The panel has coined the phrase *RAISE The Health Of Texans* to express its vision. Each letter of RAISE represents an element of how to accomplish this: R-regional solutions; A-access to care, especially other than the emergency room; I-incentives for personal responsibility, S-sound use of resources, and E-education regarding consequences of acting or failing to act.

This report starts with the premise that the current levels of uninsured in Texas are unacceptable and must be addressed. Although any successful effort will need to involve all levels of government and community initiative, state leadership is needed to coordinate, focus and energize what is a far more serious problem in Texas than in other states. With the growing consensus that something needs to be done and Texas’ forecasted $14.3 billion budget surplus\(^5\), Texas is well-positioned to adopt a bold plan of action that incorporates

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\(^1\) **Note:** All calculations contained in this report use estimates of uninsured Texans developed by Dr. Steve Murdoch, Texas State Data Center, extrapolated from U.S. Census Bureaus, Current Population Survey (2004-2005).
multiple approaches to target specific sub-groups of the uninsured. Although reducing the number of uninsured Texans will not be easy, it is possible.

This report contains the following Chapters:

- **Chapter 2. Health Coverage in Texas.** An overview of healthcare coverage and the uninsured in Texas.

- **Chapter 3. How Insurance Works.** A discussion of private health coverage, including the impact of the uninsured on health insurance premiums

- **Chapter 4. Health Coverage and the Economy.** An examination of the positive fiscal and economic benefits for Texas if more Texans had healthcare coverage.

- **Chapter 5. State Best Practices to Reduce the Uninsured.** A look at the best practices and innovations in other states to increase access to affordable healthcare.

- **Chapter 6. Finding Solutions for Texas’ Uninsured.** A list of options for addressing healthcare coverage that could cut the number of Texans without healthcare coverage by almost half over the next three to five years.

- Appendices
CHAPTER 2. HEALTH COVERAGE IN TEXAS

Healthcare coverage may be funded by employers, individuals or a governmental entity (federal, state, or local), or a combination of these sources. In 2005, about 75 percent or 17 million Texans had access to needed medical services as a result of healthcare coverage – at least part of the year – through either traditional insurance or non-insurance health plans, such as employee health plans.\(^6\)

Of those Texans with health coverage in 2005, about 11 million or 48 percent received it through their employer, which is below national levels. Five percent more or 53 percent of all Americans with health insurance received coverage through their employers. When analyzing only the population under age 64, the gap is even wider; with 53 percent of Texans receiving coverage through their employers compared with 61 percent of all Americans.

Public programs, primarily Medicaid and Medicare, covered 12 percent and 10 percent of Texans, respectively. Medicaid is a federal-state funded program designed to provide healthcare coverage to the poorest and most vulnerable citizens; women, children, and the elderly.\(^7\) Medicare, a federally financed program, provides insurance to individuals aged 65 and older (regardless of their income), as well as certain disabled persons, or those with permanent kidney failure.\(^8\)

Only 4 percent of Texans had private, individual coverage in 2005. These individuals generally do not qualify for public healthcare coverage plans and do not have access to employer supported insurance (ESI). Many of these individuals are self-employed. Securing private non-ESI coverage can be both difficult and expensive especially for individuals from 50 to 65 years old (after which point Medicare goes into effect) or someone with a health condition.\(^9\)

Table 1 below summarizes where people in Texas get their healthcare coverage and compares this with Americans as a whole.

**Table 1.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>10,805,450</td>
<td>48</td>
<td>156,326,430</td>
<td>53</td>
</tr>
<tr>
<td>Individual</td>
<td>928,550</td>
<td>4</td>
<td>14,162,970</td>
<td>5</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2,743,730</td>
<td>12</td>
<td>37,868,010</td>
<td>13</td>
</tr>
<tr>
<td>Medicare</td>
<td>2,223,200</td>
<td>10</td>
<td>34,654,120</td>
<td>12</td>
</tr>
<tr>
<td>Other Public</td>
<td>281,230</td>
<td>1</td>
<td>3,358,460</td>
<td>1</td>
</tr>
<tr>
<td>Uninsured</td>
<td>5,537,960</td>
<td>25</td>
<td>46,577,440</td>
<td>16</td>
</tr>
</tbody>
</table>


Upon examination of Texas’ uninsured population, we learn some surprising facts.
Who Are The Uninsured?

The Uninsured Work

At least 72 percent of Texas’ uninsured live in households where one or more members work full-time. An additional 10 percent live in households where a household member works part-time. So, contrary to popular opinion, the overwhelming majority of uninsured participate in the labor force. Most uninsured workers are employed by small businesses (with 50 or fewer employees). This means that uninsured workers in Texas lack access to coverage through their employers because the employers don’t offer it, the employee isn’t eligible for what’s offered, or what’s offered is too costly for the employee to afford.

In 2005, Texas had more than 412,520 employer businesses operating in the state – that is businesses that have employees. Over 85 percent or about 360,000 of these Texas businesses have fewer than 50 employees. In addition, Texas is home to over 1.1 million sole proprietors. Nationally about 26.3 percent of self-employed workers are uninsured.

At least 85 percent of Texas employers with over 100 employees offer health insurance. However, even employees in these firms may lack insurance if they do not work full time – 30 hours per week or more – or do not meet their company’s other criteria for healthcare coverage eligibility such as length of employment.

In contrast to employers with over 100 employees, only 24 percent or about 86,000 of Texas’ small employers provided their employees with insurance. In 2005, the Texas Department of Insurance (TDI) estimated that these small businesses provided health insurance coverage for approximately 1.12 million employees down from a high of more than 1.4 million covered lives in 2000.

In discussions about the uninsured in the U.S. we often talk about income levels of the uninsured in terms of the federal poverty level (FPL). Because the FPL will be used as a frame of reference throughout this document, Table 2 below lists the 2006 FPL for households with one to four members.

<table>
<thead>
<tr>
<th>Persons in Families or Household</th>
<th>100% Federal Poverty Level (FPL)</th>
<th>200% FPL</th>
<th>300% FPL</th>
<th>400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$9,800</td>
<td>$19,600</td>
<td>$29,400</td>
<td>$39,200</td>
</tr>
<tr>
<td>2</td>
<td>$13,200</td>
<td>$26,400</td>
<td>$39,600</td>
<td>$52,800</td>
</tr>
<tr>
<td>3</td>
<td>$16,600</td>
<td>$33,200</td>
<td>$49,800</td>
<td>$66,400</td>
</tr>
<tr>
<td>4</td>
<td>$20,000</td>
<td>$40,000</td>
<td>$60,000</td>
<td>$80,000</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Health and Human Services, The 2006 HHS Poverty Guidelines
In 2005, 50 percent of all working uninsured Texans had incomes above 200 percent of the federal poverty level – an income level considered to be “non-poor.” In contrast, of the Texans who were uninsured and unemployed in 2005, more than 75 percent had incomes below 200 percent of the federal poverty level with almost two-thirds of those individuals with incomes below 100 percent of the federal poverty level. Table 3 shows uninsured Texans by employment status and poverty level.

Table 3.

<table>
<thead>
<tr>
<th></th>
<th>All Workers</th>
<th>Worked full-time year-round</th>
<th>Worked &gt; full-time year-round</th>
<th>Did not work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sum</td>
<td>%</td>
<td>Sum</td>
<td>%</td>
</tr>
<tr>
<td>Total Uninsured 19-64</td>
<td>4,162,417</td>
<td>100%</td>
<td>1,869,708</td>
<td>100%</td>
</tr>
<tr>
<td>Below 100%</td>
<td>1,156,226</td>
<td>28%</td>
<td>261,237</td>
<td>14%</td>
</tr>
<tr>
<td>100% to below 200%</td>
<td>1,386,712</td>
<td>33%</td>
<td>681,692</td>
<td>36%</td>
</tr>
<tr>
<td>200% and above</td>
<td>1,619,479</td>
<td>39%</td>
<td>926,779</td>
<td>50%</td>
</tr>
</tbody>
</table>


According to a study by the Families USA Foundation, the average cost for coverage for a family of four, two parents and two children, averages over $9,000 per year. A family living at two-times (or 200 percent) the federal poverty level (FPL) in 2005 made about $40,000 per year. With average annual premiums at $9,000, health insurance premiums would consume almost 25 percent of their income.16

Obtaining coverage can be difficult and costly for small businesses and individuals. The Texas Department of Insurance (TDI) conducted an initial survey of small employers related to health coverage status in 2001 and followed up again in 2004 with an updated survey. TDI found that cost continued to be the primary reason why small businesses failed to offer or dropped health insurance coverage. In addition, business owners reported feeling overwhelmed by the complexity of the insurance market and that selecting a health plan to meet their employee’s needs was both time consuming and frustrating.17

Sixty-nine percent of respondents to the TDI survey indicated they could afford less than $100 per employee per month for health coverage. Just as importantly, surveyed employers indicated that even when they are able to offer coverage, employees often cannot afford their share of the cost of coverage – this was particularly true for “family coverage.” Survey results indicate family coverage cost an average of $11,000 per year in Texas in 2004.18

A family of four – two parents and two children -- living at two-times (or 200 percent) the FPL in 2005 made about $40,000 per year. With average annual premiums at $11,000, health insurance premiums would consume over 25 percent of their income..

Texas Department of Insurance, 2005
Many states, including Texas, enacted small business health insurance reforms in the 1990s. These reforms, such as guaranteed issue and limits on pre-existing conditions exclusions, have had a positive impact on the number of businesses offering health coverage in Texas. However, recent studies suggest that these reforms may have reached their limit in terms of having a substantial impact on lowering the number of uninsured because they had not had a meaningful effect on reducing health coverage premiums.\(^9\) At least one Texas study found that once the worker’s share of the premiums exceeded five percent of their family’s income, the likelihood that the employee would enroll in the offered health plan declined significantly.\(^{20}\)

### The Uninsured Are Young

Slightly more than 23 percent of Texas’ uninsured are children 17 years of age or younger. Another 36 percent or almost 2.2 million of Texas’ uninsured are between 18 and 34 years of age. (Table 4 below). This group between 18 and 34 years of age, is the most likely group of uninsured to say they cannot afford insurance and that they do not need insurance.

### Table 4.

<table>
<thead>
<tr>
<th>Texans 18 to 34 Years of Age by Insurance Status, 2005</th>
<th>Persons</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Uninsured All Ages</td>
<td>5,590,477</td>
<td>n/a</td>
</tr>
<tr>
<td>Insured 18-34 yr olds</td>
<td>3,800,640</td>
<td>64%</td>
</tr>
<tr>
<td>Uninsured 18-34 yr olds</td>
<td>2,166,048</td>
<td>36%</td>
</tr>
</tbody>
</table>

**Source:** Texas Department of Insurance, November 2005
Geography Matters

Where Texans live has important implications for how the state should craft policy solutions and engage in outreach efforts. Half of the state’s uninsured live in five large urban counties—Bexar, Dallas, El Paso, Harris, and Tarrant. Ten Texas counties account for almost two-thirds or 64 percent of Texas’ uninsured. However, these 10 counties account for only 58 percent of the population. (Table 5) When we look at the counties with the highest number of uninsured as a percent of the county’s total population, a very different picture emerges. Nine of the 10 Texas counties with the highest percent of uninsured reside along the Texas-Mexico border. Webb County has the highest percent of uninsured in the state with one-in-three residents uninsured. (Table 6).

Table 5.
Ten Texas Counties With Highest Numbers of Uninsured 2005

<table>
<thead>
<tr>
<th>Population</th>
<th>Total Census</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris</td>
<td>3,693,051</td>
<td>1,115,478</td>
</tr>
<tr>
<td>Dallas</td>
<td>2,305,455</td>
<td>642,031</td>
</tr>
<tr>
<td>Bexar</td>
<td>1,518,372</td>
<td>383,233</td>
</tr>
<tr>
<td>Tarrant</td>
<td>1,620,480</td>
<td>369,635</td>
</tr>
<tr>
<td>El Paso</td>
<td>721,600</td>
<td>236,775</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>678,277</td>
<td>229,428</td>
</tr>
<tr>
<td>Travis</td>
<td>888,185</td>
<td>171,752</td>
</tr>
<tr>
<td>Ft Bend</td>
<td>463,652</td>
<td>129,419</td>
</tr>
<tr>
<td>Collin</td>
<td>659,458</td>
<td>125,212</td>
</tr>
<tr>
<td>Cameron</td>
<td>378,312</td>
<td>123,466</td>
</tr>
<tr>
<td>Total</td>
<td>12,926,842</td>
<td>3,526,429</td>
</tr>
</tbody>
</table>

Source: Texas State Data Center, December 2006

Note: This is 64.12 percent of the total uninsured in the state in 2005

Table 6.
Top 10 Texas Counties By Uninsured As A Percent of Population

<table>
<thead>
<tr>
<th>Population</th>
<th>Uninsured</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webb</td>
<td>224,696</td>
<td>78,136</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>678,277</td>
<td>229,428</td>
</tr>
<tr>
<td>El Paso</td>
<td>721,600</td>
<td>236,775</td>
</tr>
<tr>
<td>Cameron</td>
<td>378,312</td>
<td>123,466</td>
</tr>
<tr>
<td>Starr</td>
<td>60,941</td>
<td>18,603</td>
</tr>
<tr>
<td>Maverick</td>
<td>51,183</td>
<td>15,537</td>
</tr>
<tr>
<td>Harris</td>
<td>283,631</td>
<td>9,517</td>
</tr>
<tr>
<td>Zavala</td>
<td>11,797</td>
<td>3,536</td>
</tr>
<tr>
<td>Willacy</td>
<td>20,383</td>
<td>5,994</td>
</tr>
<tr>
<td>Zapata</td>
<td>13,373</td>
<td>3,933</td>
</tr>
</tbody>
</table>

Source: Texas State Data Center, December 2006
The map below shows the distribution of Texas’ uninsured by state public health region.

**Illustration 1. Uninsured by Texas Public Health Regions 2005**

![Map of Texas showing uninsured rates by region](image)

Source: Texas State Data Center, December 2006 and Texas Department of State Health Services, July 2005

**Ethnicity Matters**

Texas minorities are more likely than Anglos to be uninsured. Hispanics are three times more likely and Blacks twice as likely as Anglos to be uninsured. The Texas Office of the State Demographer, projects that over the next 15 to 30 years, Hispanics will become the majority population in our state. If Hispanics remain uninsured at current rates, Texas can expect its level of uninsured to increase significantly in coming years. **Table 7** examines Texas’ uninsured by age and ethnicity.
Table 7.

Texas Uninsured by Age Group and Ethnicity - 2005

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Uninsured Anglos</th>
<th>% Uninsured</th>
<th>Uninsured Hispanics</th>
<th>% Uninsured</th>
<th>Black/ Other Uninsured</th>
<th>% Uninsured</th>
<th>Total TX Uninsured</th>
<th>% Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>321,570</td>
<td>13%</td>
<td>877,988</td>
<td>32%</td>
<td>236,125</td>
<td>23%</td>
<td>1,435,683</td>
<td>23%</td>
</tr>
<tr>
<td>18-34 yrs</td>
<td>576,496</td>
<td>23%</td>
<td>1,242,710</td>
<td>50%</td>
<td>346,842</td>
<td>35%</td>
<td>2,166,048</td>
<td>36%</td>
</tr>
<tr>
<td>35-44 yrs</td>
<td>249,891</td>
<td>15%</td>
<td>483,058</td>
<td>42%</td>
<td>141,698</td>
<td>25%</td>
<td>874,647</td>
<td>26%</td>
</tr>
<tr>
<td>45-64 yrs</td>
<td>410,546</td>
<td>13%</td>
<td>465,883</td>
<td>37%</td>
<td>198,257</td>
<td>26%</td>
<td>1,074,686</td>
<td>21%</td>
</tr>
<tr>
<td>65 + yrs</td>
<td>9,313</td>
<td>1%</td>
<td>19,943</td>
<td>5%</td>
<td>10,157</td>
<td>4%</td>
<td>39,413</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>1,567,816</td>
<td>14%</td>
<td>3,089,582</td>
<td>39%</td>
<td>933,079</td>
<td>26%</td>
<td>5,590,477</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: Texas State Data Center, December 2006

Non-Citizens Represent 26 Percent of the Uninsured

The final group of uninsured Texas residents that needs to be mentioned is uninsured non-citizens. While three-fourths of the state’s uninsured are U.S. citizens, one-fourth are non-citizens. This fact has implications for the state’s ability to employ certain types of solutions for covering all the state’s uninsured. For instance, with the exception of the state’s hospital districts and county indigent health care programs, most federal and state funded healthcare programs such as Medicaid and the Children’s Health Insurance Program (CHIP) exclude coverage for most non-citizens. Table 8 below summarizes Texas’ uninsured by citizenship status.

Table 8.

Table 8. Texas’ Uninsured by Citizenship Status (2005)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>%</th>
<th>Insured</th>
<th>%</th>
<th>Uninsured</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Texans</td>
<td>22,331,125</td>
<td>100%</td>
<td>16,770,890</td>
<td>100%</td>
<td>5,560,235</td>
<td>100%</td>
</tr>
<tr>
<td>Citizen</td>
<td>19,834,256</td>
<td>89%</td>
<td>15,703,081</td>
<td>94%</td>
<td>4,131,176</td>
<td>74%</td>
</tr>
<tr>
<td>Non-Citizen</td>
<td>2,496,868</td>
<td>11%</td>
<td>1,067,809</td>
<td>6%</td>
<td>1,429,059</td>
<td>26%</td>
</tr>
</tbody>
</table>

CHAPTER 3. HOW INSURANCE WORKS

As previously noted, almost three-quarters of Texas’ uninsured work or live in a household where one or more members work full-time. Most of these Texans lack coverage because their employer does not offer health insurance, they cannot afford the coverage offered, or they are ineligible for employer supported insurance (ESI) or publicly funded programs such as CHIP or Medicaid. Individual coverage, which is generally more expensive than group coverage, also is unaffordable for many uninsured, working Texans.

Before presenting specific proposals for increasing the number of Texans with healthcare coverage, a basic understanding of the mechanics governing private health insurance is provided. Gary Glaxton of the Institute for Health Care Research and Policy defines private health care coverage as:

> a mechanism for people to (1) protect themselves from the potentially extreme financial costs of medical care if they become severely ill, and (2) ensure that they have access to health care when they need it.22

Of those with private health insurance coverage, most obtain coverage through their employers. About 48 percent of Texans have ESI coverage while only 4 percent have private, individual coverage. Private insurance is generally delivered through state-licensed health insuring organizations or self-funded employee health benefit plans. Commercial carriers such as Aetna, Blue Cross/Blue Shield Plans, and health maintenance organizations (HMOs) are all state-regulated, licensed insuring entities. Self-funded employee plans operate under federal law and are sponsored by employers, employees or both.

Below we briefly describe the Employee Retirement Income Security Act of 1974 (ERISA), the factors and underwriting practices insurers use to determine insurance premiums, efforts of the federal and state governments to increase access to health insurance, and relevant Texas insurance law.

