This report examines how people receive health coverage in Texas and who in the state is uninsured. It also reviews efforts in other states to reduce the number of the uninsured, including efforts in some cases to achieve universal coverage.
coverage on the private, individual market. However, many lower-income families say they cannot afford insurance premiums without an employer or other entity contributing to premium payments. Affordability declines further if insurers deem a family a health risk based on demographics or health status.

In recent years, improved fiscal situations permitted many states to undertake comprehensive health reforms, restructuring their insurance markets and assistance programs in an attempt to increase the availability of affordable, comprehensive health coverage. Last session, Texas reform efforts targeted the Medicaid program. In previous sessions, the Texas Legislature grappled with the declining rate of insurance provided by small employers. The approaches by different states reflect widely divergent views on the extent to which state governments should address the problem of the uninsured and how they should do so. The more recent economic downturn has caused some states to reconsider whether they can continue to pursue new initiatives to expand health insurance coverage. Others suggest that difficult economic times make it even more critical to insure more people and to minimize costs to treat the uninsured who cannot pay their medical bills.

Critics of state efforts to expand health care coverage say that insuring more people, particularly non-indigent populations, is not necessary to achieve the more critical objective of health care access. They say that, however well intentioned, efforts to reduce the number of uninsured often lead to regulatory interventions that only drive up the cost of health care, making insurance less attainable for the people the interventions were intended to benefit. Insured consumers, desensitized to the real cost of their health care, often feed rising costs because they overuse medical services. Many people have the means to pay for necessary health care expenses, opponents say, and consumers who cannot afford their health care would benefit most from a competitive insurance market that provided a wide array of affordable coverage options. Opponents say health care reforms should focus on cost containment in order to benefit the vast majority of consumers and directly invest in coverage only for the most vulnerable populations.

Supporters of state efforts to expand health care coverage say such reforms are critical to achieving access to affordable health care for the majority of the uninsured. They say cost containment is only part of the solution because major cost-drivers, such as demand for new medical technologies, are beyond the scope of state-level reforms. Confronting steep health costs, many people are unable to pay “out of pocket” even for basic or preventive care, supporters say, much less for a chronic condition or health emergency. Ultimately, insurance consumers and taxpayers foot the bill for uncompensated care provided to the uninsured, and employers lose substantial productivity from a work force that does not receive proper care. Supporters of expanding health coverage say the right combination of reforms could guarantee access to health care for more people with only a minimal impact on health costs. Some suggest that universal health coverage should be the state’s objective and argue that a properly implemented universal coverage initiative could vastly reduce uncompensated care costs and make a state’s population healthier and more productive.

This report examines how people receive health coverage in Texas and who in the state is uninsured. It also reviews recent efforts in other states to reduce the rate of the uninsured, including attempts in some cases to achieve universal coverage for all state residents.

Who is uninsured in Texas?

In the last 10 years, the rate of people without health insurance in Texas generally has remained within a couple of percentage points of its current 25.2 percent rate, with the exception of a decade-low uninsured rate of 21.4 percent in 2000. The decade-high uninsured rate of 25.8 percent occurred in 2002.

Recent U.S. Census data, as reviewed and reported by the Health and Human Services Commission, revealed significant facts about people in Texas who reported having no health coverage in 2007:

- **Age.** Adults between the ages of 18 and 34 constituted nearly 39 percent of Texas’ uninsured population. More than 40 percent of those in this age group were uninsured. More than 21 percent of children aged 17 and under were uninsured.

- **Citizenship.** U.S. citizens made up almost 75 percent of Texas’ uninsured. Sixty percent of non-citizens, including legal and illegal residents, were uninsured.
• **Income.** Among Texans with incomes below 200 percent of the federal poverty level, 40 percent were uninsured, and these individuals constituted nearly 58 percent of Texas’ total uninsured population. In 2007, for a single adult, 200 percent of the federal poverty level was $20,420 and for a family of four was $41,300.

• **Employment.** Among the adult uninsured population, 69 percent were employed. Nearly 45 percent of uninsured workers worked for businesses with 24 or fewer employees. The uninsured rate among employees of these small firms was more than 44 percent.

• **Location.** According to 2005 estimates based on statistics on the uninsured from the state demographer, nearly half of the uninsured population resided in Texas’ five largest counties: Bexar, Dallas, Harris, Tarrant, and Travis counties. Harris and El Paso counties were among the 10 counties with the highest uninsured rates, along with eight south Texas counties along the Texas-Mexico border.

### Effects of people being uninsured

Policy makers evaluate both the health and fiscal consequences of people being uninsured when deciding how extensive state efforts should be to expand coverage. People without insurance are less likely than those with coverage to seek medical care when they need it, to follow a doctor’s recommended course of treatment, or to obtain prescribed medication, according to a 2006 National Health Institute Survey by the National Center

### Uninsured Texans in 2007 by demographic group

**By Age**
- Ages 35 - 64 (35.5%)
- Ages 18 - 34 (38.8%)
- Under Age 18 (24.1%)
- Age 65 and Over (1.7%)

**By Income as a Percent of the Federal Poverty Level (FPL)**
- Under 100% FPL (27.3%)
- 100 - 199% FPL (30.6%)
- 200 - 249% FPL (12.6%)
- 250% or Higher FPL (29.4%)
- Not Reported (5.9%)

**By Employment Status**
- Employed (69%)
- Not in Labor Force (25.9%)
- Unemployed (5.1%)

**By Number of Employees at Work Place**
- Fewer than 10 (31.2%)
- 10 - 24 (13.6%)
- 25 - 99 (14.1%)
- 100 - 499 (11.1%)
- 500 or More (24%)
- Not Reported (5.9%)

The uninsured also are less likely to receive preventive care, such as screenings and vaccinations, according to the same study. Without early detection or proper treatment, illnesses often become more acute and more time- and resource-intensive to treat.

While some uninsured people can afford private health care, treatment costs for services in acute care settings, community health centers, and private providers’ offices often go unpaid. These uncompensated care costs are passed on to taxpayers through higher taxes and to the insured through higher premiums. Most of Texas’ uncompensated care costs are accrued in acute-care hospitals, including emergency rooms, as bad debt or charity care. In 2006, total uncompensated care charges in Texas’ acute-care hospitals were $11.6 billion. This was equal to charges of $460 per Texan in 2006 for uncompensated hospital care. Texas’ per capita uncompensated care charges were exceeded only by Florida’s among the seven most populous states and were significantly above U.S. average per capita uncompensated care charges of $287 during the same year. Still more uncompensated care is provided in charitable clinics or by physicians.

In 2007, the Disproportionate-Share Hospital program reimbursed hospitals more than $1.4 billion for uncompensated care costs. Several other programs reimburse hospitals at lower levels. To the extent that state and federal government assistance does not cover the full cost of uncompensated care to hospitals, many of the remaining expenses are written off. Public hospitals often raise taxes in local hospital districts to maintain operations. Taxpayers in these largely urban districts express frustration that their dollars disproportionately subsidize the cost of care for the indigent and uninsured in the state. Hospitals and doctors also may raise rates to cover these costs. Insurers, in turn, recover the cost by charging higher premiums.

Health coverage options in Texas

Texans can obtain health coverage both on the private market through various group and individual purchasing arrangements and through government programs. According to U.S. Census data for 2007, about 50.4 percent of Texans have employer-sponsored health coverage that is sold as a group plan on the private market. Government programs, including Medicare, Medicaid, CHIP, and military health programs, cover the next largest population of Texans with health coverage. Only about 7.2 percent of Texans have private, individual coverage. Individual plans in the private market sometimes may be used as supplemental rather than primary coverage.
Government programs

The federal and state governments offer several coverage options for people who qualify based on age, income, disability status, or participation in the armed services. Most coverage at the federal level is administered through the Centers for Medicare and Medicaid Services (CMS).

Medicare and military health care. Medicare and military health care programs are funded and regulated entirely by the federal government.

Medicare is health insurance for people age 65 or older or for people under age 65 with certain disabilities. Medicare has more than 2.8 million enrollees in Texas. A Medicare patient has access to certain providers and facilities under plans managed by either the federal government or by private insurance carriers that contract with the government.

Military health care includes TRICARE and programs financed by the Department of Veterans Affairs. TRICARE is a health care plan available to those in the uniformed services and their families and to retired members of the military. The plan contracts with both military health care providers and with a civilian network of providers and facilities similar to the Medicaid system. Programs from the Department of Veterans Affairs cover eligible veterans and their dependents and survivors. More than 1 million Texans had military health coverage in 2007.

Medicaid. Medicaid is the federal-state health insurance program for the poor, elderly, and disabled. Medicaid is an entitlement program that must provide benefits to all who meet the eligibility criteria. In 2008, federal funds pay for nearly 61 cents of every dollar spent in Texas on Medicaid.

CMS mandates minimum populations that a state must cover to participate in the Medicaid program and has defined optional populations that a state may choose to cover and still receive federal matching funds. For example, CMS mandates that all state Medicaid programs cover pregnant women up to 133 percent of the federal poverty level, and states may opt to cover pregnant women up to a maximum of 185 percent of the federal poverty level. Texas has opted to cover pregnant women up to the maximum income level. The chart on page 6 shows the income eligibility levels for several of the major categories of individuals covered by the Texas Medicaid program.

In Texas, low-income adults may qualify for Medicaid only if they are disabled, pregnant, or have dependent children. Children are eligible if their family’s income is at or below a certain threshold for the child’s age bracket. The Medically Needy program in Texas covers dependent children and pregnant women who “spend down” to the established income eligibility threshold through high out-of-pocket medical expenses. Total Medicaid enrollment for all eligibility categories was 2,866,256 in March 2008, the most recent month for which full enrollment data are available.

Each state has a Medicaid state plan approved by CMS that defines the services and populations covered by its Medicaid program. A state may request approval from CMS for an amendment to its plan in order to change services or eligibility criteria in ways that meet existing federal Medicaid requirements. For example, a state plan amendment could seek coverage for an optional Medicaid population or service that the state did not previously cover. States also may apply to CMS for waivers to use Medicaid funds in ways that do not meet traditional federal Medicaid requirements. A waiver request could seek to cover expanded populations, vary the services provided to different populations, or deliver services in a new way or setting.

Texas waiver request. SB 10 by Nelson, enacted by the 80th Legislature in 2007, was designed to expand the number of people eligible for Medicaid services, leverage Medicaid dollars to increase participation in insurance plans, and decrease program costs with more efficient health care delivery. To implement many of the proposals, HHSC must receive a waiver from the Centers
for Medicare and Medicaid Services, and the state submitted such a waiver request in April.

The Texas waiver request seeks approval to finance many of the SB 10 proposals using funds from a new Health Opportunity Pool (HOP) Trust Fund. The HOP would be an HHSC-administered pool of money made up of federal and appropriated state funds and other money designated for defraying costs of uncompensated care. HOP funds would be used to reimburse hospitals, provide health care coverage for target populations, and finance grants to develop infrastructure and improve health care delivery. The waiver request proposes using HOP funds beginning in waiver year one for CHIP benefits (see page 7) for certain low-income children under age 19 and for foster children up to age 23 who attend college. The request also proposed using HOP funds in waiver year three to subsidize private health coverage for parents and caretakers up to 133 percent of the federal poverty level and childless adults up to 100 percent of the federal poverty level, with the option to later cover these groups up to 200 percent of the federal poverty level. Subsidies for low-income adults would be used to purchase employer-sponsored coverage, if an acceptable plan were available, and state-approved private health benefit packages if employer coverage were not available.

In an August letter to HHSC executive commissioner Albert Hawkins, CMS acting director of the Family and Children’s Health Programs Group Dianne Heffron cited several aspects of the Texas waiver request that either require further explanation or are deemed unlikely to be approved. The key concern was that the proposal may not be broad-based enough in its coverage initiatives in year one to warrant federal approval. The letter indicated CMS would not discuss financing mechanisms unless the agency saw a proposal it considered a “broad, health-care reform package.” CMS also expressed concern that the level of benefits proposed for some populations may be too limited and indicated Texas’ request proposed using HOP funds to cover certain child populations that could not be covered with federal matching funds. In early September, representatives of HHSC traveled to Washington D.C. to meet with representatives of federal agencies about the waiver request. HHSC has since engaged in weekly discussions with federal regulators to negotiate both the benefits to be provided under the waiver proposal and how these benefits would be funded.

2008 Texas Medicaid Income Eligibility for Selected Populations

*Income limit for TANF is based on the monthly income limit of $188 for a family of three. Income limit for pregnant women and children in the Medically Needy Program is based on the monthly income limit of $275 for a family of three.
Children’s Health Insurance Program. The Children’s Health Insurance Program (CHIP) provides primary and preventive health care to low-income, uninsured children who do not qualify for Medicaid. The federal match rate on CHIP spending varies from year to year, and in 2008 federal funds pay for more than 72 cents of every dollar spent in Texas on CHIP.

The CHIP caseload has increased steadily since the 80th Legislature in 2007 enacted HB 109 by Turner, which reversed many program and eligibility requirement changes made to CHIP in 2003. Twelve months of CHIP eligibility is granted to a child under age 19 whose family’s gross income, excluding certain child-care expenses, is at or below 200 percent of the federal poverty level. For those with incomes above 150 percent of the federal poverty level, family assets may not exceed $10,000 or include vehicles in excess of specified values.

The CHIP caseload was 465,094 as of October 2008. The CHIP Perinatal Program, implemented in January 2007 to extend CHIP benefits to unborn children, covered an additional 60,953 individuals as of September 2008.

The private market

The private insurance market includes both group and individual private plans. Most private health coverage in Texas is provided through employer-sponsored programs. Private group plans may be distinguished further by the way the plan is administered and by the size of the group covered. Under Texas insurance law, groups with two to 50 full-time employees are considered small employers, and groups with more than 50 full-time employees are considered large employers.

Federal and state regulation. Private coverage is regulated by both federal and state law. The U.S. Department of Labor regulates employee benefit plans through the federal Employee Retirement Income Security Act. ERISA has a “savings clause” that permits states to regulate insurance products, which enables states to influence employee health benefit plans. However, more than 50 percent of health plans provided by large employers in Texas “self fund” — that is, they assume the primary risk of health coverage for their employees rather than contract for insurance products. Because these plans are not formal insurance products, ERISA preempts state regulation of them.

The Texas Department of Insurance (TDI) is responsible for regulating private insurers and insurance agents and brokers in Texas. TDI investigates consumer complaints and sets rules for the insurance industry, such as minimum capital requirements to cover claims and maximum time frames for claim payment.

Large employer market. In 2006, nearly 89 percent of large firms offered insurance, but only about 58 percent of employees of large firms had employer-sponsored coverage, according to the most recent Medical Expenditure Panel Survey (MEPS) by the federal Agency for Healthcare Research and Quality. Employer plans often exclude part-time, seasonal, and contract employees. Those who do not accept employer-sponsored coverage may have elected not to enroll for various reasons, including the cost of the employee’s share of the premium or access to other insurance, such as government programs, coverage through a spouse, or coverage on the private, individual market. According to MEPS data, the average annual premium for large group health insurance in Texas in 2006 was $4,057 for single coverage and $11,745 for family coverage.

Small employer market. Among the 294,072 small firms in Texas in 2006, 32.2 percent offered insurance. MEPS data show the average annual premium for small employer health plans in Texas in 2006 was $4,463 for single coverage and $11,310 for family coverage.

Smaller groups pose higher risks to insurers because they include fewer plan participants over which to spread risk. Therefore, Texas, like most states, regulates the small employer insurance market more extensively than it does the large employer market. Texas uses rate bands, which limit the variability of premium costs due to demographic and health factors, in order to prevent pricing schemes that could price high-risk groups out of the market. State law also permits insurers to require small employers to contribute to their employees’ premiums and prohibits small employer carriers from requiring more than 75 percent of an entity’s employees to participate in a plan in order to offer coverage.

Cooperatives. Texas allows cooperatives, in which employers band together to gain certain benefits of insurance for a larger group. Each type of cooperative is subject to unique regulations. All cooperatives may save money with volume purchasing and reduced
administration. Some are treated as single entities for both benefit elections and price rating. These cooperatives can reduce group premiums because the risk pool used for rating is expanded over a larger population.

**Three-share programs.** SB 10 by Nelson, enacted by the 80th Legislature in 2007, permits counties to form local or regional health care programs, called “three-share” programs, that pay premiums for insurance or non-insurance benefit packages using employer, employee, and public or private contributions. If Texas’ Medicaid waiver request is approved to implement the HOP, these programs will be able to apply for HOP funds for the public contribution. In March, HHSC and TDI awarded start-up grants to two coalitions of communities for developing three-share programs.

**Private individual coverage.** Individuals may obtain insurance for themselves and their families on the private, individual market. In 2007, about 1.7 million Texans had individual coverage. On the individual market, insurers may deny coverage to high-risk individuals and may exclude people with pre-existing conditions. Individual plans can be more expensive than group plans because insurers may vary premiums for individual plans more extensively based on age and health status, causing such policies to exceed the budgets of many of the uninsured.