ERISA

State insurance agencies regulate and monitor licensed insuring organizations while employee health plans are governed by the federal ERISA. Generally, ERISA pre-empts state insurance laws, meaning that in most cases ERISA governs what employee health plans can do rather than the states. There are several major differences between employee health plans and insurance. Under an employee health plan:

- an individual may not recover economic (e.g. lost wages) or non-economic damages (e.g. pain and suffering) in the event they have been harmed by the action of a health plan,
- the plan is exempt from the inclusion of certain state-mandated benefits in the health plan, and
- the plan must assign a fiduciary who controls the management of the employee benefit plan.
Large employers – those with 500 or more employees – are more likely to “self-insure” than employers with fewer employees. Because these plans are not regulated by the states, there is no state-level data on the number of employees covered by these plans. Although recent data is unavailable, in 1995 TDI reported that 40 percent of Texans with healthcare coverage had coverage through self-funded employee health plans.23

### Premiums

In order to understand why insurance premiums are priced as they are, it is important to understand the basis for determining premiums. The premium is the price an individual, an employer or another third-party payer pays to participate in a given health plan. Insurers base the costs of the insurance policies they sell on likelihood or risk of having to pay to cover high healthcare expenses. Therefore, all other things being equal, the lower an insurer’s risk, the lower the cost of a health insurance policy.

Healthcare coverage providers (HCP) pool healthcare risks to bring predictability to the costs they incur related to the claims they pay. To create predictability, HCPs try to create insurance pools that look as much like the general population as possible. Specifically, HCPs do not want the number of individuals with poor health in any given pool to exceed the levels you would find of them in the general population. Therefore, it is essential for a given group of people with coverage to include healthy people, in addition to those with existing health conditions.

If the pool has a disproportionate share of people in poor health, with high medical expenses, the cost of providing coverage to that group of individuals will rise. When a higher number of high-cost individuals than expected join an insurance pool it is called *adverse selection.* Whenever reforms to the state’s insurance system are proposed one of the first concerns raised is whether the proposed change will result in “adverse selection.” This will be discussed in more detail as it relates to the proposals for increasing the number of Texans covered with private healthcare coverage.

Insurers also seek groups that are stable. This, among other things, puts small employers at a disadvantage relative to larger businesses in obtaining affordable healthcare coverage. Small businesses tend to be less stable both in terms of employee turnover and employee mixture. For example, if a healthy employee leaves to be replaced by an employee with relatively poorer health, it would change the employee mixture and could significantly impact the cost of the business’ health coverage premiums.

### Underwriting

To determine what to charge for a given health insurance policy and protect against adverse selection, HCPs underwrite policies. Glaxton defines underwriting as:

*The process of determining whether or not to accept an applicant for coverage and determining what the terms of coverage will be including the premium.*24

In underwriting, an insurance agent or actuary examines a group’s claims history, age distribution, industry and geographic location. When considering an individual for coverage, insurers examine the individual’s health status and claims history. For the purposes of underwriting, insurers make a distinction between large employers, small employers, and individuals. Each of these represents a distinct market.
When determining a group’s premium levels, an agent will consider the different characteristics of the group. For example, the higher the median age in a group, the higher the premium is likely to be because older people are expected to have higher healthcare costs than younger people. In fact, people over 50 cost (as a group) as much as twice as much as people under 20 years of age.

The larger the group, the more likely the insurer will be able to manage their risk. This is one of the reasons it is so costly and difficult for individuals to find healthcare coverage – insurers cannot spread their risk. An individual in poor health will be charged a higher premium than a healthy individual or a member of a group if an individual can find someone to write them a policy at all.

Other ways HCPs limit adverse selection include limiting enrollment in their health coverage product to open enrollment periods, excluding certain conditions (i.e. pre-existing conditions clauses), requiring a certain percentage of a group to enroll, and limiting certain benefits. All of these activities inject predictability into determining the cost of providing health coverage, but these efforts to minimize adverse selection can make it very difficult for certain uninsured individuals or businesses to obtain healthcare coverage at an affordable cost.

Texas Underwriting

The Texas Department of Insurance (TDI) licenses and regulates health insurance and to some extent employee health plans. Although TDI does not set or approve premium rates for small employers, state law and TDI regulations establish limits and guidelines that carriers must use when calculating rates for small employers. These limits are referred to as “rate bands.”

When underwriting small group plans, Texas law allows insurers to use five characteristics in establishing premium rates for the group. These criteria are generally considered to be good predictors of expected health care claims costs. The characteristics are:

- **Age of employees** – The older your employees are, the more you can expect to pay for health insurance;
- **Gender of employees** – Females tend to be more expensive during the ‘child-bearing’ ages. This difference diminishes as women age and then males exceed women in healthcare costs after age 50;
- **Size of the small employer group** – As the size of the group increases, administrative costs diminish and risk can be spread over a larger number of people;
- **Industry classification** – Some industries have higher claims because of the danger of the job. Others incur higher administrative cost because of high employee turnover; and
- **Geographic area** – Medical costs vary from region to region and may even differ within an area.

Insurers are not required to use all criteria. Regardless of which of the allowed characteristics the insurer uses, they must apply the same ones to all the small businesses they cover unless the insurer receives prior approval from TDI regulators.
When determining the cost of a health plan, insurers look at the characteristics of the group they are covering and the specifics of the health coverage plan the group is buying. Insurers may add up to an additional 15 percent to the premium related to the group’s industry and another 20 percent for the group’s size. Finally, the insurer considers the group’s “risk load.” Factors related to health status or experience of a small employer group or of any member of a small employer group are considered “risk characteristics.” This factor may add up to 67 percent to the cost of the group’s premium. Any premium costs assigned as a result of the group’s risk must be applied to all members of the group uniformly.

Promoting Access and Affordability

While HCPs need to protect themselves against adverse selection, the government – both state and federal – has taken steps to minimize the impact of underwriting on access to healthcare coverage. Some of the protections included in federal law are described briefly below.

Health Insurance Portability and Accountability Act (HIPAA)

The 1996 federal Health Insurance Portability and Accountability Act (HIPAA) contains regulatory provisions designed to help people retain coverage when an employer drops healthcare coverage or the individual changes or loses employment. Specifically, HIPAA addresses portability, access to coverage, renewability, non-discrimination, and mandated benefits. HIPAA applies to both insuring organizations and employee health plans.

Portability means the ability to access healthcare coverage when changing from one job to another. In the past, workers were unable to obtain coverage in a new job because of pre-existing conditions. A pre-existing condition is an illness or medical condition a person was diagnosed with or treated for prior to becoming insured under a policy. HIPAA limits pre-existing conditions exclusions to 12 months, and the number of months a new enrollee can be excluded is reduced by the number of months they had been covered by a private or public health plan.

Although HIPAA does not address the premiums that can be charged, the law does require insurers to make any small group products they sell available to all small groups that apply regardless of the group’s claims experience or health of the group. It also requires insurers to accept certain people leaving the group market in the individual market regardless of their health status.

Although HIPAA does not govern what can be charged, it does guarantee that coverage can be renewed at the end of the coverage period. Finally, HIPAA prohibits insurers and health plans from considering an individual’s health status in determining the individual’s eligibility for group coverage or premium contribution.

Texas Specific Provisions

Texas law contains a number of provisions and programs established to increase access to and affordability of healthcare coverage for the state’s residents. These include consumer protections similar to those established in federal law regarding health coverage issuance and renewal, programs such as insurance cooperatives created to bolster small employers’ entry...
into the private insurance market and the state’s High Risk Pool designed to provide access to individuals that are generally considered uninsurable.

**Guaranteed Issue and Renewability**

To increase the accessibility and affordability of health coverage, states may establish standards for the terms under which a licensed insuring organization must accept an applicant. The standards also may govern whether an insurer must renew a policy and limit the amount above the state’s standard rate certain policies can be written. States also may require or mandate inclusion of certain benefits in plans written by insurance companies.

Over the past few years state and federal lawmakers have improved healthcare coverage affordability and availability for small employers – those with two to 50 employees – by providing guaranteed issue protection. This means if a licensed insuring organization sells small employer coverage in Texas, it may not refuse to cover small employers who have employees with health problems. Texas law requires that all eligible employees and their dependents must be offered coverage. Although health status may be screened to determine premiums, group members cannot be excluded for health reasons.27

Texas also has a statute that requires insurers to renew a business’ health policy. This is “guaranteed renewability”, which means that the insurer must allow a business or individual to renew a policy. However, this provision does not prevent an insurer from changing the premium rates (i.e. charging a higher rate) upon renewal.
Chapter 4. Health Coverage and the Economy

Discussions on the uninsured often begin with the negative consequences that result when people lack healthcare coverage. Although the negative consequences are well documented, the economic and fiscal benefits that may result from increasing the number of insured are rarely examined. The following sections quantify the fiscal and economic benefits the state could achieve if the number of uninsured were decreased by half.

The economic benefits resulting from increased healthcare coverage can be broadly categorized as improved health outcomes, increased worker productivity, and enhanced quality of life. The literature on these benefits is described briefly below.

The economic benefits resulting from increased healthcare coverage can be broadly categorized as improved health outcomes, increased worker productivity, and enhanced quality of life. An August 2005 Commonwealth Fund study stated, "A healthy workforce is one of our most important economic assets as a nation." Simply put, healthy workers are more productive than workers who are similar but not healthy. Numerous studies link investments in health and nutrition of the young to adult wages. Better health also raises per capita income through a number of other channels; for example, decisions about expenditures may be altered, which in turn affect savings over the life cycle. Increased savings substantially boosts investment and economic growth.

We propose that health status is one of the important underlying factors in enhancing or maintaining productivity in the labor force. Health status is one of the many factors that determine the quantity (working time) and quality (productivity) of employees. The health status of employees may, in addition, affect the efficient use of capital. For example, work-loss days or reduced productivity at work result in idle physical capital, which may represent a serious loss for the company.

Economic Benefits of Improved Health Outcomes

The economic benefits of improved health outcomes can be described from a variety of perspectives.

Decreased Mortality

Most researchers who assess the effects of mortality on the economy assume that the value of an individual’s work and its contribution to society is measured in terms of a person’s potential income generation. The impact of mortality is typically measured as the present value of forgone future income.
As healthcare has improved, so too has average life expectancy. "Full income" is a concept economists often use that captures the value of changes in life expectancy by including them in an assessment of economic welfare. Estimates of changes in full income are typically generated by adding the value of changes in annual mortality rates to changes in annual gross domestic product (GDP) per person. In 2003, Nordhaus assessed the growth in full income per capita in the United States in the 20th century. He concluded that more than half of the growth in full income in the first half of the century - and less than half in the second half of the century - has resulted from a decline in mortality. In this period, real income in the United States increased six fold and life expectancy increased by more than 25 years.\(^3\)

**Increased Labor Force Participation**

When people are unable to work or drop out of the workforce because of serious health problems or disability, they do not generate economic output, pay taxes on earnings, or help raise the nation's economic standard of living. A survey by the Commonwealth Fund estimated that 18 million Americans ages 19 to 64 are not working due to health reasons, including disability and chronic disease.\(^3\) As study authors Davis et al. note:

> Investing in the health of workers and the prevention of disability and serious illness could have an economic payoff. The U.S. labor force would expand, with the potential for a significant increase in the nation's standard of living and economic output. Even valuing lost work-time at the minimum wage, the nation gives up $185 billion each year in economic output because of its workers' health problems.\(^3\)

**Fewer Sick Days**

As noted in the Commonwealth Fund's study, the health problems of workers and their families constitute a substantial source of lost productivity in days absent from work. They estimate that among active workers, 29 percent of those employed full or part time reported having chronic health problems. Another substantial number of workers are in good health, but miss work days to care for family members who are ill or disabled. Their survey found that:

- An estimated 69 million workers took sick days in 2003, amounting to 407 million lost days of work. Valuing this missed time at workers' actual wage rates, an estimated $48 billion of economic output was not generated due to time off while sick.

- Nearly two-thirds (64%) of survey respondents said they had missed at least one day of work in the past year because of their own health problems or a family member's health problems. About 20 percent of workers miss six or more days.

Poor health status was found to be the most significant predictor of missed work compared to other factors such as wage rate, sick leave benefits, family structure, and age. Compared with healthier workers, workers with health problems have two-and-a-half times the risk of having six or more sick days during the year, holding all other factors constant.

"A healthy workforce is one of our most important economic assets as a nation."

Common Wealth Fund 2005
Increased Productivity on the Job

"Presenteeism" is a term that describes health-related productivity loss while at work. It describes an employee who is present at work, but is limited in some aspect of job performance by personal health-related problems or problems of a family member. Many workers go to work even when they do not feel well or are worried about a family member who is ill. In addition to creating a heightened risk of injury or a spread of infectious diseases, such presenteeism exacts an economic price as well, in reduced productivity or output.

A Commonwealth Fund study notes that illness-related presenteeism has a significant impact on the economy. Based on the survey, 55 million workers experience a time when they are unable to concentrate on the job because of a personal or family member's illness. The total number of days per year of reduced productivity due to illness is 478 million. Assuming these workers were working at half-capacity, and based on their average earnings, the economic output not generated during these days would be valued at $27 billion.

Measuring the Impact of Increasing Health Coverage

A 2003 study by two economists, Jack Hadley and John Holahan, begins to answer the question, "What is the impact of failing to cover the uninsured?" TXP, a Texas-based economic consulting firm, commissioned for this report, has used the Information from the Hadley and Holahan study to develop estimates of increased medical spending in Texas if the number of uninsured is decreased by 2.75 million or cut in half. The secondary economic effects of this new spending are then modeled, yielding the total economic impact.

Hadley & Holahan 2003 Study

Hadley and Holahan attempted to quantify the impact of health insurance on patterns of medical spending by the currently uninsured. Their analysis estimated the cost of increased medical care used by the uninsured under two alternative assumptions: The newly insured's spending would be similar to that of either lower or middle-income people covered by (1) the average private health insurance policy, or (2) the average public insurance policy (primarily Medicaid and the State Children's Health Insurance Program).

To simulate health care spending of the uninsured if they should gain insurance coverage, Hadley and Holahan estimated a series of statistical models that relate annual health care spending to measures of insurance coverage, socio-demographic characteristics, and health status. They estimated separate models that combined a sample of uninsured people with samples of lower and middle-income people with either private or public insurance. In the simulations, differences in predicted expenditures between the public and private insurance models were attributable to a combination of:

- Differences in the effects of each type of insurance coverage on medical spending. Private insurance generally incorporates cost sharing through deductibles, coinsurance and co-payments; and offers a range of covered services. Private insurance also provides access to a broad set of providers under varying payment rates. Public insurance typically incorporates very little patient cost sharing and covers a broad range of services but limits access to a more narrow set of providers who are willing to accept lower payment rates.
Differences in the characteristics of the uninsured relative to people with full-year private or public insurance. There are likely differences in care-seeking behavior attributable to socio-demographic differences between the uninsured and the insured populations.

The predictions in the models are based on the characteristics of the uninsured population under the assumptions that they have coverage for a full year. The effects of socio-demographic and health characteristics reflect the average behavior of the uninsured and of the specific insured sample used to estimate the statistical models.

Hadley & Holahan’s analysis is summarized in the Table 9 below, which reports the simulated impact of insurance coverage on medical expenditures per uninsured person. Baseline spending figures include out-of-pocket payments, insurance payments for people with part-year coverage, and identified sources of uncompensated care (i.e. public hospitals and clinics, workers’ compensation, and local welfare programs), but they do not include uncompensated care paid for by implicit sources, such as general government payments to private providers, private philanthropy, or providers’ financial surpluses. The authors note that prior research indicates that this would add approximately 15 percent to the estimate of baseline per capita spending by people uninsured any part of the year.

Table 9.

<table>
<thead>
<tr>
<th>Per Capita Annual Healthcare Spending by Insurance Status: 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Children</td>
</tr>
<tr>
<td>Adults</td>
</tr>
</tbody>
</table>

Source: TXP, December 2006

The study goes on to estimate total simulated spending for the populations of people who would gain coverage under these universal insurance scenarios. The baseline estimate of the amount of medical care used by the uninsured is $98.9 billion, which includes all uncompensated care (explicitly and implicitly financed), insurance payments for people with part-year coverage, payments from other identified sources, and the insured's out-of-pocket payments. Under the private insurance scenario, total spending for all people who are uninsured would increase to $167.6 billion. Under the public insurance scenario, total spending would be $132.8 billion.

Interestingly, the authors point out that the results of this study are quite similar to unpublished estimates made by researchers at the U.S. Agency for Healthcare Research and Quality, who used the same data but used some different methodological assumptions. The study estimates of the percentage increase in healthcare spending are also similar to projections from earlier studies that simulated the cost of increases in the use of specific services. The authors note, therefore, that:
…in spite of methodological variations across studies, our estimates are consistent with the results of other studies that predicted an increase in total health spending of 3-6 percent associated with expanding insurance coverage to the uninsured.

**Application in Texas**

The data developed by Hadley & Holahan can be used to create current estimates for Texas. As a first step, the dollar values in their study, which were based on 2001 data, are inflated to current dollars, using the national Medical Consumer Price Index as the basis for inflation. See Tables 10 and 11 below.

**Table 10.**

<table>
<thead>
<tr>
<th>Medical Consumer Price Index (M-CPI)</th>
<th>Annual Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>272.8</td>
</tr>
<tr>
<td>2002</td>
<td>285.6</td>
</tr>
<tr>
<td>2003</td>
<td>297.1</td>
</tr>
<tr>
<td>2004</td>
<td>310.1</td>
</tr>
<tr>
<td>2005</td>
<td>323.2</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td><strong>18.5%</strong></td>
</tr>
</tbody>
</table>

*Source: U.S. Census Bureau, TXP*

**Table 11.**

<table>
<thead>
<tr>
<th>Per Capita Annual Healthcare Spending by Insurance Status: 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
</tr>
<tr>
<td>Children</td>
</tr>
<tr>
<td>Adults</td>
</tr>
</tbody>
</table>

*Source: TXP, December 2006*

The difference between spending by the uninsured and spending by those with insurance is the incremental basis for estimating the direct impact of increasing health insurance coverage. Table 12 provides more detail.
Table 12.

<table>
<thead>
<tr>
<th></th>
<th>Uninsured</th>
<th>“Average” Uninsured</th>
<th>Public</th>
<th>“Average” Public</th>
<th>“Private” Differential</th>
<th>“Public” Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>$733</td>
<td>$1,408</td>
<td>$1,008</td>
<td>$800</td>
<td>$326</td>
<td></td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td>$1,644</td>
<td>$3,187</td>
<td>$2,568</td>
<td>$1,828</td>
<td>$1,095</td>
<td></td>
</tr>
</tbody>
</table>

*Source*: TXP, December 2006

For purposes of this examination, it was assumed that the number of uninsured Texans was reduced by half (approximately 2.75 million people), existing ratios of lack of insurance coverage among children and adults remain in place, and that a million of those newly insured would be covered by public insurance, with the balance (1.75 million) being covered by private insurance. Table 6 provides the results. As illustrated, an additional $3.7 billion in health care spending would have occurred in Texas during 2005 under this scenario.

Table 13

<table>
<thead>
<tr>
<th></th>
<th>Private</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>$317,063,137</td>
<td>$73,477,742</td>
<td>$390,540,879</td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td>$2,488,964,885</td>
<td>$847,824,464</td>
<td>$3,336,789,348</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$2,806,028,022</td>
<td>$921,302,206</td>
<td>$3,727,330,228</td>
</tr>
</tbody>
</table>

*Source*: TXP, December 2006

**Economic Impact Methodology**

The economic impacts extend beyond the direct activity outlined above. In an input-output analysis of new economic activity, it is useful to distinguish three types of expenditure effects: direct, indirect and induced.

*Direct effects* are production changes associated with the immediate effects or final demand for a product or service. Payment for medical services rendered (by either the patient or a third party such as an insurance company) is an example of a direct effect, along with purchases made at the gift shop or in the cafeteria at the hospital.

*Indirect effects* are production changes in backward-linked industries caused by the changing needs for goods or services of directly affected industries – typically, additional purchases to produce additional output. This is the initial secondary effect as the direct activity begins to move through the local economy. When a physician’s office or a hospital buys supplies, invests in new diagnostic equipment, or contracts with a janitorial company for cleaning services, the money is said to ripple, as these downstream purchases affect the economic status of other local merchants and workers.

*Induced effects* (the final ripple) are the changes in regional household spending patterns caused by changes in income generated from the direct and indirect effects. Both the medical supply vendor and its employees experience increased income. Induced effects capture the way in which this income is in turn spent by them in the local economy.
Once the ripple effects have been calculated, the results can be expressed in a number of ways. Three of the most common are “Output,” which describes total economic activity, and is equivalent to a firm’s gross sales; “Earnings,” which represents the compensation to employees and business owners; and “Employment,” which refers to permanent jobs that have been created in the local economy. The interdependence between different sectors of the economy is reflected in the concept of a “multiplier.” An output multiplier, for example, divides the total (direct, indirect and induced) effects of initial spending injected into the economy by the value of that injection – i.e., the direct effect. The higher the multiplier is, the greater the interdependence among different sectors of the economy. An output multiplier of 1.4, for example, means that for every $1,000 injected into the economy, another $400 in output is produced in all sectors.

The results of running the $3.7 billion in increased health care spending levels through the model are summarized and detailed in the following tables. Note that the allocation between major sub-sectors of health care was based on existing patterns. Also, the estimate of the fiscal impact to the State of Texas is based on the Comptroller’s rule-of-thumb of five percent of total personal income ultimately translating into State revenue.

**Table 14**

<table>
<thead>
<tr>
<th></th>
<th>Direct Spending</th>
<th>Total Output</th>
<th>Total Income</th>
<th>Total Employment</th>
<th>New State Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Health Care</td>
<td>$1,891,620,091</td>
<td>$4,834,224,303</td>
<td>$1,643,817,859</td>
<td>44,233</td>
<td>$82,190,893</td>
</tr>
<tr>
<td>Hospitals &amp; Nursing Homes</td>
<td>$1,835,710,137</td>
<td>$4,606,163,893</td>
<td>$1,593,821,875</td>
<td>44,562</td>
<td>$80,229,712</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,727,330,228</strong></td>
<td><strong>$9,440,388,196</strong></td>
<td><strong>$3,237,639,734</strong></td>
<td><strong>88,795</strong></td>
<td><strong>$162,420,604</strong></td>
</tr>
</tbody>
</table>

*Source: TXP, December 2006*
### Table 15
Detailed Annual Economic Impacts of Increased Health Insurance in Texas

<table>
<thead>
<tr>
<th>NAICS</th>
<th>Output</th>
<th>Earnings</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture, forestry, fishing, and hunting</td>
<td>$65,275,128</td>
<td>$9,102,851</td>
<td>822</td>
</tr>
<tr>
<td>Mining</td>
<td>$50,150,210</td>
<td>$9,308,444</td>
<td>103</td>
</tr>
<tr>
<td>Utilities</td>
<td>$158,666,277</td>
<td>$28,819,336</td>
<td>349</td>
</tr>
<tr>
<td>Construction</td>
<td>$45,621,680</td>
<td>$16,917,255</td>
<td>473</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>$849,965,036</td>
<td>$135,827,368</td>
<td>3,070</td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>$294,503,545</td>
<td>$93,417,480</td>
<td>1,712</td>
</tr>
<tr>
<td>Retail trade</td>
<td>$394,274,704</td>
<td>$132,639,277</td>
<td>5,582</td>
</tr>
<tr>
<td>Transportation and warehousing</td>
<td>$272,985,573</td>
<td>$94,655,691</td>
<td>2,401</td>
</tr>
<tr>
<td>Information</td>
<td>$279,463,421</td>
<td>$72,118,578</td>
<td>1,394</td>
</tr>
<tr>
<td>Finance and insurance</td>
<td>$528,542,827</td>
<td>$138,570,782</td>
<td>2,730</td>
</tr>
<tr>
<td>Real estate and rental and leasing</td>
<td>$908,439,914</td>
<td>$65,241,902</td>
<td>2,127</td>
</tr>
<tr>
<td>Professional, scientific, &amp; technical</td>
<td>$386,393,571</td>
<td>$184,891,593</td>
<td>3,271</td>
</tr>
<tr>
<td>Enterprise &amp; company management</td>
<td>$46,339,163</td>
<td>$22,482,227</td>
<td>414</td>
</tr>
<tr>
<td>Admin &amp; waste management services</td>
<td>$340,222,131</td>
<td>$147,219,653</td>
<td>6,559</td>
</tr>
<tr>
<td>Educational services</td>
<td>$72,429,460</td>
<td>$32,529,318</td>
<td>1,399</td>
</tr>
<tr>
<td>Health care and social assistance</td>
<td>$4,255,645,178</td>
<td>$1,877,377,102</td>
<td>46,315</td>
</tr>
<tr>
<td>Arts, entertainment, and recreation</td>
<td>$40,253,601</td>
<td>$16,373,037</td>
<td>957</td>
</tr>
<tr>
<td>Accommodation and food services</td>
<td>$230,467,706</td>
<td>$88,540,920</td>
<td>6,110</td>
</tr>
<tr>
<td>Other services</td>
<td>$220,749,071</td>
<td>$71,606,920</td>
<td>3,007</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$9,440,388,196</strong></td>
<td><strong>$3,237,639,734</strong></td>
<td><strong>88,795</strong></td>
</tr>
</tbody>
</table>

**Source:** TXP, December 2006

### Findings

The connection between health status and the economy is receiving increasing attention. It is both intuitive and a well-documented fact that individuals with health insurance have better access to medical care and correspondingly better health outcomes. In addition to improving worker productivity, significantly increasing the number of Texans with health insurance coverage would also increase overall medical spending, which would in turn have positive economic implications. This section has taken work done elsewhere on this basic relationship, updated the data to current values, extrapolated the results to Texas, and then measured the secondary effects. The overall finding is that the expenditure of $1.6 billion of state money coupled with the other options outlined in Chapter 6 would mean the Texas economy would see a total increase in annual economic activity of just over $9.4 billion, in the process creating almost 90,000 permanent jobs and providing the State with an additional $162.4 million in revenue.
CHAPTER 5. STATE BEST PRACTICES TO REDUCE THE UNINSURED

In a February 2006 opinion poll, 86 percent of Americans said they supported providing affordable health care for all Americans. A poll commissioned by the Texas Hospital Association and released in April 2006 found nearly nine out of 10 Texans agreed with the statement “Texas should find a way to increase health insurance among those who need it so that the portion paid by those with health benefits does not continue to increase.”

Another poll conducted in November 2006 found 77 percent approve increased governmental funding for health coverage for children from low-income families and 69 percent endorse expanding Medicaid to cover all adults, including single adults, who make less than the federal poverty level.

For many people, the issue of healthcare coverage is a question of what is affordable. For the State Children’s Health Insurance Plan (CHIP) the maximum out-of-pocket expenses for a family is five percent of the family’s income. An employee who has employer sponsored insurance (ESI) and an income of 300 percent of FPL can expect to pay about five percent of their incomes annually for their share of their insurance premiums. As part of the state of Massachusetts’ recent reforms to expand health coverage to the state’s uninsured, families with incomes at 300 percent of FPL are required to pay 4.7 percent of their incomes for access to a comprehensive health coverage plan.

Many states have undertaken initiatives in the past five years to reduce their levels of uninsured residents. These efforts comprise four main approaches:

1. Increasing work-based coverage for employees of small businesses. Examples include 3-share programs, premium assistance, group purchasing arrangements, and tax credits.
2. Lowering the cost of coverage. Examples include state-funded reinsurance, basic health plans, and pre-paid medical plans.
3. Targeting specific groups of the uninsured. Examples include young adults and non-poor children less than 18 years of age.
4. Expanding coverage to low-income residents (generally those with incomes below 200 percent of the Federal Poverty Line). Examples include federal Health Insurance Flexibility and Accountability (HIFA) Waivers using CHIP and Medicaid funds to expand coverage to low-income children and adults, and increasing the availability of Federally Qualified Health Centers (FQHC).

The best practices described below do not represent every good idea for reducing the uninsured. Rather, these initiatives represent ideas that either Texas already has adopted or ones that have applicability for reducing Texas’ uninsured population.
Increasing Small Employer Access

All of the initiatives described in this section were developed to make it easier for small employers to offer healthcare coverage and for their employees to take advantage of the coverage offered.

3-Share/Multi-Share Plans

Three-Share/Multi-Share is a term used to describe a public-private health coverage model that divides premium or coverage costs between three (or more) parties, usually an employer, an employee, and another entity, which may include a not-for-profit 501(c)3 or public entity such as a county or state. This cost-sharing approach lowers the amounts the employer and employee must pay to participate in a health plan, thus improving accessibility to coverage among the working poor.

Muskegon County, Michigan a community of about 170,000 launched one of the country’s most successful 3-share initiatives in 1999 called Access Health. The Muskegon 3-share plan divides the employer health plan premiums three ways with the employer and employee paying 30 percent each and the public sector picking up 40 percent of the cost. To further lower premiums for small employers and their employees, the county sought and obtained discounts from local physicians and providers. The county also invested in healthcare prevention and disease management to lower overall healthcare costs.

Monthly premiums for the Muskegon program run about $150 for adults and less than $100 for children. Employees pay co-payments ranging from $10 for a physician visit to 50 percent of non-generic prescription drugs. Maximum out-of-pocket payments for in-patient services are $300 per year and $6,000 for prescription drugs.

Eligible businesses must be located in Muskegon County, have offered no health insurance in the previous 12 months, and have a workforce with a median wage of $11.50 per hour. A company that participates in the Muskegon’s 3-share plan has access to every health service offered in the county, but only services offered in the county, including:

- Physician Services
- Inpatient hospital services
- Outpatient services
- Emergency Room services
- Ambulance services
- Behavioral health
- Prescription drugs (formulary)
- Diagnostic lab and x-rays
- Home health
- Hospice Care

Enrollment in the Access Health program has grown slowly. However, as of December 2006, The Muskegon 3-share had more than 1,500 people and 400 businesses enrolled.
Communities in Louisiana, Illinois, South Carolina, Arkansas and Florida have developed similar 3-share programs. A number of 3-share initiatives are also underway in Texas, including efforts in Austin, Dallas, El Paso, Galveston and Houston.

Three-share programs can fill an important niche in the private ESI market. However it is important to understand their limitations and potential for growth. The report “Community Health Ventures: An Overview of Community Sponsored Multi-Share Health Coverage Initiatives Modeled on Access Health of Muskegon” explains the potential market for 3-share health plans this way:

<table>
<thead>
<tr>
<th>Example Market Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of businesses in a mid-sized community = 4,000</td>
</tr>
<tr>
<td>90% will be businesses with fewer than 20 employees = 3,600</td>
</tr>
<tr>
<td>50% of these small businesses will already offer some type of insurance = 1,800</td>
</tr>
</tbody>
</table>

Of the remaining 50% of uninsured businesses:
- 720 (20%) will not meet the eligibility criteria for the multi-share plan
- 720 (20%) will not be at all interested regardless of price
- 360 (10%) will be interested
  - 180 of these “interested” will likely participate in year one of sales


Their analysis suggests that overall only a limited number of businesses will find this model feasible because of its eligibility criteria, while others may simply find the price or other aspects of the program unacceptable. Nonetheless, it is a health coverage concept that has garnered broad community support in numerous localities, including several in Texas.

**Premium Assistance**

Premium assistance is similar to a 3-share program, however, unlike 3-share programs, healthcare coverage is provided through a traditional insurance plan. As a result, the premiums are subject to the same risk factors as any other insurance product. Massachusetts, Maine, and Vermont have developed plans that provide premium assistance for ESI on a sliding fee basis to residents with incomes below 300 percent of the Federal Poverty Level. Both Maine and Massachusetts have combined premium assistance with Medicaid expansions. Massachusetts has coupled their program with a mandate on employers and individuals to obtain healthcare coverage by July 2007.44

When Massachusetts developed its plan, the state was about to lose $385 million in federal Medicaid funds. They were able to use the Medicaid funds they were about to lose to partially cover the cost of their initiative. Massachusetts will use a combination of sources to fund its plan including funds from their existing uncompensated care pool, state general revenues, and employer contributions. These funds will be used to fund its premium subsidy, a Medicaid expansion, and all other aspects of its plan to cover the state’s uninsured.45
Health Insurance Premium Payment Programs

Health Insurance Premium Payment (HIPP) programs offer another option for states to provide premium assistance. HIPP uses Medicaid funds to pay ESI premiums for Medicaid eligible individuals when it is more cost-effective to pay for the individual’s health insurance premiums than to enroll them in Medicaid. Several states, including Texas, California, Georgia, Iowa, Missouri, Pennsylvania, Rhode Island, and Virginia have HIPP programs. However, HIPP covers a very limited number of people.

In 2004, Texas paid premiums for fewer than 7,000 individuals. Currently, a dollar change in income can mean the difference between continued access to ESI through Medicaid premium assistance and losing coverage altogether. Some workers may feel it necessary to leave their employment rather than lose healthcare coverage. Allowing HIPP eligible workers continued access to premium subsidies on a sliding fee basis allows states to continue realizing savings in their Medicaid programs while facilitating the workers’ transition to full ESI as their income increases. Other states that cover higher percentages of adults with higher income levels through their Medicaid programs have been able to increase enrollment in their HIPP programs.

Group Purchasing Programs

Group purchasing arrangements (GPAs) allow more than one small or large employer or individuals to pool together to collectively purchase health insurance. These arrangements are designed to achieve greater accessibility and lower costs by giving the small groups banding together the ‘purchasing power’ of larger groups. There are many different types of GPAs including association health plans (AHP), employer alliances or health insurance purchasing coalitions (HIPC), and multiple employer welfare arrangements (MEWA).

Nine states currently allow group purchasing arrangements, including Arkansas, Kansas, Montana, New Mexico, New York, Ohio, Texas, West Virginia, and Wisconsin. California abandoned its group purchasing program effective December 31, 2006, because of the withdrawal of participating insurers from the voluntary program. States rarely mandate insurer participation in GPA markets. As a result, insurers may leave the market at any time. The departure of the last three participating insurers left 6,200 small California employers without coverage for more than 116,000 employees.46

Some opponents of GPAs express concern about the potential impact these groups have on the existing small group and individual markets in a state. Of particular concern are association health plans. Federal proposals would allow the creation of inter- and intra-state plans that would not be subject to many state insurance regulations, such as prompt payment to providers and minimum benefit package requirements. Opponents suggest that allowing exemptions from state minimum benefit package requirements would result in adverse selection with the healthiest groups leaving the small group market, making it even more difficult and costly for less healthy groups to obtain coverage.

However, when GPAs work well they can provide coverage to large groups of previously uninsured individuals. Ohio’s Council of Smaller Enterprises’ (COSE) purchasing pool has almost 14,000 employer members who provide coverage for more than 225,000 people. The
Ohio program offers 19 different health plans and coverage for self-employed individuals as well as small businesses with two-to-fifty employees.\textsuperscript{47}

West Virginia’s Small Business Plan website promises premiums 17 to 22 percent below rates available in the small group market and comprehensive coverage. West Virginia’s plan uses the state employee health plan rates for medical services reimbursement set in law for the state employee health plan. Participating insurers must offer policies that contain all the preventive, primary and major medical services mandated by West Virginia law.\textsuperscript{48}

### Tax Credits

Currently, employees who obtain healthcare coverage from their employers receive a premium subsidy in effect equal to their marginal tax bracket because the employer’s contribution to their healthcare premiums is not taxed by the federal government. Individuals with high incomes get a relatively larger subsidy than those with lower incomes because their tax brackets are higher than workers with low-incomes. Tax credits differ from tax deductions because they are not dependent on a household’s income to be meaningful. Tax credits can simultaneously increase affordability of health coverage and increase its value. Alone, however, such credits will not reduce premiums or otherwise mitigate against rising health services costs.

A 2001 study conducted by Mark Pauly and Bradley Herring identified three important design parameters for any tax credit programs. In addition to determining who will be eligible for the credit, the plan must establish:

- the dollar or proportional subsidy the credit provides;
- whether the credit is a set dollar amount or a set percentage of the premium; and
- the premium for the lowest-cost insurance plan eligible for the credit.

Using two approaches, one conservative and the other optimistic, Pauly and Herring determined that refundable tax credits for healthcare coverage could have a profound impact on the number of uninsured employees. Specifically, a tax credit equal to 50 percent of the premium could result in a 50 to 80 percent reduction in uninsured workers.\textsuperscript{49}

In 2002, Congress included a provision in the Trade Adjustment Assistance Act to subsidize health coverage through health coverage tax credits for workers displaced by international trade and early retirees. In 2005, Congress included new employer tax credits for those employing up to 100 workers. This plan gives employers tax credits of up to $200 per individual and $500 per family businesses that make contributions through a health savings account (HSA).

Several states have implemented tax credits for employers who provide healthcare coverage to their employees, including Arizona, Kansas, Montana, and West Virginia. Tax credits enable businesses to leverage their employer health plan contributions and can be relatively easily implemented because they can be administered through an existing tax system.
Lowering Premium Costs

This section examines initiatives specifically designed to lower health coverage costs. Not all the programs described have been equally successful in reducing premiums. The method by which states implement their reinsurance programs, basic and standard health plans, and prepaid medical initiatives directly impacts the degree to which health coverage costs will be lowered.

State-Funded Reinsurance

Reinsurance is insurance purchased by insuring organizations or self-funded employer plans from another insurance company to protect themselves against all or part of the losses that may result if they experience unusually high claims from participating providers, policy holders, or employees and covered dependents. Reinsurance also may be called “risk control” or “stop-loss” insurance or “insurance for insurers.” Reinsurance spreads risk levels more broadly among insurers so no one insurer has to assume the risk for very high claims. Reinsurance can reduce premiums by helping stabilize an insurer’s loss experience thereby reducing the amount the insurer would have to keep in reserves to cover unexpectedly high claims costs.