**Programs under state oversight**

Two programs that are run by boards appointed by the TDI commissioner provide policies for covered individuals that actually are considered private plans.

**Texas Health Insurance Risk Pool.** The Texas Health Insurance Risk Pool (THIRP) was created as a safety net for the medically uninsurable who were unable to get coverage through commercial insurers and could afford the risk pool’s premiums. Since the pool began operations in early 1998, about 70,000 Texans have obtained health coverage through the risk pool. As of September of this year, 27,201 people were participating in the risk pool. Because of the high-risk population that uses the pool, it consistently operates at a deficit. For expenses not covered by the members’ premiums, health benefit plan issuers are assessed based on their market share in Texas in order to recover the cost.

**Texas Health Reinsurance System.** Reinsurance is a type of insurance obtained by insurers to protect against extraordinary losses by policyholders. An objective of reinsurance is to lower the risk to the insurer so that lower prices may be charged to consumers.

In Texas, insurers may purchase reinsurance on the private market or from the Texas Health Reinsurance System (THRS). An insurance carrier participating in THRS may purchase reinsurance through the system for a small employer group or any individual plan member, and the reinsurance pays for claims in excess of $10,000 in any calendar year. THRS claims are paid by premiums from participating insurers. If the system incurs a net loss for the year, reinsured carriers are assessed for the difference based on each carrier’s proportion of the Texas small employer market. Because of a low participation rate — only 24 individuals were covered in August 2008 — the TDI commissioner recommended to the 79th Legislature that THRS be closed, but the Legislature did not follow this recommendation.

**Targeted proposals for covering the uninsured**

Many states seeking to provide health care coverage for their uninsured populations have tried targeted plans for efficiently using state money to reach the largest number of uninsured people or the most vulnerable populations. Some of these proposals have been discussed in Texas or implemented in other states. The common factor among the proposals is the tension between reducing the number of uninsured and controlling health care costs. Incremental proposals to increase health coverage among targeted groups may rely on government programs, the private market, or programs under state oversight as vehicles to increase coverage.

**Government program proposals**

Proposals in Texas to expand government health coverage involve both enrolling those who are eligible but not enrolled and expanding eligibility so more Texans qualify. One of the most common arguments for
expanding coverage under government programs is that Texas loses the opportunity to leverage federal matching funds when the state does not cover all populations that could be eligible for Medicaid and CHIP. Others fear over-broad expansions of eligibility for government-subsidized health care programs will cause the state to pay for the health care of some people who could otherwise afford another form of coverage. They also fear it may cause some who had private coverage to drop that coverage in favor of the government program.

**Medicaid expansions.** Like all states, Texas covers the populations it is required by the federal government to cover in order to participate in the Medicaid program and also covers some optional populations allowed by the Centers for Medicare and Medicaid Services (CMS) (see chart, page 6). Texas may explore expanding Medicaid to optional populations that the state program does not now reach. This could be done through CMS approval of a Medicaid state plan amendment. Examples of opportunities to expand Medicaid eligibility through a state plan amendment include:

- increasing income eligibility levels for the aged, blind, and disabled to 100 percent of the federal poverty level instead of the current 74 percent;
- expanding the medically needy program to more demographic groups; and
- expanding eligibility for low-income parents with changes to income and resource determinations.

Medically needy programs may cover certain populations — pregnant women, children, parents and caretakers, and the aged and disabled — whose incomes are too high to qualify for Medicaid yet whose out-of-pocket medical expenses are high enough that they “spend down” to the medically needy income threshold. Texas eliminated its medically needy program in 2003 for everyone except pregnant women and children under age 19, the minimum populations federally required for a state to operate a program. Texas has the only medically needy program that does not cover the aged, blind, and disabled, and coverage could be extended to these populations. Texas also could extend medically needy coverage to parents, caretakers, and young adults under age 21. The Texas waiver request in April proposed providing a catastrophic coverage plan for parents and caretakers who spend down to the medically needy threshold. The August CMS response to the waiver request indicated it is unlikely this proposal will be approved as part of the waiver request unless more extensive benefits were granted to those eligible. Medically needy coverage for this population still may be pursued through a state plan amendment.

Before federal welfare reform in 1996, those eligible to receive cash assistance through the Aid to Families with Dependent Children (AFDC) program automatically were eligible to receive Medicaid benefits. Although formal ties between Medicaid and cash assistance programs have been broken, income eligibility levels for low-income parents remain tied to a state’s July 16, 1996, eligibility levels for AFDC benefits. Section 1931 of the Social Security Act gives states flexibility to set income eligibility for parents using less restrictive income and resource determination methods. Based on Texas’ close reliance on the 1996 AFDC levels, Medicaid eligibility levels for working and non-working, single parents in a household of three are 21 percent and 13 percent of the federal poverty level, respectively. Because the federal poverty level annually is adjusted for inflation and the eligibility criteria for Medicaid parents are not, the eligibility level for Texas parents annually decreases relative to the federal poverty level. Other states have used the flexibility of Section 1931 to implement income disregards, asset disregards, or a combination of the two to expand eligibility for low-income parents. For example, California has crafted rules that effectively disregard any earnings between its 1996 AFDC standards and 100 percent of the federal poverty level for low-income parents. Advocates of expanding eligibility for parents argue that parents enrolled in Medicaid are more likely to enroll their eligible children.

In addition, many states have been experimenting with Section 1115 “research and demonstration” waivers that, if approved by CMS, would allow them to reach populations not traditionally covered by Medicaid, such as low-income adults who are not parents. The Texas waiver request submitted in April — including
the Health Opportunity Pool proposal and the plans to cover low-income, childless adults — is an example of a Section 1115 waiver request. These waivers allow states to offer coverage with more limited benefits than traditionally required by Medicaid. Also, this type of waiver request must be made budget-neutral for federal dollars by shifting existing program spending. The Texas HOP waiver request proposes to meet this requirement largely by shifting existing federal and state funding for uncompensated care costs. Other states have used other sources of funding, such as unspent CHIP dollars and tobacco tax or settlement funds.

A review of other states’ waiver proposals shows the different ways that Section 1115 waivers may be used to test innovative approaches to covering the uninsured. Some states, including Arkansas, New Mexico, and Oklahoma, have tried to insure more low-income adults by making employer coverage more affordable for both the business and the employees. In New Mexico’s State Coverage Insurance program, employers may seek subsidized coverage for their employees if they have 50 or fewer eligible employees and have not dropped commercial health insurance in the previous year. Employees are eligible if their income is below 200 percent of the federal poverty level. The employer’s and employees’ shares of the premium are determined based on an employee’s income level. Coverage is offered through managed care organizations offering plans comparable to other basic commercial insurance.

**Enroll children eligible for CHIP and Children’s Medicaid.** In 2007, more than 1.4 million Texas children were uninsured. HHSC’s most recent projection for the number of children who will be eligible for, but not enrolled in, CHIP and Children’s Medicaid in 2009 is 850,000. Some have proposed expanding outreach and education to identify all children who are eligible for CHIP and Children’s Medicaid and to enroll them in those programs. This would cut the uninsured rate among Texas children in half. Some say if more help were available to parents applying for their children’s health coverage, fewer “procedural denials” would result due to issues like missing paperwork.

Others propose improving the eligibility and enrollment process for CHIP and Children’s Medicaid.

Since the state began contracting services to determine eligibility and new eligibility-determination software called TIERS was partially implemented, many people have been declined inappropriately or dropped from coverage. Application processing times also have increased. In June 2008, only 72.9 percent of Medicaid applications were processed in TIERS within time frames established by federal standards. Proposals to address these issues include increasing the number of eligibility workers, training workers more extensively, and suspending the transition of clients from the old eligibility system into TIERS until training and system issues have been resolved.

**Twelve-month continuous eligibility for Children’s Medicaid.** Among the changes made to the CHIP program by the 80th Legislature in 2007 was an increase from six months to 12 months of continuous eligibility. Some say Texas also should implement 12 months of continuous eligibility for Children’s Medicaid. Supporters of this approach say it would eliminate interruptions of coverage for children who remain eligible for the program but encounter processing problems during the re-enrollment process at six months. Supporters also say it would cost less to process half as many re-enrollments and would ease the burden on the eligibility system so applications could be processed more quickly. Opponents of the 12-month eligibility period for Children’s Medicaid say the existing six-month period is preferable because many children in the program no longer qualify for coverage after their initial six months of eligibility and it saves money to disenroll children as soon as they are ineligible.

**Expand CHIP eligibility.** Some have proposed expanding CHIP eligibility to include more children. Texas and Oregon are the only states that still require an assets test for CHIP, and more children would qualify if the test were eliminated. Supporters of eliminating the assets test say families should not have to fear that if they save too much for their children’s education or family emergencies, their children will lose health coverage. Opponents of eliminating the assets test say the 80th Legislature already loosened asset restrictions and if families can afford to save beyond this reasonable amount, they should prioritize paying for child health care before savings. Texas also could reinstitute the CHIP

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*In 2007, more than 1.4 million Texas children were uninsured.*
income “disregards” that had allowed more families to qualify before state eligibility changes in 2003, including disregards for work-related expenses and child support payments that reduce a family’s disposable income.

Another proposed option is increasing the income eligibility cap for CHIP beyond the current maximum of 200 percent of the federal poverty level. Federal statutes permit state CHIP programs to set income eligibility levels for CHIP at 50 percent of the federal poverty level above those for their Children’s Medicaid program. For Texas, this would mean a CHIP eligibility level of 235 percent of the federal poverty level, based on the eligibility levels for infants in Children’s Medicaid. One consideration is whether such an increase would cause Texas to exceed its capped allotment of federal matching funds for CHIP. Texas has yet to exceed this allotment in the history of its CHIP program, and state allotments could be reset in early 2009 as the U.S. Congress considers reauthorization of federal CHIP legislation.

CMS has approved waiver requests for several states to increase their income eligibility levels for CHIP to 300 percent of the federal poverty level. However, an August 2007 directive from CMS has caused concern among states about expanding CHIP eligibility. The federal CMS directive would have required states to enroll at least 95 percent of the CHIP-eligible population below 200 percent of the federal poverty level before applying for a waiver to make children eligible for CHIP at 250 percent or more of the federal poverty level using federal funds. Many states challenged the directive, arguing that CMS had overstepped the bounds of its authority, and CMS has indicated it currently will not enforce compliance with the directive. Several states that have established or proposed CHIP programs with eligibility up to 300 percent of the federal poverty level would not have met the new federal enrollment requirements. Some of these states intended to fully fund CHIP benefits between 250 percent and 300 percent of the federal poverty level with state funds if the federal government ceased to provide a match.

CHIP buy-in. Some states have implemented a CHIP buy-in program in which parents with incomes above subsidized CHIP eligibility levels may pay to receive CHIP coverage for their children. For example, through Wisconsin’s BadgerCare Plus program, the state CHIP program, families between 200 and 300 percent of the federal poverty level may receive health coverage for their children by paying sliding-scale premiums that increase for those with higher incomes. Above 300 percent of the federal poverty level, families pay the full cost of health coverage for their children. CHIP buy-in programs are intended to leverage the existing CHIP infrastructure and purchasing power to provide a low-cost coverage option for uninsured children. Opponents of CHIP buy-in say many parents would drop their individual or employer-sponsored coverage in favor of a cheaper CHIP option, and the state would incur expenses for program subsidies for a population that has other options. Supporters of buy-in programs note some states avoid “crowd-out” of dependent coverage through employer-sponsored plans by prohibiting parents with employer-sponsored coverage from enrolling their children in CHIP buy-in programs.

Private market proposals to reduce cost

Cost is the number one reason stated in TDI State Planning Grant focus groups of both employers and individuals for either not offering or not purchasing insurance. Between 2000 and 2006 in Texas, family health insurance premiums for employer-based coverage rose 5.1 times faster than median family income (see graph, page 13). Several proposals enacted in other states could be implemented in Texas to reduce the cost of providing or purchasing health coverage, with the goal of making health insurance more affordable for certain consumers. Many of the proposals stir debate about whether reducing costs for some consumers will diminish the ability of others to obtain coverage. At the heart of this debate is often the extent to which efforts should be made to reduce costs for those with higher health risks if it increases costs for healthier consumers.

Reducing mandated benefits. The state and federal government may require health plans to provide benefits for certain conditions and treatments or access to certain types of practitioners. All plans include federal mandates for maternity and newborn coverage and mastectomy

Cost is the number one reason stated in TDI State Planning Grant focus groups of both employers and individuals for either not offering or not purchasing insurance.
benefits. Some states have allowed the sale of “mandate-light” plans, which have fewer mandates. Texas Consumer Choice Plans may exclude certain mandated benefits if the insurer meets disclosure requirements explaining the mandated benefits not covered. Florida enacted a law permitting the sale of health plans that may exclude some or all state-mandated benefits. Targeted monthly premiums for the plans are $150 or less.

Some argue for more “mandate-light” options in the private insurance market, saying mandates drive up the cost of premiums and that with fewer mandates, more consumers could afford coverage. Supporters of the “mandate-light” approach say the state high-risk pool was meant to provide lower-cost coverage for those with high-cost conditions and should be the tool for addressing the medically uninsurable so that healthy consumers do not subsidize the costs of the less healthy. Opponents of expanding “mandate-light” plans argue that insurance premiums are driven up relatively little by current mandates because mandates distribute the risks of more costly care over a broad population. They say mandates allow people with certain medical conditions to receive care they otherwise could not afford because even the high-risk pool premiums are too costly for many consumers. They say if too many healthy consumers opted for “mandate-light” options, the cost of plans that include all of the mandated benefits could rise significantly because those plans would cover a larger proportion of people with greater health risks.

**Rate review and minimum medical loss ratios.** With a few exceptions, Texas does not require health insurers to file their rates with the state, and generally addresses concerns about rates only if a complaint is filed. Rates may be disputed on the basis of discrimination. Many other states require insurers to file their rates with the state insurance department. Some states have a “file and use” system, by which an insurer may implement new rates immediately upon notifying the insurance department, and if any problems are discovered, the state may suspend the rate changes pending review. Other states use a “prior approval” system in which insurers file rates and must await approval from the insurance department before implementing them.

In other states, regulators also use minimum medical loss ratios requiring a certain percent of collected premiums — for example, 75 percent — to pay directly for medical services. Depending on the state, if medical loss ratios are not met, the insurer must decrease rates the next year or refund excess premium charges to policyholders.

Supporters of rate review and minimum medical loss ratios see them as tools to provide more pricing transparency and make sure insurers do not charge consumers excessive rates for coverage. If rates are deemed too high, they say, these tools enable regulators to influence rates charged to consumers through a fair application of rules across the market. Opponents of rate review and minimum medical loss ratios say regulators should not influence rate setting because insurers set rates based on actuarial principles designed to prevent losses as claims levels fluctuate over the years. Opponents say strict regulations may cause some insurers to leave the market, decreasing overall competition and increasing prices.

**Rate regulation.** In the Texas small employer market, insurers first determine a group’s premium rate based on demographic factors, including the age and gender of the group members and the group’s size, industry, and geographic location. After the group’s premium rate has been determined, a carrier may increase this rate by as much as 67 percent based on factors associated with the group’s health status. Rates for individual health insurance premiums are not limited by health status or demographic factors.

Other states have different forms of rate regulation that allow for less variation among the rates charged to individuals and groups with similar characteristics. For example, some states have “tighter” rate bands that permit less rate variation based on health status or individual demographic factors or prohibit variation based on gender and industry altogether. Other rate regulation methods are community rating and modified community rating. In pure community rating, the approach used in New York, everyone in a single geographic area pays the same premium. In modified
community rating, premiums may vary within a geographic area based on a group’s demographics, but rates may not vary based on health status.

Some advocate implementing one of the more restrictive rate regulation methods in Texas. They say the wide rate variation in the Texas insurance market enables insurers to set premiums prohibitively high so that many older or higher-risk groups and individuals cannot afford coverage. Supporters of stricter rate regulation acknowledge this may cause some younger, healthier individuals to pay higher rates if those most at risk pay less. Supporters of increased rate regulation say lower-risk consumers still would be able to afford coverage at a slightly higher rate while many more high-risk individuals could get coverage if it were more affordable. Opponents of stricter rate regulation say the young and healthy should not have to face decreased affordability and the potential to be priced out of coverage in order to subsidize costs of the older and less healthy. Opponents say if the risk pool begins losing young, healthy members, the overall health status of the pool will decline, causing premiums to rise and defeating the purpose of making coverage more accessible.

**Employer tax incentives.** The average annual premium for employer-based family coverage more than doubled between 1997 and 2006. Many states offer incentives for employers to provide health insurance in the form of tax credits or deductions that allow those employers to offset part of their premium contributions.