One of the ways reinsurance stabilizes costs for insurers is by creating an “attachment point.” An attachment point is triggered when expenses reach a specified level. This way the insurer knows they only have to cover expenses up to the attachment point. Another way is with an “upper limit” – the highest amount an insurer would have to cover. Again, this helps the insurer manage their risk.

If a state becomes the reinsurer and assumes some or all of the reinsured risk, premiums may be reduced even further. Arizona, Connecticut, Idaho, New Hampshire, New Mexico and New York all have state-sponsored reinsurance programs.

Reinsurance can cover “aggregate losses” or “excess losses.” Aggregate losses occur when a group’s claims collectively exceed some predetermined threshold. Excess losses occur when an individual’s annual claims become excessive. For example, when an individual’s claims level falls in the top five percent of all individual claims they may trigger a reinsurance pay-off. Arizona’s reinsurance program is an example of an aggregate stop-loss program, while New York’s is an example of an excess-loss reinsurance program. We describe these two programs in more detail below.

Arizona

Arizona added a reinsurance component to its insurance pool for small employers, self-employed individuals and political subdivisions in 2000 when the Arizona Legislature appropriated $8 million in general revenue to subsidize or “reinsure” its Healthcare Group of Arizona (HCG). The Legislature took this step because between 1997 and 2000 HCG saw its costs increase, which in turn caused premiums to rise. As premiums rose, enrollment in HCG declined and those individuals that remained in the program were sicker with higher medical costs. The state’s reinsurance appropriation worked to lower costs and the next year the Legislature was able to reduce the appropriation to the program by one-half.
Arizona imposes no income limits on individuals or employees of small businesses wishing to enroll, but HCG does have employee participation requirements. Employers with one to five employees must enroll 100 percent of their employees who do not have coverage elsewhere. Businesses with up to 50 employees must enroll 80 percent of employees without alternative coverage. All employees that work 20 hours or more a week must be included in the employee count for this program. There is a 12 month waiting period for services related to the pre-existing condition.

These guaranteed issue products are delivered by three managed care organizations and one preferred provider organization. Furthermore, businesses can select between several benefit packages. As of October 2006, the HCG reported enrollment of 23,444 lives and 8,294 small business groups. More than 90 percent of businesses enrolled have three employees or less. \(^5\)

**New York**

New York named its state-subsidized reinsurance mechanism Healthy New York (HNY). The state invested $89.4 million in general revenue funds in 2003, $49.2 million in 2004, and $22 million for the first half of 2005. Up to 10 percent of the funds appropriated may be spent on marketing activities to promote the program.

The state requires HMOs to participate in the reinsurance program. The state pays for 90 percent of claims between $5,000 and $75,000 on behalf of individual members enrolled in the plan in a calendar year. New York HMOs assume the risk for claims below $5,000 and above $75,000.

Small employers, sole proprietors, and individual workers may qualify for the program. Employers must have fewer than 50 employees with at least 30 percent making less than $33,000 annually. Employers must pay for at least half of the employee’s premium and offer dependent coverage, but the employer does not have to pay a share of the dependent coverage.

Sole proprietors and individual workers with incomes below 250 percent FPL can participate if they or their spouse has been employed in the past 12 months and was uninsured or lost coverage during that time period. In 2004, HNY enrolled more than 120,000 New Yorkers. Approximately 60 percent of the enrollees were individual workers, 20 percent sole proprietors and 20 percent small employers.

The benefit package includes:

- Inpatient and outpatient hospital services
- Physician services
- Pre-admission and diagnostic testing
- Laboratory and x-ray
- Maternity care
- Preventive health services
- Emergency services
- Therapeutic services
- Prescription drugs (now an optional benefit)
Enrollees are subject to co-payments and deductibles with co-payments that range from $10 for prenatal services to $500 for inpatient hospital services. There is a maximum annual benefit of $3,000 per individual for prescription drugs with a $100 annual deductible.

New York’s program has been extremely successful in reducing premiums costs. The program debuted in 2001 with premiums for individual coverage at about half that for individuals in the regular direct-pay, individual market in New York. Premiums for small employers were 15 and 30 percent less than those of typical policies for small employers. Today, premiums for individuals are almost two-thirds lower than those for comparable individual policies and 40 percent lower for similar small employer policies.

Differences between Risk Pools and Reinsurance

High-risk pools make insurance coverage available to individuals who have been unable to obtain insurance in the individual market. Generally speaking, when obtaining coverage through a high-risk pool, an individual must have been denied healthcare coverage and complete an application. In addition, the individual’s claim history will be reviewed and risk pool coverage medically underwritten. Finally, they are likely to have to re-apply at least annually and may be denied coverage, or the coverage available through the risk pool may be so expensive as to be completely unaffordable.

In contrast, an individual whose healthcare expenses are covered under a reinsurance program does not have to complete a special application for reinsurance, is not medically underwritten, and need not re-apply annually. This transparency to the covered individual makes it easier for them to remain covered because they do not have to endure the underwriting-denial-re-application cycle generally necessary with most risk-pools. Many state reinsurance programs such as those in New York, Idaho, and Arizona require that participating insurers enroll anyone in any of the reinsured options available in the state who meets the state’s eligibility standards. Reinsurance programs also generally afford more plan choices for individuals seeking coverage than risk pools. In New York, participants can select from more than 20 different plans. This affords individuals greater portability and flexibility within the individual market.

Perhaps the most important difference between high-risk pools and reinsurance programs is who can be covered. Risk-pools cater strictly to the individual market while reinsurance programs can accommodate small employers and their employees in addition to individuals. Some states have both high-risk pools and reinsurance programs. In some of these states, the high-risk pool acts as the reinsurance mechanism for individuals while a separate reinsurance pool reinsures employer groups.

Texas law currently sets the cap for the Texas Insurance High Risk Pool (TIHRP) premiums at 200 percent of the standard rate for commercial individual health insurance. In 2004, average monthly premium were $490 per month per enrollee or $5,880 per year. Individual premiums covered 65 percent of the costs incurred by the pool in 2005, and the remaining costs were funded with an assessment on insurance carriers and HMOs.
To be eligible for TIHRP an individual must have:

- Eighteen months of previous health insurance coverage, with no gap in coverage greater than 63 days
- Denial by an insurer to issue individual health insurance like that offered by the pool due to health reasons
- Offer by an insurer to issue health insurance like that offered by the pool, but with exclusions for a medical condition
- Diagnosis of one of the medical conditions established by the Board for automatic eligibility such as cancer
- Certification from an insurance agent that the applicant would be declined for health insurance like that offered by the pool due to a medical condition

Numerous ideas have been considered over the past five years that would improve access to TIHRP. One suggestion would allow individuals who are eligible for continued health benefits under COBRA (Congressional Omnibus Budget Reconciliation Act) to instead enroll in the pool if coverage in the pool is more affordable or offers better coverage.

COBRA coverage is available to individuals who previously had group ESI, but lost that coverage due to job loss or a change in family status such as divorce or the death of a spouse. When this happens, the person can maintain their previous coverage if they pay the full price of the premiums. However, at the point at which they lose their employment or suffer the loss of spousal income they may be least able to pay COBRA premiums. The individual may choose to go without coverage until they can afford it not realizing that if they have a gap in coverage of more than 63 days, they will be unable to qualify for TIHRP coverage.

Another suggestion would allow individuals with limited benefit healthcare plans to purchase coverage through the pool. Employees may have access to a limited benefit plan through their employer. Many times a limited benefit plan will not meet the health needs of a person with significant health issues. The person may want to purchase a low-deductible, TIHRP plan that will meet their health needs, but the cost will be too high. The current TIHRP rules do not permit the individual to participate in their employer’s limited benefit healthcare plan and purchase coverage through the pool.

**Principles of Successful Reinsurance Programs**

Successful state reinsurance programs have several common traits, which are described below.

1. **Mandatory** – States with substantial enrollment in their reinsurance programs mandate insurer participation. In New York, all HMOs must participate. In Connecticut, any insurers can purchase reinsurance on any individual. If expenses exceed the reinsurance premiums collected, all insurers pay a one percent assessment. Connecticut’s program ultimately results in all insurers participating whether they purchase reinsurance or not. In voluntary programs, larger insurers are less likely to participate making it difficult to spread risk extensively, which in turn, affects the program’s ability to positively impact premium costs.

2. **Track enrollment, revenues, and expenditures** – States must track the reinsurance premiums collected so that they know what funds are available to pay insurers claims...
for reinsurance payments. The state also must know the number of people eligible for reinsurance or the expenses incurred by insurers so that the state knows when the attachment point or upper limit, as applicable, has been reached.

3. **Review insurer’s premium rates** – Premium rate review is essential for maximizing premium savings. Some states approve rates, but this is not necessary. States should require insurers to file certain rate-related information, including the percentage of premiums spent on medical services (i.e. loss-ratio) for each major health expenditure category (e.g. hospital, physician, prescription drug, etc.) and each market segment (e.g. small employer, individual, etc.) This enables a state to encourage insurers to scale premiums to their actual risk exposure under such programs.

4. **Certify and periodically review benefit packages** – Similar to the review of rates, monitoring benefits packages ensures that healthcare benefits available through the reinsured plans are adequate and reasonable given premiums collected and individual enrollment.

According to the Robert Wood Johnson Foundation, reinsurance programs can be supported with a minimum up-front investment as long as adequate systems are put in place to track revenues and expenses so the state knows when its attachment point has been reached.53

### Basic Health Plans

As noted previously, many large companies self-insure. By self-insuring, the healthcare coverage that large employers offer does not have to include all state mandated healthcare benefits. In contrast, small employers usually get their coverage through traditional insurance markets that are subject to state regulation, including rules that require insurers offer certain mandated benefits.

Basic Plans (also known as bare-bones or limited-benefit plans) reduce premiums by limiting the healthcare benefits offered and are often coupled with high deductibles and co-payments. At least 11 states, including Texas, Arkansas, Colorado, Florida, Maryland, Minnesota, Montana, New Jersey, North Dakota, Utah, and Washington have enacted legislation that eliminates or reduces the number of state-mandated benefits that must be offered by an insuring organization.

The advantage of these products is that generally they are guaranteed issue, meaning no physical exam or health claims history is necessary; limited or no wait periods for pre-existing conditions; and available to part-time or contract workers. Florida just recently extended eligibility in its limited benefits plan to contract workers who work 15 or more hours per week for a participating employer.54

In addition to lowering premiums, these basic plans are designed to redirect the uninsured from the emergency room – the most expensive setting for care – to a primary care medical home with the ultimate goal of lower treatment costs and improved health outcomes. These goals will only be met if sufficient numbers of employees enroll in these basic plans.

While the availability of basic plans is relatively new, many states have found so far that few employees want to enroll in such plans, few insurers want to market these plans, and premium savings are modest. At mid-point in its three-year pilot, Florida found about 500 people had enrolled in its limited benefit plan – one-third the number they had projected originally.55
2004, Arkansas saw premium savings of only 4 to 9 percent. Minnesota and North Dakota both experienced reluctance on the part of insurers to offer such plans because insurers feared consumer confusion and adverse selection with only healthy people choosing to jump from comprehensive to basic healthcare coverage.\textsuperscript{56}

In 2003, the Texas Legislature passed SB 541, which created consumer choice health benefit plans also known as standard health benefit plans. After this law was enacted in 2003, health plans in Texas could be either state-mandated health benefit plans or consumer choice health benefit plans. Consumer choice plans eliminate the requirement that insurers offer all mandated state benefits.

As of May 23, 2006, TDI has approved a total of 55 consumer choice or standard plans filed by 45 indemnity carriers and 10 by HMOs, respectively. An indemnity plan allows policy holders to select any provider they wish, generally requires the insured to cover a portion of their healthcare costs (i.e. co-insurance) and includes deductibles that the insured must pay out of pocket before the insurance company starts covering claims.

Indemnity carriers estimate premium savings range 5 percent to 38 percent while HMOs report savings of up to 26.5 percent over state-mandated health benefit plans. However, only a small portion of the estimated savings results from the elimination or reduction of mandated benefits, rather the savings occur because most of the consumer choice plans have increased co-pays and higher deductibles and insurers indicate that healthier people tend to choose these plans.\textsuperscript{57}

**Health Savings Accounts**

Consumer Choice Plans are often coupled with Health Savings Accounts (HSAs) because such plans often have high deductibles, co-insurance, and co-payments, employees may be encouraged to invest in an HSA to cover out-of-pocket expenses. These tax-sheltered accounts may be used to pay for doctor's visits and other health services until deductibles are met. Although HSAs have not caught on as a replacement for traditional or more comprehensive health coverage, they are beginning to play an important role in limiting out-of-pocket costs for families who have high-deductible or limited-coverage policies.

**Pre-paid medical plans**

Unlike HMOs that may be funded on a capitated or pre-paid basis and are insuring organizations regulated by state insurance agencies, Prepaid Medical Plans (PMPs) are not insurance and do not offer the range of services or the protections of traditional health insurance products. The goal of these plans is to provide workers with a medical home and keep them healthy so that they can remain productive at work.

PMPs are designed to give workers access to basic preventive, primary, and other health care services provided in physicians’ offices for illnesses and minor injuries. These plans fill a health coverage gap for employers who cannot afford a traditional health plan and uninsured workers who currently seek care in hospital emergency rooms or free clinics. Covered services may include routine doctor’s visits, annual check-ups, limited laboratory tests, immunizations, and minor surgeries that can be performed in a doctor’s office.
Uninsured workers are given access to a designated medical provider network for a small monthly fee paid by the employer on their behalf. Generally, employees pay no or very low co-payments or fees for office visits and covered procedures.

Employers may contract with providers directly for basic clinical care through a pre-paid plan. Providers that join pre-paid plan networks accept lower payments provided by the plans because they get been paid in advance and no longer need to submit claims or invoice for payments, which reduces their administrative overhead.

Costs per employee are generally around $50 per month. Some pre-paid plans offer discounts for medical services not covered under the plan and access to catastrophic coverage insurance products to supplement the benefits available under the pre-paid plan.  

Pre-paid plan experts believe that this type of health coverage benefit will appeal to between 5 and 10 percent of Texas’ uninsured workers – about 150,000 to 300,000 employees – primarily those businesses that can afford no other type of health coverage and employees who currently obtain their healthcare through either free clinics or emergency rooms.

Covering Targeted Populations

Many states have focused on covering specific populations, especially children under 18 years of age. Fewer states have focused on young adults, who tend to be the healthiest of the uninsured and therefore the most desirable potential participants in a health plan. This section examines best practices related to covering uninsured young adults particularly those attending colleges and universities and children under 18 years of age living in families with incomes above 200 percent of the Federal Poverty Level.

Young Adults 18 to 24 Years of Age

With almost one million uninsured between the ages of 19 and 24, this group of young adults makes up one of the largest segments of the uninsured population—and the most likely to be uninsured by choice. Young adults frequently believe that insurance is unnecessary, unaffordable, unavailable or not worth the money. Many of these individuals attend colleges and universities where they have access to low cost health insurance but fail to take advantage of it.

Most private universities and colleges require health insurance for enrollment, while many public universities are beginning to require it. Public universities in Minnesota, Illinois, Washington, New York, Connecticut, Virginia, New Jersey, and Colorado, as well as a number of public schools in the state of Ohio require proof of or enrollment in the university’s student health insurance plan (SHIP). Many universities have noted a link between student health and drop-out rates, which adds to the institution’s incentive to require health coverage.

Since 2002, Ohio State University students at the Columbus campus have been required to carry adequate health insurance. This requirement applies to any student carrying six hours or more per semester. Students may meet the health insurance requirement by showing proof of comprehensive coverage or enrolling in SHIP. Students who do not show proof of coverage are automatically enrolled in the SHIP and the premiums are included in their tuition.
In 2004, Texas had 2.1 million young adults between the ages of 18 and 24. As of April 2006 more than 1.2 million of these Texas residents were enrolled in public and private institutions of higher education. Many of these individuals have access to low-cost health insurance through their universities, but according to TDI, only about 11 percent of those enrolled take advantage of the available coverage. At least two private universities, Rice and Trinity Universities, and one state college, Texas State University, require students to have health coverage before enrolling.

A review of several university websites indicates policies cost about $100 per month per student or less. Hundreds of websites advertising inexpensive student health coverage products exist. A comprehensive health plan with a $100,000 maximum benefit and $100 deductible can cost as little as $53 per month.

**Children Above 200 percent of FPL**

Since 2004, 35 states experienced increased enrollment in their state children’s health insurance programs (CHIP). By the following year, 43 states had expanded coverage to children at or above 200 percent of the FPL. Five states have expanded coverage to children at or above 300 percent FPL.

In 2005, Illinois lawmakers enacted the *Covering All Kids Health Insurance Act*. Families with annual incomes up to $100,000 will pay premiums ranging from $40 to $100 per child per month. Families with incomes above $100,000 will still have access to coverage, but will pay higher premiums.

Texas covers children up to 200 percent of FPL through CHIP, but has experienced significant drops in enrollment due to eligibility criteria and administrative changes that have made it more difficult for children to enroll and remain enrolled in the program. For families with income over 200 percent of FPL, only 24 percent of Texas’ small employers offer healthcare coverage and even fewer offer or subsidize coverage for dependents—leaving few options for obtaining dependent coverage.

**Expanding Coverage for Individuals with Incomes Below 200 Percent of Poverty**

The initiatives described below focus on creating coverage for poor and near-poor individuals. Most of these plans build on existing publicly-funded health coverage programs.

**CHIP Expansions, Health Insurance Flexibility and Accountability Waivers**

In 2004, Texas submitted a federal Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Waiver to decrease the number of uninsured parents by using unspent CHIP funds to pay employer-sponsored insurance premiums for adults whose children qualify for CHIP. The state would cover family premiums.

Only parents of CHIP-eligible children would qualify. In addition to the parents having to meet eligibility criteria, the ESI plan must also meet certain criteria to qualify for the subsidy. Specifically, the benefit package must include certain basic services such as inpatient and
outpatient hospital services, physician’s surgical and medical services, and well-baby and well-child care.

Employers must pick up 40 percent of the costs of the premiums. The state would pay a maximum amount equal to the cost of a monthly CHIP premium. The employee/parent(s) would be responsible for any difference between the employers and the state’s maximum contributions, any coinsurance, co-payments, or deductibles required by the employer plan.

The Health Human Services Commission estimates that up to 6,500 parents would qualify for and enroll their family in an ESI plan. The waiver request has not yet received final approval from the federal government. However, once the waiver request is approved there will still be almost 400,000 Texas parents without access to dependent coverage through their employers.

At least eight states, including Texas, Arkansas, Illinois, Massachusetts, Michigan, Minnesota, Rhode Island, and Washington have expanded CHIP coverage for prenatal care for pregnant women with incomes below 200 percent of Federal Poverty Level.