The Texas business margins tax gives employers a 50 percent deduction on health care costs for the first year they offer employer-sponsored insurance and a 25 percent deduction for the second year. Tax incentives can be structured in other ways. They may be designed to encourage employers to offer Health Savings Accounts or be tiered so that employers have greater incentives for covering previously uninsured employees. Incentives may be limited to firms smaller than a certain size in order to address the lower rate of coverage among those employers. They also may target employers with low-wage workers to help less profitable firms that have difficulty paying for employees’ insurance premiums. An incentive may be a deduction, like the incentive in the Texas margins tax, or it may be a tax credit equal to a percentage of employer health costs. For example, Maine provides employers a tax credit of 20 percent of qualified health expenses, with a cap of $125 per employee.

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**Percent change in median family incomes and family premiums since 2000**

![Graph showing percent change in median family incomes and family premiums since 2000]

*The graph shows the percent increase since 2000 in both median family income and employer-based family premiums in Texas. Income data are from the U.S. Census Bureau, American Community Survey. Premium data are from the federal Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.*
**Requiring section 125 plans.** Section 125 “cafeteria” plans allow employees to use up to $5,000 of pre-tax earnings on health expenses. Some states, such as Kansas, Minnesota, and Massachusetts, require employers of a certain size to provide section 125 cafeteria plans. Supporters of requiring these plans say it is an immediate way to provide people with more money to purchase health insurance because it frees the amount they would have spent on taxes on their contribution for this purpose. Opponents say there would be a fixed administrative cost to employers to set up the savings accounts for these plans and a system for transferring employee contributions from wages to these accounts. They say administering these plans would create another financial burden for employers, some of whom may be struggling to stay in business.

**Proposals to make private insurance more available**

Private insurers have an interest in attracting a pool of policyholders that reflect the health status of the population at large. If a carrier’s plan is subject to adverse selection — that is, it attracts a disproportionate share of people with adverse health risks — the carrier exposes itself to the potential for greater costs. Insurers use the underwriting process to compensate for higher assumed risks by setting the costs and terms of coverage for an individual or group based on health and demographic factors. Policies among insurers to limit risk also have limited the availability of coverage for some consumers. Some states have enacted regulatory insurance laws designed to increase the health insurance options for those with difficulty getting coverage.

**Guaranteed issue for individuals.** The guaranteed-issue provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 require carriers to issue insurance policies to all small groups requesting coverage. Several states have found ways to make health coverage more available by also providing guaranteed issue for plans sold to individuals. Guaranteed coverage especially benefits those with greater health risks who otherwise would have difficulty finding a carrier to insure them. Some states have legislated that guaranteed-issue requirements apply to all plans for all consumers requesting coverage in the individual market. In 2007, 13 states offered small-group coverage to the self-employed as a “group of one.” This allowed the self-employed in those states to receive the guaranteed-issue coverage that already was available to their small group markets through HIPAA. In many cases, the group of one plans also were less expensive than an individual market plan because states often have stricter rate regulation in their small group market than in their individual market.

Supporters of guaranteed-issue plans for individuals say they increase availability of coverage by allowing any eligible person who requests coverage and can afford the premium to obtain it. Opponents of these policies say the people who would be denied coverage on the individual market are another example of those better suited for coverage in a high-risk pool to avoid driving up overall premiums in the individual market.

**Pre-existing condition exclusions.** When a group obtains new coverage, HIPAA limits to 12 months the period during which an insurer may exclude coverage for pre-existing conditions — conditions for which a group member received treatment, diagnosis, or advice before enrolling in the new plan. HIPAA also limits to six months the “look-back” period — the time before enrollment during which an insurer may review a policy holder’s medical record for pre-existing conditions.

For the small group market, Texas law meets federal standards of a maximum 12-month pre-existing exclusion period and a maximum six-month look-back period. Protections for pre-existing conditions under HIPAA do not apply to the individual market, but most states have developed their own protections for individual plans. Texas allows a pre-existing exclusion period of up to 24 months and a look-back period of up to 60 months for individual plans.

Other states have exceeded the HIPAA small group requirements on pre-existing conditions. For example, Kansas limits both the pre-existing exclusion period and look-back period to three months. In the individual market, many states have applied to individual policy holders the more strict HIPAA small-group requirements for the length of pre-existing exclusion periods.

Supporters of less restrictive pre-existing condition regulations argue people are more likely to obtain health insurance if they will have coverage for pre-existing conditions sooner because most cannot afford to pay for both premiums and out-of-pocket expenses for excluded medical conditions for an extended time. Opponents of less restrictive pre-existing condition regulations say
that by excluding certain risks they maintain affordability for other policyholders. They say the high-risk pool is better for isolating from other policyholders the elevated costs of coverage for people with pre-existing conditions.

**Participation requirements.** Texas carriers require a minimum of 75 percent participation by a small employer’s workforce to issue a small group plan. Some employers cite this requirement as a barrier to obtaining coverage because if more than 25 percent of their workers are not interested in employer-based insurance, coverage cannot be offered to any of a small company’s employees. Some people advocate for lowering the maximum percent at which insurers may set participation requirements to below 75 percent, saying employers would be more successful enrolling employees if a smaller percentage were required to participate. Opponents of reducing participation requirements say this would remove a safeguard against adverse selection because those in poor health would be the most likely to seek benefits and would be participating in a smaller pool of individuals.

**Private market proposals for children, young adults**

Advocates of expanding children’s coverage cite studies indicating that children with health insurance are more likely to be vaccinated against a host of major illnesses and that lack of insurance can lead to more illness, which causes poorer educational performance because children miss more days of school. They say these high returns on child well-being come at a relatively low cost for providing health coverage. Young adults are another focus of targeted coverage proposals because adults ages 18 to 34 have the highest uninsured rate by age in Texas. Focus group surveys in TDI State Planning Grant research suggest many young adults feel insurance is a wasted expense because if they are healthy, they may not incur health costs during the year. Young adults also are less likely to work for companies that offer insurance than are older adults, and they face challenges getting coverage when they no longer are eligible for dependent coverage from their parents.

**Employer-based, children-only benefit plans.** Oregon allows small employers to provide comprehensive coverage for employees’ children even if the employees do not enroll. This is intended to provide an option to small employers who feel they are unable to afford coverage for their employees. The Oregon plan requires the employers to contribute at least $50 a month per participating employee. Although some have called this an innovative approach, enrollment in these plans has been low, and some observers suggest that even with the employer’s contribution, children-only benefit plans may remain unaffordable for many families.

**Private pooled coverage for child support recipients.** In January 2008, Texas Atty. Gen. Greg Abbott, whose office oversees collection of delinquent child support, outlined a proposal to insure about 200,000 uninsured children in the child support system in Texas. Under the proposal, if a judge determined that a parent could obtain employer-based coverage for any uninsured child who was the subject of a child support payment order, the parent would be required to enroll the child. If no employer-based coverage were available, the non-custodial parent would have to buy the child private insurance from a pool created to cover children in the child support system who lacked other insurance options. Premiums for coverage would be withheld from the non-custodial parent’s paycheck. Parents could opt out of pool coverage if they showed proof of insurance from another source. Some say uninsured children in the child-support system would be better served if their parents participated in a CHIP buy-in program, rather than private insurance, because the infrastructure for CHIP already is established.

**Mandatory enrollment of college students.** New Jersey requires full-time college students to have health insurance. Students may meet the requirement through dependent coverage, private insurance, or a university health plan. A March 2008 study by the U.S. General Accountability Office said more than half of college plans provide less than $30,000 in coverage. Some students, unaware of the limits of their university plans, have encountered medical bills they could not afford after a catastrophic medical event for which their health plan covered less than anticipated. Supporters of mandatory insurance for college students say more education and disclosure requirements could prevent students from encountering surprises about the limits of their coverage.
**Extending dependent coverage.** In Texas, dependents remain eligible for insurance at least until age 25. New Jersey allows people to retain dependent coverage up to age 30, whether or not they attend school, as long as they do not have dependents of their own.

**Proposals for programs under state oversight**

States try to influence plan pricing and the availability of health insurance not only by regulating insurers but also through reinsurance systems and risk pools that aim to fill the gaps in coverage that can be challenging to address in the private market.