The unborn child qualifies for CHIP once born. This makes sense both medically and economically because it enhances the likelihood the mother will receive prenatal care and deliver a healthy baby. Normal deliveries are much less costly than a premature delivery. Benefits, which are really for the child, include services related to labor and delivery. In addition, services are available for the mother and child prior to and after delivery for 12 contiguous months from the initial month of enrollment. Once born, the child has access to the same range of benefits any other eligible CHIP child would have.

**Adults Under 100 Percent of Poverty**

Over 1.6 million uninsured Texas adults have income below 100 percent of the federal poverty level. Of these, about 417,000 are parents of Medicaid eligible children. Texas has the lowest income threshold for Medicaid eligibility among the 10 most populous states for parents of Medicaid children with 14 percent of FPL for non-working parents and 30 percent for working parents. In contrast, five of the 10 most populous states cover parents with incomes over 90 percent of FPL with one state, Illinois, cover parents up to 192 percent of the federal poverty level. Table 16 below compares Texas to the 10 most populous states on income eligibility for parents of Medicaid eligible children.
Table 16. Comparison of 10 Most Populous States by Income Eligibility for Parents of Medicaid Eligible Children (2005)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>43%</td>
<td>$6,996</td>
<td>67%</td>
<td>$10,849</td>
</tr>
<tr>
<td>California</td>
<td>100%</td>
<td>$16,090</td>
<td>107%</td>
<td>$17,170</td>
</tr>
<tr>
<td>Florida</td>
<td>23%</td>
<td>$3,636</td>
<td>60%</td>
<td>$9,672</td>
</tr>
<tr>
<td>Georgia</td>
<td>32%</td>
<td>$5,088</td>
<td>56%</td>
<td>$9,068</td>
</tr>
<tr>
<td>Illinois</td>
<td>185%</td>
<td>$29,772</td>
<td>192%</td>
<td>$30,852</td>
</tr>
<tr>
<td>Michigan</td>
<td>34%</td>
<td>$5,508</td>
<td>58%</td>
<td>$9,285</td>
</tr>
<tr>
<td>New Jersey</td>
<td>100%</td>
<td>$16,090</td>
<td>100%</td>
<td>$16,090</td>
</tr>
<tr>
<td>New York</td>
<td>150%</td>
<td>$24,135</td>
<td>150%</td>
<td>$24,135</td>
</tr>
<tr>
<td>Ohio</td>
<td>90%</td>
<td>$14,481</td>
<td>90%</td>
<td>$14,481</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>31%</td>
<td>$5,052</td>
<td>63%</td>
<td>$10,104</td>
</tr>
<tr>
<td>Texas</td>
<td>14%</td>
<td>$2,256</td>
<td>30%</td>
<td>$4,807</td>
</tr>
</tbody>
</table>

Source: Excerpted from Kaiser Family Foundation, State Health Facts, Medicaid & SCHIP “Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2005.”

Community Health Centers

In 2002, President Bush announced his intent to add 1,200 new and expanded Community Health Center (CHC) sites and increase the number of people served annually from nearly 10 million in 2001 to 16 million in 2006. CHCs must:

- Be located in areas of high need,
- Be governed by a consumer Board of Directors,
- Provide comprehensive primary health, oral, and mental health/substance abuse services without regard for patients’ ability to pay, and
- Develop a Board-approved sliding-fee scale based on patients’ family size and income.69

Community Health Centers (CHCs) include Federally Qualified Health Centers (FQHC), which receive federal grants; FQHC Look A-likes, which operate like FQHCs, but do not receive federal grants; Rural Health Centers; Migrant Health Centers; Homeless Health Centers; and Public Housing Health Centers. These centers play an important role by providing access to healthcare for millions of low-income Americans who otherwise would have no medical care other than emergency care available to them.

In response to President Bush’s initiative to expand the number of CHCs, several states have contributed state resources to encourage center development. By providing state funds that can be used for purposes that federal funds cannot be used for such as capitol construction, states that invest state resources to support CHCs help them compete for federal funds for new and CHC expansion projects. As of August 2006, more than 15 million people were receiving services through more than 1,000 FQHC with over 5,500 sites.70
The number of CHC’s in Texas grew from 31 in 2000 to 49 in 2005 representing 63 percent increase. In 2005, the 49 FQHCs plus five FQHC Look A-likes cared for 642,701 Texans. More than 377,000 of the patients seen at these CHCs were uninsured. These 54 CHCs operate 257 sites in medically underserved areas of Texas.

In addition to providing state funding to increase or expand the number of FQHC sites within a state, low cost loans for infrastructure construction and medical and dental student loan payment programs can also encourage community health center expansion. Recently the federal government developed regulations which allow community health centers to leverage direct federal grants with non-federal dollars. These regulations allow properly certified community center organizations such as the Texas Association of Health Centers to receive dollar-for-dollar matching funds for non-federal funds, up to a maximum of $5 million over three-years. Texas community health centers have been able to leverage some private donations, but have not been able to maximize this resource.

One of the biggest challenges for CHCs is finding personnel to work in rural and underserved communities. Texas has six dental and medical loan payment programs for students who agree to practice in medically underserved parts of the state. These loan programs currently are divided among two different agencies making it difficult for students to access these resources.

The New Baylor Plan

Blue Cross plans patterned their capitation based insurance model on the first healthcare plan devised by scholars at the Baylor University Medical Center in the early part of the century. Current levels of uninsured have led Baylor to delve into the healthcare arena again. The New Baylor Plan developed by Earl L. Grinols, Distinguished Professor of Economics and James Henderson, Ben Williams Professor in Economics of Baylor University attempts to create incentives that will encourage virtual universal health coverage. The authors begin with the premise that it is an individual’s responsibility to obtain healthcare coverage. The Plan provides publicly funded healthcare subsidies for the uninsured based on income so that they can purchase healthcare coverage in the private market.

Insurance policies eligible for public subsidy would be those with high deductibles and low premiums – also known as “consumer driven plans.” Before an individual qualifies for a public subsidy, they would have to spend a percentage of their income on health-related expenses. Table 17 below describes the out-of-pocket amounts or deductibles as a percent of household income an individual would have to incur before they would be entitled to financial assistance for medical services proposed under the New Baylor Plan.
Table 17. New Baylor Plan Out-of-Pocket Expenditures Required Government for Aide Eligibility

<table>
<thead>
<tr>
<th>Household Income (HHI)</th>
<th>Health care spending required (% of HHI) before receiving aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Full Aid</td>
</tr>
<tr>
<td>$3 to $9277</td>
<td>1%</td>
</tr>
<tr>
<td>$9278 to $19348</td>
<td>1.5%</td>
</tr>
<tr>
<td>$19349 to $24999</td>
<td>2%</td>
</tr>
<tr>
<td>$25000 to $35455</td>
<td>5%</td>
</tr>
<tr>
<td>$35456 to $44999</td>
<td>7%</td>
</tr>
<tr>
<td>$45000 to $54999</td>
<td>10%</td>
</tr>
<tr>
<td>$55000+</td>
<td>Little or no aid</td>
</tr>
</tbody>
</table>

Source: Earl L. Grinols and James Henderson, Presentation, October 2006

Failure to obtain healthcare coverage would result in the imposition of an 8 percent tax levy or compliance tax on all retail goods purchased by the uninsured individual. The state would create a health coverage database that would track whether an individual had healthcare coverage. Coverage would be confirmed at the cash-register with a swipe card, driver’s license or health insurance card. Retail establishments would be linked to the database much as they are linked to credit card companies. If the card reader indicated the purchaser 8 percent compliance tax would be automatically added to the uninsured person’s bill and collected by the retailer.

The benefit package Grinols and Henderson suggest tries to strike a balance between a plan that is too comprehensive and therefore too costly and a plan too sparse to provide meaningful healthcare to policy holders. They suggest the base insurance plan should include:

- Benefits with a premium lowering or neutral effects,
- Benefits mandated by 25 or more states,
- Benefits that every state Medicaid plan includes, and
- Preventive services as outlined by the United State Preventive Services Task Force

Grinols and Henderson estimate that their approach would result in 90 percent of the 45 million currently uninsured Americans obtaining healthcare coverage. The authors have placed the national cost for the plan at $92 billion and estimate that to implement their plan in Texas would cost about $9 billion dollars.
CHAPTER 6. FINDING SOLUTIONS FOR TEXAS’ UNINSURED

A November 2006 Health Affairs study by Lisa Dubay, et. al. examined how much individuals with incomes at 300 percent of FPL could theoretically afford to pay for private, individual healthcare coverage. The study found that on average, coverage today would consume 13.8 percent of a single individual’s income and 17.2 percent of a family’s income. These percentages far exceed the 5 percent or less allowed under S-CHIP or typically expected by covered employees. A Texas A&M University study examined attitudes of Texans with incomes in excess of 200 percent of FPL’s towards healthcare coverage. The results of this study are described in the next section of the report.

TAMU Study

In 2002 the Texas Department of Insurance (TDI) engaged Public Policy Research Institute (PPRI) at Texas A&M University (TAMU) to investigate non-poor, uninsured adults’ attitudes towards healthcare coverage. The PPRI study conducted 15 focus groups around the state with uninsured and small employers. They also conducted a telephone survey with 598 Texans who were uninsured and had incomes above 200 percent FPL.

Based on focus group responses, PPRI divided the participants into four groups:

- **The Prepared**: People who have the money to buy health insurance and are willing and motivated to purchase it, but could not get it;
- **The Reluctant**: People who have the money to buy health insurance, but are not inclined to do so;
- **The Complacent**: People who do not have the means to purchase health insurance, and would not buy it even if they had the money;
- **The Hindered**: People who want to buy insurance, but do not have the money to do so. (See Figure 1)
Sixty-four percent of the participants were categorized as wanting insurance, but having difficulty obtaining it because of their health status or limited financial resources. In fact, the PPRI study found that the number one reason among its focus group and telephone survey participants for not having insurance was cost or affordability, with inability to obtain coverage due to pre-existing conditions as the number two reason. Participants still cited cost as the top barrier even though they all had incomes in excess of 200 percent of FPL – generally the cut-off for even the most generous public health coverage programs in Texas.

A third of those participating in the survey, however, could have purchased coverage and did not, or could not afford coverage and did not see their lack of coverage as a major problem.
This implies that while affordability will be key to developing solutions to increase the level of coverage for this and other uninsured groups, affordability alone won’t accomplish universal coverage. Measures also will need to improve access for those with health conditions and enhance individual perceptions of the value of having health coverage.

Insuring Texas Workers

In the previous chapter, we described some best practices undertaken by states to increase employer and worker access to healthcare coverage. Many of these noteworthy initiatives have already been adopted by Texas, such as HIPP, group purchasing arrangements, and basic health plans. In some cases, Texas can improve upon what is already in place, in others, Texas can benefit from state’s innovations to increase the number of covered Texans.

In the sections that follow we propose solutions that, if taken together, can reduce the state’s uninsured by almost half. This package of recommendations builds on best practices adopted in other states and addresses every segment of the uninsured: workers, children, young adults, and Texas’ poor.

Solution 1. Provide Technical Assistance and Seed Funds for 3-Share/Multi-Share Programs

Although 3-Share programs have been slow to grow, interest remains significant in these private-public partnerships. At least five Texas communities have launched efforts to develop 3-share programs including Austin, Dallas, El Paso, Galveston, and Houston. Dallas hopes to enroll 32,000 uninsured in its non-insurance health plan, Galveston estimates 2,700 uninsured will be enrolled during their initial start-up. Austin, El Paso and Houston are still in the preliminary stages of development.

More of these initiatives could be started and the existing ones would benefit greatly from technical assistance and planning grants or seed-money from the state to help them plan and develop the appropriate cost sharing arrangements and provider networks. The majority of the state grants would facilitate planning activities and infrastructure development. A portion of the money would be used as matching funds to subsidize the community share of the premium payments. The match would be a one-to-one match with the community and the state paying one half of the communities’ share of the premiums for a limited period of time while the programs are in their initial start up.

The estimated enrollment is a conservative number based on existing efforts initiated in Texas. Two percent of the funds would be available for evaluation so that other communities and the state can take the lessons learned from these pioneering 3-Share programs and apply them to future 3-Share initiatives.
Table 18. Cost Estimate Solution 1. Support 3-Share Initiatives

<table>
<thead>
<tr>
<th>Potential Uninsured Adults</th>
<th>State GR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support 3-Share Initiatives</td>
<td>150,000</td>
</tr>
</tbody>
</table>


Solution 2: Expand Use of Medicaid Health Insurance Premium Program (HIPP)

Currently in Texas, a single dollar change in income can mean the difference between continued access to employer supported insurance (ESI) through Medicaid premium assistance and completely losing coverage. Some workers may feel compelled to terminate their employment rather than lose healthcare coverage. Granting HIPP-eligible workers continued access to premium subsidies on a sliding fee basis would allow Texas to continue realizing savings in the state Medicaid program while facilitating workers’ transition to full ESI as their income increases.

Under this proposal Texas would continue HIPP premium assistance on a sliding fee basis until the individual’s income reaches 200 percent of Federal Poverty Level. Numerous studies suggest that below this income level individuals do not have the discretionary income to pay the employees share of premiums, co-payments, and deductible that accompany a typical comprehensive health plan.

The estimate below assumes the number of HIPP eligible and participating individuals would double from 7,000 to 14,000 persons. This change would represent a net savings to the state. In 1997, the Texas Performance Review estimated that Texas would save about $200 per month HIPP enrollee. This estimate assumes that 25 percent of the individuals who receive premium assistance for ESI coverage would leave employment rather than lose access to health insurance. The state would pay on reduced basis premiums for the remaining individuals that would otherwise become uninsured because of inability to pay the employee share of their employer-supported insurance.

Table 19. Cost Estimate Solution 2. Expand Medicaid Health Insurance Premium Payments

<table>
<thead>
<tr>
<th>Current HIPP Eligible Workers</th>
<th>Potential HIPP Eligible</th>
<th>Potential Total Potential</th>
<th>Employees who would leave Employment</th>
<th>State Cost</th>
<th>Federal Costs</th>
<th>State Cost Per Enrollees</th>
<th>Federal Cost Per Person/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,000</td>
<td>14,000</td>
<td>7,000</td>
<td>1,750</td>
<td>$823,620</td>
<td>$1,276,380</td>
<td>$157</td>
<td>$243</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc.

Solution 3: Enact Employer Tax Credits

Texas has no state income tax, but recently changed its businesses franchise tax structure. Effective January 1, 2008 businesses with more than $300,000 in taxable revenue will be subject to a one percent business tax. Under the new tax, businesses may deduct certain...
business costs for determining their taxable margin from their total revenues. They may deduct either the cost of goods sold or employee compensation. If a business chooses to use the employee compensation method they may deduct all benefits including worker’s compensation, healthcare, and retirement benefits. The state expects to realize about $6.95 billion in new general revenue funds from the revamped business tax in state fiscal years 2008-09.

Small businesses surveyed by TDI favored a number of ideas that would help them offer health coverage to their employees. One of the most widely supported was offering tax incentives for health coverage. A tax credit has greater value than a tax deduction because it is applied after taxes are computed rather than before. Tax credits provide a subsidy to help offset the employer’s cost of offering healthcare coverage.

Slightly more than 50 percent or over 1.5 million of Texas’ uninsured workers have incomes below 200 percent of the federal poverty level. Of these, about 844,000 work in firms with fewer than 50 employees. Tax credits could be targeted to these individuals with a phase out of the credits as an employee’s income approaches 300 percent of the federal poverty level. Specifically, the state would give employers full tax credits for each employee enrolled in their health plan whose income was at or below 200 percent of FPL and a reduced credit for employees between 200 and 300 percent of federal poverty level. No credit would be available for employees with incomes over 300 percent of poverty.

Tax credits would be available for any employer providing healthcare coverage for any worker who works at least 20 hours per week and that has not had employee coverage in the past 12 months. The tax credit would be applied to general revenue taxes including franchise, and other fees and taxes. The credits also would be transferals so that employers with low-tax liabilities could sell them to companies with greater tax liabilities.

Research suggests that the tax credit should be at least equivalent to 50 percent of the premiums of a standard health plan. Monthly premiums for standard health plan in Texas vary widely from less than $175 per month to more than $1,500 per month. However the average cost of a standard health plan or consumer choice health plan is about $310 per month based on rate information available from the Texas Department of Insurance. This figure is used for the fiscal estimate below. This estimate assumes that only half of the employees with incomes below 300 percent FPL will benefit from the tax credit.

We estimated a cost to the general funds resulting from lost tax dollars as a result of providing tax credits to employers who enroll their low and moderate income employees in a health plan. However, there would be gains to the economy and potential offsets against county indigent healthcare programs and the state’s Medicaid programs that are not estimated.

Table 20. Cost Estimate Solution 3. Create Tax Credits

<table>
<thead>
<tr>
<th>Total Uninsured Employees in Small Firms</th>
<th>Number - Full Tax Credit</th>
<th>Amount</th>
<th>Number - Reduced Credit</th>
<th>Amount</th>
<th>Total Number Employees Covered</th>
<th>Total General Revenue Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>844,303</td>
<td>211,076</td>
<td>$379,936,453</td>
<td>105,538</td>
<td>$94,984,113</td>
<td>316,614</td>
<td>$474,920,566</td>
</tr>
</tbody>
</table>

Solution 4: Replace Existing Reinsurance Program

The existing Texas Reinsurance System provides small employer insurance carriers with a mechanism to reinsure risks they cover under small employer health benefit plans. Originally, the idea of the reinsurance system was to offset carrier risk associated with small employer market guaranteed issue and renewability. Additionally, the system was designed to ensure the availability of reinsurance for carriers serving the small employer market and to decrease their risk of financial harm—thereby encouraging their entry into or continued participation in the small employer market.

Participation in the Texas Reinsurance System is voluntary with a carrier electing to be either a reinsured or a risk assuming carrier. A risk assuming carrier must be able to support the assumption of risk and meet other conditions required by the state. The amount charged carriers for small employer reinsurance is set by a nine member Board.

Only 21 of the 60 carriers writing small employer policies in Texas are reinsured carriers. Any net-loss experienced in a calendar year is recouped by assessments on reinsured carriers only. Because so few carriers participate the initial intent of spreading the risk has not proven to be effective.

In December 2004, the Texas Department of Insurance recommended phasing out the Texas Reinsurance System. The old system should be replaced by a reinsurance mechanism that adheres to the principals of successful reinsurance programs described in the previous chapter.

The program could use either an aggregate-loss or excess-loss mechanism to trigger reinsurance payments. New York’s excess-loss reinsurance program has achieved greater premium reductions and larger enrollment than Arizona’s aggregate-loss program.

In 2002 and 2003 New York paid $13.4 and $11.2 million, respectively for claims that exceeded the trigger point of $5,000. At the beginning of 2004 the New York Legislature appropriated $44 million dollars to claims related costs that exceed the state’s reinsurance trigger.

This estimate assumes an attachment point of $5,000 and an upper limit of $75,000 on healthcare costs for a Texas Reinsurance program. It further assumes that only employers where 30 percent of their workforces make less than 250 percent of FPL would be eligible to participate in the program.


<table>
<thead>
<tr>
<th>Uninsured Workers With Incomes Below 250% FPL</th>
<th>Potential Uninsured Workers Benefiting from Reinsurance</th>
<th>Cost to State General Revenue Fund</th>
<th>State Cost Per Enrollee Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurance</td>
<td>1,902,849</td>
<td>$44,000,000</td>
<td>$220</td>
</tr>
</tbody>
</table>

Solution 5: Expand Eligibility for Texas Insurance Health Risk Pool

Reinsurance initiatives can replace or work in conjunction with high-risk pools. The Texas Insurance High Risk Pool (TIHRP) was first funded in 1997 and serves as the “insurer of last resort” for more than 28,000 Texans. Of uninsured Texans, the Public Policy Research Institute (PPRI) study found about 28 percent of the focus group participants may have trouble obtaining coverage due to health-related issues.

Texans eligible for COBRA should have the option of purchasing TIHRP coverage if it is more affordable or offers better coverage than their employers’ plan. They also should be able to combine limited benefit ESI healthcare plans with a high-deductible TIHRP plan so that all their health needs would be met.

In 2005, about 28,000 Texans obtained coverage through the pool. The average cost per person that year was about $8,500 per year. Most people who would be eligible for the pool can obtain coverage through the Reinsurance program recommended in Solution 4 above, however, some individuals may still find better coverage through the pool. We estimate 25 percent growth to the pool with these changes in eligibility.

Table 22. Cost Estimate Solution 5 Expand TIHRP Eligibility

<table>
<thead>
<tr>
<th>Current TIHRP Enrollee¹</th>
<th>Potential TIHRP Enrollees</th>
<th>Current-Potential Enrollees</th>
<th>Cost to State</th>
<th>State Cost Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>28,132</td>
<td>36,000</td>
<td>7,868</td>
<td>$23,434,838</td>
<td>$8,510</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc.
¹ TIHRP enrollment at the end of state fiscal year 2004

Solution 6: Promote Pre-Paid Medical Plans

Pre-paid medical health plans do not take the place of insurance or other comprehensive medical plans, but they do three things that are important in the absence of other coverage. First, they create a medical home for the consumer by having a defined network of providers and assigning a primary care physician. Second, they make offering some healthcare coverage affordable for employers by keeping costs below $50 per month per employee. Third, by having access to regular primary care these plans help keep employees healthy thereby helping improve employee productivity.

However, currently if a firm has one person enrolled in the TIHRP then that person would lose their healthcare coverage with the risk pool when the firm adopts the pre-paid medical plan (PMP) The recommendations under Solution 5 would address this problem so the employee in the risk pool could retain their coverage and everyone in the firm (including the individual enrolled in the risk pool) would have access to the pre-paid medical plan.

This recommendation has no cost implications for the state. However, the changes recommended in Solution 5 to TIHRP would help make these plans more available.
Solution 7: Require All Texas Higher Education Students to Have Health Coverage

In 2006 more than 1.2 million Texas residents were enrolled in public and private institutions of higher education. About half of these students have health coverage under a parent’s insurance policy. Another 10 percent or so enroll in health plans provided by their college or university. The remainder or about 480,000 had access to low-cost health coverage, but declined enrollment.

Table 22 below shows the number Texans ages 18 to 24 in 2005 by work and insurance status.

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Non-Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2,210,529</td>
<td>718,613</td>
</tr>
<tr>
<td>Percent</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured</td>
<td>1,214,616</td>
<td>360,048</td>
</tr>
<tr>
<td>Percent</td>
<td>0.55</td>
<td>0.50</td>
</tr>
<tr>
<td>Uninsured</td>
<td>995,913</td>
<td>358,565</td>
</tr>
<tr>
<td>Percent</td>
<td>0.45</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Source: Texas State Data Center based on Current Population Survey U.S. Census Bureau

Many universities, including several in Texas, already require their students to have adequate health insurance coverage prior to enrolling for classes. Mandating health insurance coverage for all college students while attending school will accomplish a number of things. First, it could potentially reduce the number of uninsured by at least 400,000. Second, it would introduce young adults to health insurance, its value and appropriate use, which would in turn make these individuals more likely to seek healthcare coverage when they leave the university setting. A third benefit is that according to American College Health Association, access to healthcare also would help students stay in school.

There are no fiscal implications for this recommendation to the state. However, if health insurance were mandatory the state should ensure that healthcare coverage would be an expense students may pay for with student loans, scholarships, and other grants.

Solution 8: Allow CHIP Buy-In At Full Premium Cost

While the Texas Health and Human Services Commission’s proposed §1115 Waiver could assist a modest number of families by paying ESI premiums, many parents’ employers do not offer ESI and even those that do, do not offer dependent coverage. At least one state, Iowa, has allowed families regardless of income to buy into the state’s CHIP program.

Texas should allow Texas workers with dependents to “buy-in” to the state’s CHIP program on a sliding fee basis with fees graduated until families over 400 percent FPL are paying the entire cost of the monthly premium, both the state and federal shares. To qualify, parents should be
required to demonstrate that they are self-employed or that their employer does not offer dependent healthcare coverage.

Estimates of uninsured children by poverty status used to develop this cost estimate employed the Texas State Data Center and the US Census Bureaus’ Current Population Survey numbers. More than 400,000 children lived in families with incomes between 200 and 400 percent of FPL in 2005. Another 70,000 lived in household whose incomes exceeded 400 percent of the federal poverty level. The cost estimate below assumes that on average children between 200 and 300 percent of the FPL will pay half of the state and federal shares of the premiums while those whose family incomes between 300 and 400 percent FPL will pay 75 percent of the cost. Children whose families exceed 400 percent FPL will pay all of the premium costs.

Table 24. Cost Estimate Solution 8. Allow CHIP Buy-In

<table>
<thead>
<tr>
<th>Total Children</th>
<th>Uninsured Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>200%-400% FPL</td>
<td></td>
</tr>
<tr>
<td>200-300% FPL+</td>
<td>405,452</td>
</tr>
<tr>
<td>300%-400% FPL+</td>
<td>234,480</td>
</tr>
<tr>
<td>400% FPL+</td>
<td>98,298</td>
</tr>
<tr>
<td>State 2007</td>
<td>72,674</td>
</tr>
<tr>
<td>Federal 2007</td>
<td>$69,989,380</td>
</tr>
<tr>
<td>State Cost Per Enrollee</td>
<td>$131,427,029</td>
</tr>
<tr>
<td>Federal Cost Per Enrollee</td>
<td>$494</td>
</tr>
</tbody>
</table>

Covering Low-Income Texans

Individuals who qualify for public healthcare coverage generally have very low incomes, severe disabilities, or high medical costs. For example, 29 percent of Texas children and 19 percent of non-elderly adults live in households whose incomes are below the federal poverty level. (Table X below) Forty-one percent or 2.25 million of these individuals are uninsured. Not surprising since, even with incomes two times the FPL, health insurance is out-of-reach for many Texans. For families living at or below poverty, the ability to afford healthcare coverage is even more unlikely.

Table 25. Percent Texans by Age at 100 % FPL or below compared to the U.S. Population Generally (2004-2005)

<table>
<thead>
<tr>
<th></th>
<th>Texas</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Children 18 and Under</td>
<td>1,998,167</td>
<td>29%</td>
</tr>
<tr>
<td>Adults 10-54</td>
<td>2,688,315</td>
<td>19%</td>
</tr>
<tr>
<td>Elderly 65+</td>
<td>424,335</td>
<td>18%</td>
</tr>
</tbody>
</table>

Sources: RH2 Consulting estimates based on estimates from the Texas State Data Center extrapolated from the Census Bureau's March 2005 and 2006 Current Population Survey

Publicly funded or subsidized healthcare coverage may be the only option for individuals whose income places them below the poverty line. The following sections examine public sector solutions to increasing healthcare coverage for low-income Texans.

Texas Children

The Texas State Data Center estimates in 2005 that about 26 percent or 1.5 million Texas children between 0-18 years of age were uninsured compared to around 12 percent of the
nation’s children overall. Of the approximately 5.3 million children with healthcare coverage, 1.8 million received coverage through Medicaid while another 322,000 children were enrolled in the Texas Children’s Health Insurance Program (CHIP) in 2005. The state’s remaining uninsured children have either private health coverage or coverage through another public program such as CHAMPUS, the insurance program for military families.

Table 25 below summarizes healthcare coverage for Texas children 0-18 years of age.

Table 26.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>3,173,050</td>
<td>47</td>
<td>43,934,050</td>
<td>56</td>
</tr>
<tr>
<td>Individual</td>
<td>231,700</td>
<td>3</td>
<td>3,459,740</td>
<td>4</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1,822,580</td>
<td>27</td>
<td>20,354,580</td>
<td>26</td>
</tr>
<tr>
<td>Other Public</td>
<td>111,910</td>
<td>2</td>
<td>1,124,430</td>
<td>1</td>
</tr>
<tr>
<td>Uninsured</td>
<td>1,366,710</td>
<td>20</td>
<td>9,035,420</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>6,705,950</td>
<td>100</td>
<td>77,908,220</td>
<td>100</td>
</tr>
</tbody>
</table>


In 1997, the federal government amended the Medicaid statute to add a new state children’s health insurance program (CHIP). The program was designed to expand healthcare coverage to uninsured, low-income children. Only children living in families who earn up to 200 percent of FPL or below may qualify for CHIP in Texas.

Under current rules, to qualify for CHIP in Texas a child must be:

- A Texas resident and citizen (although the child’s parents do not have to be citizens);
- Without health insurance for the previous 90 days; and
- Under age nineteen.

After enacting the program in 2000, Texas’ CHIP enrollment attained a high point in May 2002 with more than 529,000 low-income children enrolled in the state’s CHIP program. During the 2003 legislative session, however, the Texas Legislature made cuts to program benefits and imposed stricter eligibility requirements in response to a budget short-fall that resulted in declining enrollment. The program reached a low-point in April 2006 with fewer than 300,000 CHIP enrollees.

In 2005, lawmakers restored some benefits including dental, vision, hospice, and mental health services and eliminated the monthly premiums for families with incomes under 133 percent of FPL and replaced monthly premiums with a $25 to $50 bi-annual enrollment fee for families with incomes above 133 percent of poverty. However, lawmakers did not reverse any of the other administrative changes made in 2003 that seemed to have the most adverse effect of enrollment, such as. mandatory re-enrollment every six months, an asset test for families with incomes over 150 percent of the FPL, elimination of the child care and child support deductions, and a 90 day waiting period after enrollment before being able to access covered services.
Solution 9: Fully Restore CHIP

CHIP rolls have begun to increase slightly with an enrollment of around 326,231 as of December 2006 versus 293,342 in June 2006. More than 100 statewide, regional, local and faith-based organizations have signed-on as members of the Texas CHIP Coalition. These groups have banded together to support changes to Texas’ current CHIP and Medicaid programs to increase access healthcare coverage for children.

This solution includes many of the same changes advocated by the Texas CHIP Coalition to reduce the number of uninsured Texas children. These include:

- replacing the current eligibility period of six months with 12 months of continuous eligibility for children;
- restoring income deductions child care and child support; and
- eliminating the asset limit for CHIP families earning between 150 and 200 percent of federal poverty level.

The Texas Health and Human Services Commission estimates 517,000 children are potentially eligible for CHIP. If the program were fully restored an additional 152,615 children could be covered.

The table below summarizes (1) the current number of children who could be covered by CHIP if the changes made above were implemented and (2) the estimated state and federal funds needed to fund healthcare coverage for those children. This cost estimates uses current CHIP expenses per child per year and assumes that 20 percent of the eligible children will not enroll even if all recommended administrative changes are implemented.

Table 27. Cost Estimate Solution 9. Fully Restore CHIP

<table>
<thead>
<tr>
<th>CHIP Eligible</th>
<th>Potential Enrollees</th>
<th>Current - Potential Eligibles</th>
<th>Total State CHIP</th>
<th>Total Federal CHIP Costs Per Year</th>
<th>State Cost per Child per year</th>
<th>Federal Cost per Child per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>326,231</td>
<td>517,000</td>
<td>152,615</td>
<td>$75,319,801</td>
<td>$141,436,567</td>
<td>$494</td>
<td>$927</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc., December 2006

Solution 10: Align Medicaid and CHIP Renewal Policies and Expand Outreach Efforts to Encourage CHIP and Medicaid Enrollment for Children 0-18

Currently, Texas requires Medicaid eligible children re-qualify for coverage every six month. Seventeen other state Medicaid, 24 State CHIP, and 16 aligned Medicaid and CHIP programs have 12 months continuous eligibility for children who qualify for the state’s Medicaid and CHIP programs.

Currently, over 1.7 million children are enrolled in the state’s Medicaid program. The Texas HHSC estimates that 2.6 million children could be eligible for the state’s Medicaid program – a difference of slightly more than 900,000 children.
Texas should adopt a 12-month eligibility period for the children’s Medicaid program. This recommendation would align the CHIP and Medicaid programs’ eligibility periods with current private insurance practices in Texas. The cost estimate below uses current Medicaid expenses per child per year and assumes that one-third of the eligible children will not enroll even if all recommended administrative changes are implemented and Solution 10 below were funded.

Table 28. Cost Estimate Solution 10 Align Medicaid and CHIP

<table>
<thead>
<tr>
<th>Medicaid Eligible Children</th>
<th>Potential</th>
<th>Difference</th>
<th>Only 2/3 will enroll</th>
<th>State Cost</th>
<th>Federal Cost</th>
<th>State cost per enrollee per Year</th>
<th>Federal cost per enrollee per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,720,025</td>
<td>2,643,000</td>
<td>922,975</td>
<td>609,164</td>
<td>$559,058,584</td>
<td>$866,669,095</td>
<td>$918</td>
<td>$1,423</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc., December 2006

In addition to affordability and access, enticing individuals who have not previously been insured to enroll in a health plan, even one as low-cost as CHIP, will require a strong coordinated outreach campaign to educate families. This will be especially important if proposed changes to expand the CHIP program are implemented. The state should fund outreach and marketing to raise awareness about CHIP changes. Finally, the state should encourage and enlist community-based organizations to assist with its outreach campaign. We recommend an amount equal to five percent of the state’s funding to maximize enrollment in the program. (Table 28)

Table 29. Proposed Funding for CHIP Outreach

<table>
<thead>
<tr>
<th>Proposed State CHIP Marketing Earmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75,319,801</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc.

ADULTS AT OR BELOW 100 PERCENT FPL

During the last regular legislative session, Texas lawmakers created a Medicaid buy-in program for individuals with disabilities who would otherwise qualify for Medicaid under stringent disability criteria were they unemployed. These disabled individuals will be able to pay a premium and enroll in Medicaid.

For the remaining adult Texans with incomes between 15 and 100 percent of FPL, private healthcare coverage remains unaffordable. Without access to regular medical care, these individuals seek needed treatment in hospital emergency rooms, through county indigent care programs or at free clinics. When the uninsured seek care in hospital emergency rooms hospital bills often go unpaid. When hospitals experience higher levels of uncompensated care, administrators must react by raising rates for other care to partially offset some of their losses. These rate increases are, of course, passed on to patients with insurance, which ultimately results in higher insurance premiums and higher taxes for Texas taxpayers who pay for county indigent healthcare or the local hospital district operating costs.
Solution 11: Expand Access to Medicaid for Poor Parents

In 2003, the Texas Legislature eliminated the Medicaid Medically Needy Spend-Down Program for Parents. The Health and Human Services Commission’s “Pink Book” defined this as a program for pregnant women and children who are ineligible for regular Medicaid coverage because they make too much money, but who have high medical expenses. In this case, they were allowed to “spend down” their incomes to meet Medicaid income eligibility limits.\(^9\) Under standard Medicaid income guidelines for an adult in a family of three to qualify their income would have to be less than $188 per month. This same person would qualify for the Spend-Down program if their medical bills reduced their income below $275 per month.

In 2005, the Legislature authorized a partial restoration of the funding for the Medically Needy Program of $35 million. However, restoration of funding was contingent upon Texas’ large, urban hospitals providing the state’s match for this partial restoration of the program. However, in state fiscal year 2006-2007, the appropriated funding level still left 10,100 parents without needed healthcare coverage. The cost of providing medical care for these uninsured individuals also will fall on local hospital districts or county indigent health care programs, and ultimately on the state’s taxpayers. Full restoration of the program would require $204 million in state funds.

If Texas Medicaid covered parents up to 100 percent of poverty, the state could cover about 417,000 poor parents. Covering adults up to 100 percent of poverty would eliminate the need for the Medically Needy Program. The cost of doing so is estimated below. This estimate uses the estimates from the Texas State Data Center and U.S. Census Bureau’s Current Population Survey data on the number of uninsured adults at 100 percent of FPL and below in 2005 who have related children 18 years old and younger living in their households (minus non-citizen adults with related children). This number was multiplied times the cost per adult enrollee. The cost figure was then multiplied by the federal medical assistance percentage (FMAP) – the percentage of each dollar the federal government contributes to the state’s Medicaid program – to calculate the state and federal shares of the cost.

<table>
<thead>
<tr>
<th>Uninsured Adults w/ Related Child(ren) &gt;18 @ 100% FPL</th>
<th>Cost Per Adult Medicaid Enrollee (2003)</th>
<th>State Cost Per 1000 Enrollees</th>
<th>Federal Cost Per 1000 Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>417,688</td>
<td>$2,419</td>
<td>$365,974,286</td>
<td>$567,157,499</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc., December 2006
Solution 12. Encourage Expansion of Community Health Centers

While Community Health Centers do not provide health care coverage, they did provide a medical home for more than 600,000 Texans in 2005. All CHC patients live in medically underserved areas of the state. An area is designated by the U.S. Department of Health and Human Services as health professional shortage area (HPSA) or medically Underserved area (MUA) when the population has a shortage of medical personnel and personal health services respectively. In 2001 176 of Texas’ 254 counties were designated by the federal government as an HPSA or MUA.90

Many of individuals treated at CHCs are migrant workers or homeless and therefore are unlikely to have access to traditional health insurance or health coverage plans. An additional 60,000 persons could be served with a modest investment in Community Health Centers.

Texas should make a one time appropriation of $5 million to be used as revolving fund so that existing and new community health centers can take maximum advantage of direct federal grants. For every non-federal dollar available to the CHCs would be matched by the federal government. In addition, the state should consolidate existing medical and dental loan programs under the Higher Education Coordinating Board to facilitate the dissemination of these loan programs and to encourage more medical professionals to practice in underserved areas.

Table 31. Cost Estimate Solution 12. Encourage FQHC Expansion

<table>
<thead>
<tr>
<th>Potential Uninsured Adults</th>
<th>State GR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage FQHCs</td>
<td>60,000</td>
</tr>
</tbody>
</table>

Source: RH2 Consulting, Inc.