**Risk pools.** The Texas Health Insurance Risk Pool (THIRP) is one of more than 30 state high-risk pools, which operate in subtly different ways. Some argue that Texas’ high-risk pool is underutilized because of the high cost of risk-pool premiums that low-income and many middle-income individuals struggle to afford. A THIRP participant pays twice the average premium charged by large Texas insurers to someone of the same age, sex, and geographic location. The average monthly premium for a risk-pool enrollee in 2007 was $540. Texas is one of only four states with risk pool premiums based on a multiplier of two times the large group market rate. Some advocate decreasing risk-pool premiums to 1.5 times or less of the average premium and subsidizing the cost of premiums for low-income individuals so this demographic could use the pool. For example, New Mexico provides a 75 percent subsidy for people with incomes under 200 percent of the federal poverty level and a 50 percent subsidy for individuals between 200 and 400 percent of the federal poverty level.

**Supporters of low-income subsidies and a decreased risk pool premium** say these measures could increase risk pool participation, which would insure more Texans with existing health risks who are contributing at some of the highest individual rates to Texas’ uncompensated care costs. More participation effectively would spread the cost of the risk of these higher-need populations to Texas consumers at large because program shortfalls are covered by assessments on all insurers.

**Opponents of low-income subsidies and a decreased risk pool premium** say the existing higher premium and lack of subsidies prevent crowd-out from other coverage and participants under the current risk pool structure still generally receive a substantial discount over what coverage would have cost them in the private market.

Some also suggest that the 12-month, pre-existing conditions exclusion for THIRP participants who are not HIPAA-eligible should be reduced. More than half of states with risk pools have pre-existing condition exclusion periods of six months or less. Advocates of the longer exclusion say it is an effective way to prevent people from dropping existing coverage to join the high-risk pool. Others argue that if more high-risk individuals could receive full benefits sooner through the risk pool, their conditions could be prevented from becoming more chronic and severe, and thus more costly.

**Revise the Texas Health Reinsurance System.**

While the Texas Health Reinsurance System is voluntary and has low rates of participation, 12 other states have reinsurance systems financed by assessments on carriers that require participation from insurers. Idaho’s small-employer reinsurance system, which is financed partly with assessments on all insurers and not just participating insurers, creates an incentive for more insurers to participate. The resulting higher level of participation may lower premiums because risk is spread over a larger pool of reinsured lives. All Idaho carriers offering individual plans must offer the state’s five guaranteed-issue, reinsured plans. Claims for these reinsured plans are paid for by the system at a 90 percent rate for costs between $5,000 and $25,000 and are paid fully by the system for costs in excess of $25,000. These reinsurance claims are paid for fully by reinsurance premiums and the state’s existing premium tax.

The Healthy New York reinsurance system is a state-subsidized plan targeting small employers and low-wage workers without coverage. Small employers may participate if they have at least 30 percent low-wage workers. The program protects against adverse selection by requiring participating employers to reinsure at least 50 percent of their employees’ coverage through Healthy New York and to pay half the employees’ premiums. Individuals may be covered if they or a spouse have worked within the last 12 months and their family income is below 250 percent of the federal poverty level. New York pays for 90 percent of claims between $5,000 and $75,000, allowing premiums for participants to be lower than in the commercial market. In 2006, New York paid $92 million for the program. More than 400,000 people have participated since the program began.
Supporters of mandated participation in the state reinsurance system or of a state-subsidized reinsurance system say these proposals would increase participation significantly so that risk was spread over more lives and reinsurance played a greater role in reducing premium costs. With reduced premiums, more individuals and small employers could afford health coverage. If Texas had New York’s success, they say, a relatively small contribution from the state could reduce participants’ premiums by 50 percent or more.

Opponents of mandated participation in the state reinsurance system or of a state-subsidized reinsurance system say insurers should be able to select from a variety of privately offered reinsurance plans or forego reinsurance altogether if the insurer determines this will keep their policyholders’ premiums lowest. Opponents also raise concerns about the state subsidizing a reinsurance system that could encourage adverse selection and higher subsidized claims costs. Healthy New York has been more successful in enrolling individuals than in enrolling groups, and participation by fewer groups can decrease the number of healthy individuals participating in the system’s risk pool.

Health insurance connectors. Health insurance connectors or exchanges, accessed by Internet or phone, help individuals and businesses select and enroll in affordable health plans. A connector may promote more portable, individual plans by publishing rates for various insurers and helping individuals without access to employer-based coverage to select a private, individual plan. The Massachusetts Commonwealth Health Insurance Connector is an example of how a connector also can be used to market to people who are eligible for state-subsidized insurance financed through a state insurance pool. The health connector or insurance exchange concept has been picked up by several other states, including Maine’s Dirigo Choice program. SB 23 by Nelson proposed a connector, the Texlink to Health Coverage program, but the proposal was not enacted during the 2007 regular session.

Universal coverage efforts

Some states have chosen the most comprehensive approach to reducing the number of uninsured people by considering proposals for state-level universal health care programs. Universal health coverage is an attempt to cover everyone in a designated population. Nations around the globe — including the United Kingdom, Canada, Japan, Australia, Saudi Arabia, Russia, and Brazil — have had some form of universal health coverage for decades, but Congress failed to enact a U.S. proposal in 1994, following nearly a year of heated debate. Serious debate at the federal level has reemerged after more than a decade.

As of October 2008, three states — Massachusetts, Vermont, and Maine — had adopted universal health care programs and at least 14 either had considered comprehensive health care proposals with universal coverage goals or had formed commissions to recommend comprehensive reforms. During the 80th Legislature’s 2007 regular session, two Texas bills proposing universal health coverage, SB 1911 by Shapleigh and HB 2737 by Burnam, were referred to committee, but were not heard.

Maine was the first state to approve a universal health care program in 2003, with the goal of universal coverage by 2009. Massachusetts followed in April 2006 with a more aggressive timeline for implementation. All Massachusetts residents were required to have coverage by July 1, 2007, or receive a waiver from the state. Vermont adopted a proposal in May 2006 to achieve 96 percent health coverage by 2011. While many stakeholders are monitoring efforts in these three states, their relatively recent implementation limits what can be learned about their long-term effects. There is no precedent for universal health care plans in states with populations close to the size of Texas nor with uninsured populations representing such a large proportion of the state.

Key elements shared by the three existing state universal health plans include plans for cost containment,
more coverage options for the uninsured with outreach efforts to get people to enroll, and subsidies to obtain health coverage for populations the states deem eligible. Universal systems can vary by target population, financing, participation requirements, and the mechanisms through which the uninsured are targeted.

Opponents of universal health coverage efforts say that rather than saving a state money, these systems could drive state health costs unsustainably high. They say that in some nations with universal health coverage, citizens have access to fewer services and receive lower quality care. States should not unfairly compel those who can afford care by other means to participate in an insurance system that ultimately may cost them more, they say. Opponents also say many universal health coverage proposals have unfairly subsidized those who can afford market rates for coverage but who choose not to acquire insurance unless it is provided to them at low or no cost. Opponents say elaborate market interventions for those who choose not to contribute their fair share can drive health costs higher for all consumers and for the state. Such interventions, they say, limit the affordable options for those willing to buy private insurance individually. Opponents of universal coverage efforts say a more ideal insurance market would be highly competitive, making coverage affordable for most consumers. The health needs of those who could not afford coverage could be addressed by the state health care safety net.

Supporters of state universal health coverage efforts say that health care is a right that should be afforded to all citizens. They say the societal and budgetary costs of failing to provide a means of coverage for every person are too great. Most consumers would choose to have health coverage if given the opportunity, they say, but even some lower- to middle-income families struggle to balance the rising cost of health care with providing other necessities for their families. Some people would not be able to afford their coverage without some market intervention because their health conditions are not profitable for insurers to cover. While some

Illinois program to provide health coverage for all children

Illinois started a program in 2006 to provide health coverage for all children in the state, including undocumented immigrants. The voluntary program, known as the Illinois All Kids program, expanded eligibility for existing state Children’s Medicaid and CHIP programs among those with low incomes and made eligible those at higher incomes for higher premiums. The program is subsidized largely by savings from two new state Medicaid managed-care initiatives. Enrollment in All Kids has surpassed its targets, although more low-income and fewer middle-income children than anticipated were enrolled. High enrollment was attributed to extensive outreach and the relative ease of educating parents about the program because families of all income levels are eligible.

Families with incomes between 150 percent and 800 percent of the federal poverty level must pay premiums on a sliding scale based on their income, with maximum monthly premiums of $300 per child. Primary medical and dental care in the program are available at no cost, and cost-sharing mechanisms are available for other care. Cost sharing is designed to be affordable for those with low incomes and increasingly costly to those with higher incomes. Those with incomes between 133 percent and 200 percent of the federal poverty level may receive a rebate check, rather than All Kids enrollment assistance, to apply to the cost of private individual or employer-sponsored health coverage.

All Kids was designed to avoid “crowd out” from private insurance — that is, people dropping private insurance to obtain public coverage. The premiums for higher income individuals are designed to match closely the premiums in the commercial market. Also, a child whose family income is above 200 percent of the federal poverty level is not eligible for the program until the child has been uninsured for 12 months. The program makes exceptions to the 12-month waiting period in certain circumstances, such as a parent losing a job that provided coverage.
people can afford all their necessary expenses without insurance, more people would be financially devastated if they faced a catastrophic health event or developed a chronic condition and had no insurance. When people cannot afford primary and preventive care, their health can decline until they acquire serious, chronic conditions that are more costly to treat. Ultimately, many uninsured seek care in emergency rooms because they cannot afford care in other settings. If an uninsured person is unable to pay medical bills, the cost spreads to other state residents through higher taxes or increased premiums. Employers can lose money if workers are less productive because of preventable illnesses. In the long term, a state’s health care expenses would be less under universal coverage and its citizens would be healthier, supporters say.

**Who is covered by universal health coverage**

State-level universal health care proposals so far have targeted either all residents or only some, such as legal residents or children. Wisconsin, Washington, Pennsylvania, Illinois, and New Jersey have approved universal coverage measures for children only. Illinois was the first state to implement a child-only universal coverage requirement in July 2006 (see page 18). This program, like all other children’s universal health coverage plans enacted to date, is founded largely on expanding eligibility for Children’s Medicaid and CHIP.

For a state proposing to insure its entire population, one question is whether or not to exclude undocumented immigrants. California’s health care reform proposals have included undocumented immigrants, causing controversy. Some have said that no funds should be spent knowingly on the health care of undocumented immigrants. Others counter that a state’s safety net ultimately will pay for uncompensated care costs of undocumented immigrants who receive care in emergency rooms, so it is less costly to provide coverage and serve them in non-emergency care settings.

**Single- and multiple-payer systems**

Health care in the states is provided through a multiple-payer system in which health providers collect payments from the government, private insurers, and health consumers. People may be covered under one or multiple benefit plans, and the contribution from each payer depends on the health service provided and the type of coverage, if any, the patient has for the service. By contrast, some national programs outside the United States use a single-payer system, in which health care funds, including individual and employer health taxes and government contributions, are channeled through a single government entity or subcontractor responsible for paying health care providers. With a single-payer system, typically, all citizens or all residents are eligible for the same set of government-defined health care benefits, and individuals may purchase private insurance for services unavailable through the government plan.

**Individual mandates in a multiple-payer system.** If a state uses a multiple-payer approach to universal health care, policy makers must decide whether or not they will require individuals to obtain coverage and how they would enforce the requirement. Massachusetts currently is the only state that mandates individual insurance coverage and uses state income tax penalties to enforce the requirement. Neither Maine nor Vermont now has a mandate, but Vermont will consider one if the state fails to reach a 96 percent insured rate by 2010. An effort failed in Maine’s 2007 legislative session to establish individual mandates for Maine’s Dirigo health system.

Another proposed penalty for failing to obtain mandated coverage is wage garnishment. Most states that have considered mandates would enforce them only for populations the state determined could afford coverage, while those who could not afford coverage could receive waivers or pay subsidized premiums for insurance in a state-sponsored pool.

**Opponents of individual insurance mandates** say cost is the main reason people do not have coverage, and if a universal health coverage system were well crafted, most people could afford to participate without compulsion. Reaching a particular threshold of participation, opponents say, effectively will reap the benefits of a significantly reduced uninsured population.
Opponents of individual insurance mandates also point out that while many states have mandated auto liability insurance, compliance rates among some of these states still are only 75 percent or less. They question why insurance should be mandated if compliance may be low, particularly if penalties for non-compliance strike the economically disadvantaged or those with other hardships. The health system also would incur costs to track the non-compliant and enforce penalties.

Supporters of individual insurance mandates say they are necessary to ensure significant reductions in the number of uninsured people and reap the intended benefits of universal coverage. A higher rate of insurance participation by a healthy population spreads risk and reduces costs. Some people would not participate without compulsion, they say, because they can afford to pay for care only as needed, are relatively healthy, and do not anticipate needing health care during the year or because they have not been educated about the benefits of health insurance. Without a mandate, supporters say, the people most likely to enroll in new health care options would be higher-cost enrollees who increase premiums to other participants and, as a result, drive the healthier people out of the system.

Supporters of health insurance mandates also say compliance with car insurance mandates is an unfair analogy because many of those mandates are passively enforced only when a person is caught. Systems that actively impose penalties for non-compliance, such as Georgia’s, have high automobile coverage rates. Supporters say penalties could be crafted to allow waivers for those facing financial or other hardships. Massachusetts exempted more than 60,000 individuals from its coverage requirement this year because they were deemed unable to afford insurance.

Considerations in a single-payer system. A common misperception of single-payer systems is that they necessarily involve a system in which a governmental entity is the provider of health care. The term “single payer” refers only to the finance mechanism, not the delivery of services. The United Kingdom is an example of a single-payer system in which health care primarily is delivered at government-owned facilities by government-employed doctors. However, no U.S. state has considered proposals that include predominantly government-delivered health care services.

Canada has a single-payer system that is publicly funded, but health care services generally come from private providers working at either public or private facilities. Providers negotiate rates with the national government. In this sense, the Canadian health care system may be closer to the single-payer proposals being considered by some U.S. states than is the U.K. model.

Most state-level universal health coverage proposals in the United States have been multiple-payer systems, although a few have been single-payer. The Connecticut Health Care Security Act of 2001, PBH 5872, would have implemented a single-payer system in Connecticut, but it was not enacted. The single-payer Health for all Illinois Act, HB 311, was considered by the Illinois House but did not come to a final vote by the conclusion of the most recent session. After failing to enact intensely debated multiple-payer, universal health coverage legislation this session, the California legislature renewed debate and approved a single-payer, universal health care bill in August. SB 840 by Kuehl, a reintroduced version of a bill vetoed by Gov. Arnold Schwarzenegger in September 2006, was passed to enrollment on August 31 and vetoed by Gov. Schwarzenegger on September 30 (see page 21).

The proposed federal Improved Medicare for All Act, H.R. 676, referred to the House Subcommittee on Health in February 2007 but not yet heard, would implement a national, single-payer system.

Opponents of single-payer health care say single-payer systems can cost the state and health consumers more for health care and can reduce the quality and timeliness of care people receive. Single-payer systems, they say, force everyone into a single health plan that may provide more or fewer health services than people need. Access to too many services may increase costs due to over-utilization, while people preferring services that are not covered must pay out of pocket in addition to whatever health tax they might have paid. In addition, governments lack the incentive found in the private market to drive down costs through competition.

The term “single payer” refers only to the finance mechanism, not the delivery of services.
Opponents say other countries that have implemented single-payer systems have faced cost overruns leading to diminished quality of care. They say gaining access to specialized care has proven difficult in other nations, such as Canada, where waiting lists are used for certain services because every resident has access to them and the demand exceeds both the provider network and the health care budget. Finally, opponents say, single-payer systems harm the economy through labor market disruptions and lost tax revenue from the significant decrease of the private insurance industry because in many cases private insurers are permitted to sell only policies that supplement the government’s health plan.

Supporters of single-payer health care say single-payer systems deliver care equitably and comprehensively at a long-term savings to the state and its residents. They point to Medicare as a single payer system with administrative costs of only 2 percent, while administration and profit can be as much as 30 percent of private insurer premiums. Supporters say single payer systems such as Medicare can achieve this cost efficiency because those covered have the same benefits, use the same forms, and follow the same procedures. They say single-payer systems also provide significant savings with bulk purchasing of pharmaceuticals and medical supplies. Limited out-of-pocket expenses, supporters

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**Universal health coverage proposals in California**

In September, California Gov. Arnold Schwarzenegger vetoed a single-payer, universal health care bill, known as the California Universal Health Care Act (CUHA), that was approved by the California legislature in the summer. Debate on single-payer health care had been renewed after a multiple-payer, universal health care bill failed to pass the California legislature in January.

The CUHA was the reintroduced version of Sen. Sheila Kuehl’s SB 840, which had passed both the California Assembly and Senate in August 2006 before it was vetoed by Gov. Schwarzenegger. In vetoing the bill in 2006, the governor called that single-payer system “socialized medicine,” stating it would form an expensive, ineffective health care bureaucracy. Supporters of the bill said the governor misrepresented the plan as “government-run health care” when it actually would have retained the state’s system of private and public care delivery and people could have selected their preferred providers and hospitals.