Once Texas has taken steps to reduce its uninsured there will be one more thing to do -- make sure that the solutions adopted actually succeed in increasing the number of Texans with health coverage. A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS uses recently released numbers on the uninsured by county and region in Texas developed by the Texas State Data Center. The legislature should appropriate $45,000 per year available to allow this organization to update these numbers annually. By doing so decision–makers will have the ability to track annual progress made to increase covered lives in Texas.
<table>
<thead>
<tr>
<th>Solution</th>
<th>Cost Description</th>
<th>Estimated Uninsured³</th>
<th># To Be Covered</th>
<th>State Costs</th>
<th>Federal Costs</th>
<th>State Cost Per Person</th>
<th>Federal Cost Per Person</th>
<th>Statute Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solution 1</td>
<td>Fund 3-Share Start Up Grants (PP)²</td>
<td>150,000</td>
<td>150,000</td>
<td>$25,000,000</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Yes</td>
</tr>
<tr>
<td>Solution 2</td>
<td>Increase Medicaid Health Insurance Premium Payments (HIPPP) (Pub)</td>
<td>7,000</td>
<td>$823,620</td>
<td>$1,276,380</td>
<td>$157</td>
<td>$243</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Solution 3</td>
<td>Create Employee Tax Credit (PR)</td>
<td>316,614</td>
<td>316,614</td>
<td>$474,920,566</td>
<td>n/a</td>
<td>$1,800-</td>
<td>$900</td>
<td></td>
</tr>
<tr>
<td>Solution 4</td>
<td>Fund State-Supported Reinsurance (PP)</td>
<td>200,000</td>
<td>200,000</td>
<td>$44,000,000</td>
<td>n/a</td>
<td>$220</td>
<td>n/a</td>
<td>Yes</td>
</tr>
<tr>
<td>Solution 5</td>
<td>Expand High Risk Pool* (PP)</td>
<td>7,868</td>
<td>$23,434,838</td>
<td>n/a</td>
<td>$8,510</td>
<td>n/a</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Solution 6</td>
<td>Encourage Pre-Paid Medical (PR)</td>
<td>200,000</td>
<td>200,000</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
<td>No</td>
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<tr>
<td>Solution 7</td>
<td>Bundle Student Insurance w/ College Tuition (PR)</td>
<td>400,000</td>
<td>400,000</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<td>Yes</td>
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<tr>
<td>Solution 8</td>
<td>Allow CHIP buy-in @ full price* (PP)</td>
<td>405,452</td>
<td>405,452</td>
<td>$69,989,380</td>
<td>$131,427,029</td>
<td>$494</td>
<td>$927</td>
<td>Yes</td>
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<tr>
<td>Solution 9</td>
<td>Restore CHIP (PP)</td>
<td>152,615</td>
<td>152,615</td>
<td>$75,319,801</td>
<td>$141,436,567</td>
<td>$494</td>
<td>$927</td>
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<td>Solution 10</td>
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<td>609,164</td>
<td>$549,502,027</td>
<td>$851,854,238</td>
<td>$902</td>
<td>$1,398</td>
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<td>Solution 11</td>
<td>Cover Medicaid Parents (Pub)</td>
<td>417,688</td>
<td>417,688</td>
<td>$365,974,286</td>
<td>$567,157,499</td>
<td>$876</td>
<td>$1,358</td>
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<td>Solution 12</td>
<td>Encourage FQHC Expansion (PP)</td>
<td>60,000</td>
<td>60,000</td>
<td>$5,000,000</td>
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</tr>
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</table>

Source: RH2 Consulting, Inc. based on uninsured estimates from the Texas State Data Center extrapolated from Current Population Survey, U.S. Census Bureau 2005

Notes: ¹The total of column three "Estimated Uninsured" cannot be added together because of overlap between the Working Uninsured, Young Adults, and Uninsured Adults Below 100% of the Federal Poverty Level. The total # To Be Covered assumes that half of the Adults Below 100% of poverty will find coverage under Solutions 1 thru 6 therefore the total of this number has been subtracted from the total # To Be Covered to provide an unduplicated count. ² No cost per person is provided for Solution 1 because the funds will be for a limited time and used for planning and infrastructure in addition to coverage. ³ The cost per person is based on the total # To Be Covered minus the number that the report anticipates being covered under Solution 1 because no cost is calculated per person for this solution.

| Source: RH2 Consulting, Inc. based on uninsured estimates from the Texas State Data Center extrapolated from Current Population Survey, U.S. Census Bureau 2005

Notes: ¹The total of column three "Estimated Uninsured" cannot be added together because of overlap between the Working Uninsured, Young Adults, and Uninsured Adults Below 100% of the Federal Poverty Level. The total # To Be Covered assumes that half of the Adults Below 100% of poverty will find coverage under Solutions 1 thru 6 therefore the total of this number has been subtracted from the total # To Be Covered to provide an unduplicated count. ² No cost per person is provided for Solution 1 because the funds will be for a limited time and used for planning and infrastructure in addition to coverage. ³ The cost per person is based on the total # To Be Covered minus the number that the report anticipates being covered under Solution 1 because no cost is calculated per person for this solution.
CONCLUSIONS

With the implementation of the dozen solutions proposed in the preceding chapter and an annual expenditure of $1.6 billion in state general revenue funds, the number of uninsured Texans could be reduced by almost one half. A reduction in the uninsured will reduce uncompensated care, bad debt and charity care costs borne by our hospital districts, local governments, and health care providers. Greater health coverage and the access to necessary medical care it brings would improve the health of Texans overall.

In addition, this report documents that covering the state’s uninsured would also make the state’s economy healthier. By cutting the number of uninsured in half the state would experience a $9.4 billion increase in economic activity which in turn would create 90,000 new jobs and result in new state revenue of more than $162 million a year.


4 Paying a Premium The Added Cost of Care for the Uninsured, Families USA, June 2005, page 3.


6 Note: All percentages and numbers are for 2005 unless otherwise specified.

7 ibid.


9 The Uninsured: A Primer, The Kaiser Family Foundation, October 2006.


17 ibid.


20 The Impact of Mandated Benefits: Report to the 76th Legislature, Chapter 4, Texas Department of Insurance, December 1998.


23 Texas Department of Insurance, 1995.

24 ibid.


26 Interview with Dianne Lonley, [title], Texas Department of Insurance, December 14, 2006.


APPENDIX A: GLOSSARY OF TERMS

AGENT - A person who represents an insurance company to solicit or sell the company's insurance products. An agent may represent a single company or multiple companies. An agent must be licensed by the Texas Department of Insurance to legally sell insurance in the state.

BENEFIT IMPROVEMENT AND PROTECTION ACT (BIPA) - A federal law (PL 106-554) passed in 2000 that increased Disproportionate Share Hospital payments, modified the upper payment limit (UPL) for governmental facilities and allowed federal CHIP allocations to be carried forward. See also CHIP, DISPROPORTIONATE SHARE HOSPITAL, UPPER PAYMENT LIMIT.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) - The federal agency responsible for administering Medicare and overseeing state administration of Medicaid, formerly known as the Health Care Financing Administration (HCFA).

CERTIFIED MEDICAID ELIGIBLE – A person who has gone through the Medicaid application process and has been determined by the state to be eligible for the Medicaid program.

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) - The Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, established a new state children’s health insurance program by adding Title XXI to the Social Security Act and amending the Medicaid statute. The purpose of this new program is to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

COINSURANCE - The percentage of each health care bill you must pay out of your own pocket, including any non-covered charges and deductibles. Usually does not apply to HMO coverage.

CONSUMER CHOICE PLANS - Health care plans offered by carriers that do not include all of the state-mandated benefits. Consumer choice plans must provide members with a disclosure statement and a list describing the mandated benefits that are not covered.

COPAYMENT - The amount you must pay out of your own pocket when you receive medical care or a prescription drug. Co-payments usually refer to set fees that HMOs charge to access health care services, but they also may apply to a PPO insurance contract.

DEDUCTIBLE - The amount you must pay out of your own pocket before the insurance company or HMO begins to pay its portion of claims. You usually must meet a deductible each year. If you have a family plan that covers your spouse or dependents, you may have one deductible for the entire family, or you may have to meet a separate deductible for each family member.

1 Note: All definitions excerpted from Texas Department of Insurance Glossary and the Texas Health and Human Services’ Medicaid in Perspective Fifth Edition, Glossary.
DISPROPORTIONATE SHARE (DISPRO OR DSH) - A program which provides additional reimbursement to hospitals which serve a disproportionate share of low income patients to compensate for revenues lost by serving needy Texans. See also DISPROPORTIONATE SHARE HOSPITAL.

ELIGIBLE EMPLOYEE - An employee who meets the eligibility requirements for coverage in a group plan. To be eligible to join a group plan, you usually must work full-time for at least 30 hours a week. Some group plans may require employees to be a certain pay grade or job classification to be eligible for coverage.

ERISA PLAN - Health plans created under the Employee Retirement and Income Security Act (ERISA) of 1974. These plans are self-funded, which means that claims are paid strictly from employer contributions and employee premiums. ERISA plans are administered by the U.S. Department of Labor. (Also known as a self-funded plan.)

EVIDENCE OF INSURABILITY - Proof that you are in good health. Some insurers require you to provide information about your medical history and health status to determine whether they will insure you or whether they will exclude certain coverages.

EXCLUSIONS OR LIMITATIONS - Provisions that exclude or limit coverage of certain named diseases, medical conditions, or services, as well as some sicknesses or accidents that occur under specified circumstances.

FEDERAL POVERTY LEVELS (FPL) - Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) - A center receiving a grant under the Public Health Services Act or an entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education and mental health services.

GUARANTEED RENEWABLE - Policies that may not be non-renewed or canceled, except in certain cases. An insurer may cancel a guaranteed renewable policy for failure to pay premiums, fraud, or intentional material misrepresentation. It also may cancel your policy if the company formally leaves the individual or group health market.

HEALTH BENEFIT PLAN - In most cases, health care services provided to employees by an employer. It can be an indemnity plan or an HMO plan.

HEALTH CARE REIMBURSEMENT ACCOUNTS - Although not an insurance benefit, these accounts allow you to set aside pre-tax dollars to pay for medical care or medical costs not covered by your regular health benefit plan.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A managed care system that provides services to members through a network of physicians, hospitals, and other health care providers. HMOs eliminate the need to file claims in most cases by allowing members to "prepay" through monthly premiums and co-payments made as services are delivered.
HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM – A Medicaid program that pays for employer or private health insurance premiums for persons who are Medicaid-eligible, when the premiums are cheaper than providing regular Medicaid coverage for those persons.

MANAGED HEALTH CARE- A system that organizes physicians, hospitals, and other health care providers into networks with the goal of lowering costs while still providing appropriate medical services. Many managed care systems focus on preventive care and case management to avoid treating more costly illnesses.

MANDATED BENEFITS - Health care benefits that state or federal law says must be included in health care plans.

MANDATED OFFERINGS - Health care benefits that must be offered to the employer or organization sponsoring a group policy. The sponsor is not required to include the benefits in its group plan.

MEDICAID - A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

MEDICAID ELIGIBLE: In Texas, this term is used in reference to persons who, after going through a certification process, become eligible to receive services and other assistance under the auspices of the Medicaid program. The term does not include persons who could be eligible for Medicaid (e.g., meet all income and asset criteria tied to eligibility) that are not enrolled in the program.

MEDICAID QUALIFIED MEDICARE BENEFICIARIES - Medicare beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the deductible and coinsurance for Medicare services and covers all other Medicaid services not covered by Medicare.

MEDICALLY NEEDY PROGRAM – Pregnant women and children who are ineligible for regular Medicaid coverage due to excess income, but who meet Medicaid income eligibility limits after subtracting their medical expenses from their income (a process called “spend down”).

POOL (RISK POOL) - A defined account (e.g., defined by size, geographic location, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.

PRE-EXISTING CONDITION - A medical problem or illness you had before applying for health care coverage.

PREMIUM - A set fee to participate in a health care plan. If you have health coverage through your work, your premium will likely be deducted from your paycheck.

PREVENTIVE CARE - Health care services such as routine physical examinations and immunizations that are intended to prevent illnesses before they occur. PREVENTIVE CARE - Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well-person care.
PROVIDER - A hospital, pharmacist, registered nurse, organization, institution, or person licensed to provide health care services in Texas. A physician also may be referred to as a provider. The term provider is often used collectively to refer to individual or facilities that provide health services.

REINSURANCE - Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the unusually high claims of its participating providers, policy holders, or employees and covered dependents. Also called risk control insurance or stop-loss insurance. See also STOP-LOSS INSURANCE.

RESERVES - Funds for incurred but not reported health services or other financial liabilities. Also refers to deposits and/or other financial requirements that must be met by an entity as defined by various state or federal regulatory authorities.

STOP-LOSS INSURANCE – Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance:
   • Specific or individual-reimbursement is given for claims on any covered individual that exceed a predetermined deductible, such as $25,000 or $50,000.
   • Aggregate-reimbursement is given for claims, which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year.
See also REINSURANCE.

TEXAS HEALTH INSURANCE RISK POOL - The Health Pool provides health insurance to Texans unable to obtain coverage because of their medical history or for certain other reasons.

THIRD-PARTY ADMINISTRATOR (TPA) - TPAs administer employee benefit plans under contract with insurance companies, HMOs, and self-funded plans. They are regulated by TDI.

UNDERWRITING - The process insurance companies use to examine, accept, reject, and classify the risks associated with an applicant for coverage.

UPPER PAYMENT LIMIT (UPL) - Federal limits on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds.

WAIVER - An exception to the usual requirements of Medicaid granted to a state by the Centers for Medicare and Medicaid Services (CMS). See also CENTERS FOR MEDICARE AND MEDICAID SERVICES; 1115(a); 1915(b); 1915(c).

1115(a) WAIVER - Section of the Social Security Act which allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. System-wide changes are possible under this provision. Waivers must be approved by CMS.
# APPENDIX B. TEXAS STATE DATA CENTER ESTIMATE OF THE UNINSURED

Provisional Estimates of the Number and Percent of Uninsured by Age and Race/Ethnicity for Counties in Texas, 2005

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Anglo 2005 Census Population</th>
<th>Uninsured</th>
<th>% Uninsured</th>
<th>Hispanic 2005 Census Population</th>
<th>Uninsured</th>
<th>% Uninsured</th>
<th>Black/Other 2005 Census Population</th>
<th>Uninsured</th>
<th>% Uninsured</th>
<th>Total 2005 Census Population</th>
<th>Uninsured</th>
<th>% Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>102,580</td>
<td>19,415</td>
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**Region 10**

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**Region 11**

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## Provisional Estimates of the Number and Percent of Uninsured by Age and Race/Ethnicity for Counties in Texas, 2005

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**Anderson County**

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**Andrews County**
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### Archer County

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## Bandera County

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<td>Baylor County</td>
<td>Bee County</td>
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<tr>
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<td>----------------</td>
<td>---------------</td>
<td>------------</td>
</tr>
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<td>1,786</td>
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**Bastrop County**

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**Baylor County**

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<td>1.7</td>
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**Bee County**

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<th>35-44 yrs</th>
<th>45-64 yrs</th>
<th>65 + yrs</th>
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**Bell County**

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<th>18-34 yrs</th>
<th>35-44 yrs</th>
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**Texas Health Institute**

Page 74 of 142
### Bexar County

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<th>Number of Uninsured</th>
<th>Percent of Total Uninsured</th>
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### Blanco County

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Uninsured</th>
<th>Number of Uninsured</th>
<th>Percent of Total Uninsured</th>
<th>Number of Uninsured</th>
<th>Percent of Total Uninsured</th>
<th>Number of Uninsured</th>
<th>Percent of Total Uninsured</th>
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<tbody>
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<tr>
<td>35-44 yrs</td>
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### Borden County

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<td>17.7</td>
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### Bosque County

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<th>Percent of Total Uninsured</th>
<th>Number of Uninsured</th>
<th>Percent of Total Uninsured</th>
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<tr>
<td>0-17 yrs</td>
<td>14,798</td>
<td>2,193</td>
<td>14.8</td>
<td>2,591</td>
<td>33.4</td>
<td>18,056</td>
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<td>14.8</td>
<td>2,591</td>
<td>33.4</td>
<td>18,056</td>
<td>17.7</td>
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### Bowie County

<table>
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<th>Insured Rate</th>
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### Brazoria County

<table>
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<th>Insured Rate</th>
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<tbody>
<tr>
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<td>4,330</td>
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### Brazos County

<table>
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<th>Insured Rate</th>
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### Brewster County

<table>
<thead>
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<th>Insured Rate</th>
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<td>Brown County</td>
<td>Burleson County</td>
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<tr>
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<td>----------------</td>
<td>---------------</td>
<td>--------------</td>
<td>-----------------</td>
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<tr>
<td>0-17 yrs</td>
<td>222 34 15.3</td>
<td>111 17 15.3</td>
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<td>2,354 359 15.3</td>
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<td>185 31 16.7</td>
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<td>3,300 551 16.7</td>
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<td>150 1 0.8</td>
<td>5,553 45 0.8</td>
<td>2,282 18 0.8</td>
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<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
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</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Briscoe County</th>
<th>Brooks County</th>
<th>Brown County</th>
<th>Burleson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>156 39 25.3</td>
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<td>2,323 587 25.3</td>
<td>939 237 25.3</td>
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<td>1,608 586 36.4</td>
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<td>1,053 29 2.8</td>
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<td>191 5 2.8</td>
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<td>7,022 2,081 29.6</td>
<td>6,817 2,255 33.1</td>
<td>2,800 909 32.5</td>
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<table>
<thead>
<tr>
<th>Age Group</th>
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<th>Brooks County</th>
<th>Brown County</th>
<th>Burleson County</th>
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<tbody>
<tr>
<td>0-17 yrs</td>
<td>15 2 14.3</td>
<td>5 1 14.3</td>
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<td>1 0 24.0</td>
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<td>9 2 21.8</td>
<td>412 90 21.8</td>
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<td>5 0 1.4</td>
<td>175 2 1.4</td>
<td>355 5 1.4</td>
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<td>31 6 19.4</td>
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<td>2,189 474 21.7</td>
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<table>
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<th>Brooks County</th>
<th>Brown County</th>
<th>Burleson County</th>
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</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>393 75 19.1</td>
<td>2,214 548 24.8</td>
<td>9,156 1,624 17.7</td>
<td>4,124 715 17.3</td>
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<td>3,735 1,138 30.5</td>
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<td>35-44 yrs</td>
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<td>2,222 513 23.1</td>
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<td>1,802 619 34.4</td>
<td>9,249 1,773 19.2</td>
<td>4,330 843 19.5</td>
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<th>Briscoe County</th>
<th>Brooks County</th>
<th>Brown County</th>
<th>Burleson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
</tr>
<tr>
<td>18-34 yrs</td>
<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
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<td>35-44 yrs</td>
<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
</tr>
<tr>
<td>45-64 yrs</td>
<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
</tr>
<tr>
<td>65 + yrs</td>
<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
</tr>
<tr>
<td>Total Uninsured</td>
<td>1,155 161 13.9</td>
<td>635 93 14.6</td>
<td>29,658 4,674 15.8</td>
<td>11,816 1,830 15.5</td>
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## Burnet County

<table>
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<tbody>
<tr>
<td>0-17 yrs</td>
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## Caldwell County

<table>
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<th>Uninsured Total</th>
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<tbody>
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## Calhoun County

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<tr>
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<th>Uninsured %</th>
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## Callahan County

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### Collin County

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### Collingsworth County

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### Colorado County

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### Comal County

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### Culberson County

<table>
<thead>
<tr>
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<th>Population</th>
<th>Female (Female %)</th>
<th>Male (Male %)</th>
<th>Uninsured (Uninsured %)</th>
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<tbody>
<tr>
<td>0-17 yrs</td>
<td>113</td>
<td>17 (15.3)</td>
<td>96 (84.7)</td>
<td>620 (53.8)</td>
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<td>76 (74.0)</td>
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<td>202 (83.3)</td>
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<td>589 (85.2)</td>
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### Dallam County

<table>
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<th>Population</th>
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<td>0-17 yrs</td>
<td>1,069</td>
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<td>906 (84.7)</td>
<td>691 (65.3)</td>
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<td>852</td>
<td>221 (26.0)</td>
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<td>468 (80.9)</td>
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<td>836 (83.3)</td>
<td>320 (36.4)</td>
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<td>3,327 (83.3)</td>
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### Dallas County

<table>
<thead>
<tr>
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<th>Population</th>
<th>Female (Female %)</th>
<th>Male (Male %)</th>
<th>Uninsured (Uninsured %)</th>
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<tbody>
<tr>
<td>0-17 yrs</td>
<td>170,220</td>
<td>18,094 (10.6)</td>
<td>152,126 (89.4)</td>
<td>292,491 (45.1)</td>
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<tr>
<td>18-34 yrs</td>
<td>157,667</td>
<td>30,341 (19.2)</td>
<td>127,326 (80.8)</td>
<td>295,119 (59.3)</td>
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<td>140,061</td>
<td>18,640 (13.3)</td>
<td>121,421 (86.7)</td>
<td>127,961 (51.7)</td>
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<tr>
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<td>267,246</td>
<td>26,880 (10.1)</td>
<td>240,366 (89.9)</td>
<td>101,011 (38.5)</td>
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<td>414 (0.3)</td>
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<td>838,205 (49.3)</td>
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### Dawson County

<table>
<thead>
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<th>Population</th>
<th>Female (Female %)</th>
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<th>Uninsured (Uninsured %)</th>
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</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>1,033</td>
<td>158 (15.3)</td>
<td>875 (84.7)</td>
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<tr>
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<td>584 (80.9)</td>
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<td>1,370 (83.3)</td>
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### Deaf Smith County

<table>
<thead>
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<th>Count</th>
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<th>% Uninsured</th>
<th>Population</th>
<th>Uninsured</th>
<th>% Uninsured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>1,350</td>
<td>206</td>
<td>15.3</td>
<td>4,405</td>
<td>1,112</td>
<td>25.3</td>
<td>5,846</td>
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<tr>
<td>18-34 yrs</td>
<td>1,095</td>
<td>285</td>
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<td>1,333</td>
<td>42.9</td>
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<td>537</td>
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<td>699</td>
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### Delta County

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<th>Total</th>
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<tbody>
<tr>
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### Denton County

<table>
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<th>Count</th>
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<th>Population</th>
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### DeWitt County

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<th>% Uninsured</th>
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<td>Dimmit County</td>
<td>Donley County</td>
<td>Duval County</td>
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**Dickens County**

**Dimmit County**

**Donley County**

**Duval County**
<table>
<thead>
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<th>Age Group</th>
<th>Eastland County</th>
<th>Ector County</th>
<th>Edwards County</th>
<th>Ellis County</th>
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<tr>
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<tr>
<td>35-44 yrs</td>
<td>1,667 318 19.1</td>
<td>7,338 856 11.7</td>
<td>113 22 19.1</td>
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<td>45-64 yrs</td>
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<td>91,629 10,791 11.8</td>
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<td>Erath County</td>
<td>Falls County</td>
<td>Fannin County</td>
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</tr>
<tr>
<td>0-17 yrs</td>
<td>20,769 3,224 15.5</td>
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<tr>
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<tr>
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<td>3,866 737 19.1</td>
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<tr>
<td>45-64 yrs</td>
<td>30,458 4,622 15.2</td>
<td>6,122 1,022 16.7</td>
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<td>7,026 1,172 16.7</td>
</tr>
<tr>
<td>65 + yrs</td>
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<td>9,698 1,471 15.2</td>
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<td>Floyd County</td>
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<td>Freestone County</td>
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### Gaines County

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### Gillespie County

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<td>Goliad County</td>
<td>Gonzales County</td>
</tr>
<tr>
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</tr>
<tr>
<td>0-17 yrs</td>
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<td>705 108 15.3 757 191 25.3 82 12 14.3</td>
<td>1,841 281 15.3 2,805 708 25.3 428 61 14.3</td>
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<td>815 212 26.0 610 262 42.9 71 22 31.1</td>
<td>1,801 468 26.0 2,466 1,059 42.9 329 102 31.1</td>
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Total Uninsured:
Glasscock County: 1,328 280 21.1
Goliad County: 7,103 1,498 21.1
Gonzales County: 19,589 4,419 22.6
Gray County: 21,480 3,996 18.6
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<th>Age Group</th>
<th>Grayson County</th>
<th>Gregg County</th>
<th>Grimes County</th>
<th>Guadalupe County</th>
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<tbody>
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**Grayson County**

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**Gregg County**

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<th>65 + yrs</th>
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**Grimes County**

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**Guadalupe County**

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Hardeman County

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Harris County

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Harrison County

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Total Uninsured

<p>| Hardeman County | 3,346 490 14.6 | Total Uninsured | 4,293 761 17.7 |
| Hardin County   | 45,403 8,487 18.7 | Total Uninsured | 50,977 10,361 20.3 |
| Harris County   | 1,410,442 191,270 13.6 | Total Uninsured | 3,693,051 1,115,478 30.2 |
| Harrison County | 43,320 7,149 16.5 | Total Uninsured | 63,460 11,777 18.6 |</p>
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**Texas Health Institute**

**Education * Awareness * Policy Development * Prevention**

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### Henderson County

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### Hill County

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**Texas Health Institute**

**Education, Awareness, Policy Development, and Prevention**

Page 103 of 142
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<thead>
<tr>
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Kenedy County

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Kent County

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**Kleberg County**

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<thead>
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**Knox County**

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</tr>
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<td>18-34 yrs</td>
<td>35-44 yrs</td>
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<td>65 + yrs</td>
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### Lavaca County

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<th>Min</th>
<th>Max</th>
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<tbody>
<tr>
<td>0-17 yrs</td>
<td>14,960</td>
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<tr>
<td>18-34 yrs</td>
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<td>35-44 yrs</td>
<td>12,941</td>
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<tr>
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<tr>
<td>65 + yrs</td>
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### Lee County

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<tbody>
<tr>
<td>0-17 yrs</td>
<td>14,960</td>
<td>2,155</td>
<td>14.4</td>
</tr>
<tr>
<td>18-34 yrs</td>
<td>11,169</td>
<td>1,761</td>
<td>15.8</td>
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<tr>
<td>35-44 yrs</td>
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<tr>
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<tr>
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### Leon County

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<th>Min</th>
<th>Max</th>
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<tbody>
<tr>
<td>0-17 yrs</td>
<td>14,960</td>
<td>2,155</td>
<td>14.4</td>
</tr>
<tr>
<td>18-34 yrs</td>
<td>11,169</td>
<td>1,761</td>
<td>15.8</td>
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<tr>
<td>35-44 yrs</td>
<td>12,941</td>
<td>1,939</td>
<td>15.0</td>
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<tr>
<td>45-64 yrs</td>
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<tr>
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### Liberty County

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<tbody>
<tr>
<td>0-17 yrs</td>
<td>14,960</td>
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<tr>
<td>18-34 yrs</td>
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<td>15.8</td>
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<tr>
<td>35-44 yrs</td>
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<tr>
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<td>7,607</td>
<td>13.9</td>
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<tr>
<td>65 + yrs</td>
<td>54,685</td>
<td>7,607</td>
<td>13.9</td>
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**Notes:**

- The data represents the number of uninsured individuals in each age group for the respective counties.
- The numbers indicate the count of uninsured persons in each group.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Limestone County</th>
<th>Lipscomb County</th>
<th>Live Oak County</th>
<th>Llano County</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 yrs</td>
<td>14,662 (15.5%)</td>
<td>2,179 (14.8%)</td>
<td>6,620 (14.5%)</td>
<td>16,579 (13.0%)</td>
</tr>
<tr>
<td>18-34 yrs</td>
<td>5,639 (31.2%)</td>
<td>790 (33.4%)</td>
<td>2,646 (28.4%)</td>
<td>9,037 (16.8%)</td>
</tr>
<tr>
<td>35-44 yrs</td>
<td>5,395 (19.0%)</td>
<td>790 (18.9%)</td>
<td>1,549 (21.0%)</td>
<td>5,375 (9.0%)</td>
</tr>
<tr>
<td>45-64 yrs</td>
<td>3,101 (19.9%)</td>
<td>1,999 (21.7%)</td>
<td>1,549 (21.0%)</td>
<td>5,375 (9.0%)</td>
</tr>
<tr>
<td>65 + yrs</td>
<td>22,765 (19.4%)</td>
<td>3,101 (19.9%)</td>
<td>2,646 (28.4%)</td>
<td>16,579 (13.0%)</td>
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**Limestone County**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population</th>
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<th>Uninsured %</th>
<th>Population</th>
<th>Uninsured</th>
<th>Uninsured %</th>
<th>Population</th>
<th>Uninsured</th>
<th>Uninsured %</th>
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</thead>
<tbody>
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<td>1,294</td>
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<td>131</td>
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<tr>
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**Lipscomb County**

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<th>Population</th>
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<th>Uninsured %</th>
<th>Population</th>
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<th>Uninsured %</th>
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**Live Oak County**

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<th>Population</th>
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<th>Uninsured %</th>
<th>Population</th>
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<th>Uninsured %</th>
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<td>167</td>
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**Llano County**

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<th>Population</th>
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<th>Uninsured %</th>
<th>Population</th>
<th>Uninsured</th>
<th>Uninsured %</th>
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<td>173</td>
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<td>84</td>
<td>26</td>
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<td>7</td>
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<td>2.8</td>
<td>54</td>
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<td>1.4</td>
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<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population</th>
<th>Uninsured</th>
<th>Uninsured %</th>
<th>Population</th>
<th>Uninsured</th>
<th>Uninsured %</th>
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### Loving County

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<th>45-64 yrs</th>
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<td>15.3</td>
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### Lubbock County

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### Lynn County

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### McCulloch County

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### Martin County

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**Total Uninsured**: 2,460

### Mason County

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**Total Uninsured**: 2,984

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**Total Uninsured**: 18,905

### Maverick County

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<td>5,153</td>
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**Total Uninsured**: 1,764

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**Texas Health Institute**

[Logo]

Page 111 of 142
### Medina County

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Uninsured</th>
<th>Total</th>
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### Milam County

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<td>18-34 yrs</td>
<td>35-44 yrs</td>
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<tr>
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<td>65 + yrs</td>
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*Texas Health Institute*
### Moore County

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<thead>
<tr>
<th>Age Group</th>
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<th>Uninsured %</th>
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<tbody>
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<td>35-44 yrs</td>
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<td>19.1</td>
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<tr>
<td>45-64 yrs</td>
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### Morris County

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<tbody>
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### Motley County

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<td>35-44 yrs</td>
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<tr>
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<tr>
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### Nacogdoches County

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### Navarro County

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<th>35-44 yrs</th>
<th>45-64 yrs</th>
<th>65 + yrs</th>
<th>Total Uninsured</th>
</tr>
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<td>0-17 yrs</td>
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<td>12,606</td>
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<td>551</td>
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<td>18,656</td>
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<td>8</td>
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<th>35-44 yrs</th>
<th>45-64 yrs</th>
<th>65 + yrs</th>
<th>Total Uninsured</th>
</tr>
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<tbody>
<tr>
<td>0-17 yrs</td>
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<td>70</td>
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<td>70</td>
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<td>1,947</td>
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<td>70</td>
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### Nolan County

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<th>18-34 yrs</th>
<th>35-44 yrs</th>
<th>45-64 yrs</th>
<th>65 + yrs</th>
<th>Total Uninsured</th>
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<td>947</td>
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<td>947</td>
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<td>1,767</td>
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<td>3,771</td>
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<td>361</td>
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### Nueces County

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<th>35-44 yrs</th>
<th>45-64 yrs</th>
<th>65 + yrs</th>
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<td>18-34 yrs</td>
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<td>49,901</td>
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<td>38,532</td>
<td>16,131</td>
<td>78,001</td>
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<tr>
<td>35-44 yrs</td>
<td>15,491</td>
<td>49,901</td>
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<td>16,131</td>
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<td>63,507</td>
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### Ochiltree County

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## Polk County

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### Reagan County

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### Real County

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### Red River County

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### Reeves County

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### Refugio County

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### Robertson County

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<td>1,829 370 20.8</td>
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### Stephens County

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### Sterling County

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### Stonewall County

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### Tarrant County

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Page 126 of 142
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### Tyler County

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### Upshur County

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## Victoria County

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## Walker County

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<td>3,597 38.0 1,666 632 38.0 2,548 612 24.0 8,927 2,142 24.0</td>
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### Wichita County

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<td>1,393</td>
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<td>21,378</td>
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### Wilbarger County

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<td>210</td>
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### Willacy County

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### Williamson County

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<td>56,988</td>
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<th>Winkler County</th>
<th>Wise County</th>
<th>Wood County</th>
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<tbody>
<tr>
<td></td>
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<tr>
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<tr>
<td>35-44 yrs</td>
<td>1,123 298 26.5</td>
<td>185 35 18.9</td>
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<td>2,962 610 20.6</td>
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<td>333 126 38.0</td>
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## State of Texas

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<th>% Uninsured</th>
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<tr>
<td>0-17 yrs</td>
<td>2,420,919</td>
<td>321,570</td>
<td>2,711,098</td>
<td>13.3</td>
<td>1,016,939</td>
<td>236,125</td>
<td>23.2</td>
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<tr>
<td>18-34 yrs</td>
<td>2,502,662</td>
<td>576,496</td>
<td>2,465,729</td>
<td>23.0</td>
<td>998,297</td>
<td>346,842</td>
<td>34.7</td>
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<tr>
<td>35-44 yrs</td>
<td>1,643,895</td>
<td>249,891</td>
<td>1,143,554</td>
<td>15.2</td>
<td>483,058</td>
<td>563,732</td>
<td>25.1</td>
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<tr>
<td>45-64 yrs</td>
<td>3,096,629</td>
<td>410,546</td>
<td>1,267,466</td>
<td>13.3</td>
<td>757,559</td>
<td>198,257</td>
<td>26.2</td>
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<tr>
<td>65+ yrs</td>
<td>1,578,522</td>
<td>9,313</td>
<td>442,117</td>
<td>0.6</td>
<td>19,943</td>
<td>251,206</td>
<td>4.0</td>
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<tr>
<td>Total Uninsured</td>
<td>11,242,627</td>
<td>1,567,816</td>
<td>8,029,964</td>
<td>3.089,582</td>
<td>3,587,733</td>
<td>933,079</td>
<td>26.0</td>
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</table>
The Texas Health Institute (THI) is a nonpartisan, nonprofit organization focused on the development of health policy solutions to improve the lives of Texans and their communities. From acting as an honest broker and hosting unbiased health policy forums that facilitate dialogue among policymakers and other healthcare stakeholders, to creating a vision of an improved future healthcare system, THI is a think tank – providing evidence-based policy options and solutions as well as innovative, “outside the box” collaborative options to improve the health of Texans and their communities.


RH2 Consulting, Inc. is an Austin-based independent consulting firm specializing in health and human services policy research and analysis. Robin Herskowitz, President of RH2 Consulting, brings more than 20 years experience in public health policy development, public and private sector research and evaluation, and project management to the firm. Most recently, she contributed to the study, released December 2006, “Undocumented Immigrants in Texas: A Financial Analysis of the Impact to the State Budget and Economy.” Prior to joining the private sector Robin worked as a Senior Policy Analyst with the Texas Legislature and Texas’ award-winning Performance Review where she was responsible for developing concrete recommendations to enhance program efficiency and save state taxpayers money.

The Texas Health Institute engaged RH2 Consulting to develop and quantify a set of proposal(s) to reduce the number of uninsured in Texas by half over the next three to five years. The result is the report, “A Vision for Change: Policy Solutions for Increasing Health Coverage in Texas.”

TXP, Inc. is an Austin-based economic consulting firm. Jon Hockenyos, President of TXP, Inc., founded the firm while attending the LBJ School of Public Affairs at the University of Texas at Austin in 1987. Since then, TXP has successfully completed hundreds of projects for a wide variety of clients across the nation.

During the electricity deregulation crisis in California, for example, TXP led the team hired by the California State Auditor’s Office to determine the underlying causes of the problem and to recommend solutions. More recently, TXP contributed to the groundbreaking study released in 2005 by the Mental Health Association of Texas, “Turning the Corner.” TXP developed fiscal and economic impact estimates to demonstrate the unfortunate impact of Texas’ mental health funding history and policy direction on local governments, mental health consumers, and Texas taxpayers. TXP also has developed economic impact analysis on policy issues ranging from home health to uncompensated care for border hospitals.
Vollmer Public Relations is the largest public relations firm headquartered in Texas and the Southwest. Healthcare is among the agency’s primary areas of specialization. Peggy Hubble, Executive Vice President and General Manager of Vollmer’s Austin office, has 25 years experience in public relations, including public affairs, strategic planning, media relations, community relations and community outreach.

In its effort to provide education and awareness of health policy solutions to its targeted constituents – from the media to policymakers – the Texas Health Institute has hired Vollmer to assist with all aspects of communications and public relations for the THI “Uninsured Texans Project.” Vollmer worked previously with the Texas Health Institute on its “Disaster Preparedness” project in 2005.

The agency has 60 full-time employees, with offices in Austin, Houston, Dallas, and New York City.
A C K N O W L E D G M E N T S

WE WOULD LIKE TO THANK THE FOLLOWING PEOPLE FOR THEIR TIME AND COMMITMENT TO THE SHARED VISION FOR HEALTH CARE IN TEXAS PROJECT

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Texas Health Institute plays a critical role in improving the health of healthcare through information, education, collaboration and vision. In 2003, the THI introduced the Friends of the Institute to support our 501(c)(3) entity. Friends members receive invitations to THI events and mailings of policy briefs and other special publications produced by THI. If you would like more information on membership opportunities or other ways to participate in the work of THI, please contact us at (512) 279-3910.