The CUHA passed this year would have formed a new state health agency to regionally administer a single, statewide health plan covering all state residents, including undocumented immigrants. It would have replaced both private and former state public plans, including the state’s Medicaid program, and would have covered hospital, medical, surgical, mental health, dental, and vision care and provided full prescription drug and medical equipment benefits. Coverage would not have included long-term care beyond 100 days, cosmetic procedures, or procedures or medications with no proven medical value. Private insurers could have sold only policies offering benefits not offered under the state health care system.

Benefits would have been paid by the state government from the state Health Care Fund, which would have included all federal, state, and county health care funding and health taxes collected from residents and employers. The accompanying finance bill would have established payroll taxes of 8.17 percent on employers and 3.78 percent on employees for payroll between $7,000 and $200,000. Outside this range or among the self-employed, other tax rates would have applied. Residents would have paid no additional premiums, deductibles, or co-payments unless cost containment measures were enacted as a result of projected spending exceeding the average growth in state gross domestic product and population growth. Cost-containment measures would have permitted the imposition of limited co-payments or deductibles after the first two years. The state-elected health commissioner could not have proposed to raise health tax rates unless all other cost-containment measures had been exhausted.
say, allow health consumers to better anticipate their health costs for the year. Also, people who struggle to find coverage due to pre-existing conditions would have comprehensive health coverage with costs spread over a guaranteed universal risk pool. Supporters say state residents’ health would improve from continuous access to preventive care because coverage would be tied to residency or citizenship and not to employment.

Supporters say arguments against single-payer state plans based on waiting times for services in other nations could be addressed with targeted policies to ensure the state has enough specialized care providers. Canada is addressing waiting times in its system by imposing maximum acceptable waiting times for certain medical procedures. Policy makers can design single-payer systems in which people still could pay for and receive treatment for elective procedures if they were willing to pay out of pocket or purchase supplemental private plans for services not covered by the government plan.

Universal health coverage in Massachusetts

The Massachusetts legislature adopted universal health care legislation in 2006 with a goal of insuring nearly 100 percent of its residents. The Massachusetts system mandates individual health coverage for consumers and involves participation by employers, insurers, and the government. A new state agency, the Commonwealth Health Insurance Connector, was established to implement the program. Most Massachusetts residents were required to have qualifying health coverage by December 2007 or face tax penalties. Nearly 440,000 previously uninsured people had obtained health insurance between June 2006 and March 2008.

How the Massachusetts system works

The Massachusetts system mandates that all individuals be covered by health insurance and is enforced with tax penalties. All residents 18 years of age and older must obtain insurance that meets the minimum standards set by the Commonwealth Health Insurance Connector Authority Board. Exceptions may be made for consumers facing certain hardships or for religious reasons, and waivers are available for residents unable to afford any of the available insurance. The Connector Board publishes an insurance affordability schedule for various income levels that it uses to decide whether a waiver will be granted.

Residents must provide information about their health insurance coverage on their state income tax returns. The 2008 filings were the first income tax statements to penalize residents for not demonstrating qualifying coverage as of December 31, 2007. The individual penalty this filing year for failing to obtain qualifying health coverage is loss of the $219 personal state income tax exemption. For tax year 2008 and beyond, penalties will increase to the cost of half of a policy in the region in which the resident resides. According to standards already set, the maximum penalty can be as much as $912 for those above 300 percent of the federal poverty level who have no coverage throughout 2008.

Also, companies with 11 or more full-time equivalent employees must offer those employees health insurance and provide payroll deduction systems allowing them to purchase health coverage with pre-tax dollars. For 2008 tax filings, employers were charged up to $295 per employee if their employees were not offered a “fair and reasonable contribution” toward health coverage. The standard for fair and reasonable coverage is that at least 25 percent of a company’s full-time employees be enrolled in employer-sponsored coverage or that the employer offers to cover at least 33 percent of employees’ premium costs. Beginning in January 2009, to avoid a tax assessment, employers with more than 50 employees will have to meet both of these requirements or at least 75 percent of the company’s full-time employees will have to be enrolled in employer-sponsored coverage. Employers must pay to the state a “free rider surcharge,” representing a certain amount of health care costs provided to their employees from the state’s uncompensated care pool, if their employees exceed a usage threshold and the employer does not offer a plan to use pre-tax dollars for insurance premiums.

The main responsibility of the Commonwealth Health Insurance Connector is to help residents and businesses obtain appropriate health coverage. The Connector Board
has developed plans for people of various income levels who do not have access to employer-sponsored coverage. Commonwealth Care plans are government-subsidized, with no premium and with limited co-payments for those at or below 150 percent of the federal poverty level. The plans have reduced, sliding-scale premiums and co-payments for those between 150 percent and 300 percent of the federal poverty level. Commonwealth Choice, developed with private insurers, offers various plans that meet minimum standards set by the Connector Board for those with incomes above 300 percent of the federal poverty level. The plans have different premium, co-payment, and deductible levels.

The Connector offers low-cost Young Adult Plans for people age 18 to 26 who do not have access to employer-sponsored insurance.

Results of the new system

As of June 2008, the Massachusetts Department of Revenue reported that of the 86 percent of 2007 tax filings reviewed, 95 percent of filers had met the insurance mandate. Of the remaining 5 percent of filers, 2.1 percent were deemed unable to afford coverage or claimed religious exemptions, while 2.9 percent were deemed able to afford coverage and had the option to appeal or be assessed a tax penalty. As of May 2008, Massachusetts had assessed 750 employers that did not offer coverage and had contacted another 4,500 employers for questioning about their contributions for employee health coverage.

Rate of insured. At least 439,000 previously uninsured Massachusetts residents have obtained health insurance since the program began. Between the fall of 2006 and the fall of 2007, the uninsured rate among working-age adults fell from 13 percent to 7 percent. Employer-sponsored coverage increased by 5 percent in the year after the new health care system was enacted. As of October 2008, 167,000 residents were enrolled in Commonwealth Care plans with more than 52,000 contributing to their premiums. More than 72,000 residents joined the MassHealth state Medicaid program between June 2006 and March 2008.

Reimbursements to hospitals and community health centers from Massachusetts’ Health Safety Net Fund for services to residents with incomes below 400 percent of the federal poverty level saw a 41 percent quarter-to-quarter drop between the first quarters of 2007 and 2008. This is about a $68 million reduction in safety net payments for the first quarter of 2008 alone.

For a male of age 37, the median age of an uninsured Massachusetts adult, a plan is now available for half the cost and more benefits than the previous lowest-cost option. An Urban Institute survey before and one year after the program began showed that among both lower- and higher-income groups, the newly insured were more likely to visit health care providers and less likely to avoid care due to cost than when they were uninsured.

Health care costs. While average monthly costs per Commonwealth Care enrollee in 2008 were $352, which was 2 percent less than anticipated, overall costs for the program have exceeded estimates. This is mainly because more people than expected joined government-subsidized plans. The $472 million budget for the program for 2008 was exceeded by $155 million, and Gov. Deval Patrick has adjusted the 2009 estimate to $869 million, which is $144 million more than originally was projected in 2006. Enrollment in subsidized plans is expected to climb to 225,000 by June 2009. Some suggest that the state’s initial estimate of the number of uninsured was optimistic at 400,000 in April of 2006, when U.S. Census numbers estimated the number to be closer to 650,000.

Monthly costs per enrollee for the subsidized Commonwealth Care plans have increased as a larger number of higher-needs individuals have obtained these plans. For fiscal 2009, government payments toward premiums for the subsidized plans are expected to increase an average of 9.4 percent, and the unsubsidized Commonwealth Choice premiums will increase an average of 5 percent. In spite of early concerns about whether the state could address costs of higher-than-expected enrollment, Gov. Patrick announced in September the renewal of the Massachusetts Medicaid waiver that included $21.2 billion to continue the health care reforms at the same benefit and eligibility levels through 2011. This waiver agreement is a $4.3 billion increase from the previous three-year period.
At the same time, overall state budget issues have led to recommendations for $300 million in emergency cuts to the MassHealth Medicaid program. Summaries from an October meeting at the Massachusetts Office of Medicaid say the cuts primarily are related to provider reimbursement rates, but also may include staffing cuts and $1 increases for generic drug co-payments.

The influx of newly insured also has led to a heightened provider shortage. A Massachusetts Medical Society Survey released this October found that among community care hospitals, 56 percent reported a shortage of internists and 44 percent reported a shortage of family care physicians. The number of practices not accepting new patients has gone up 25 percent since 2006, and waiting times for new patients for appointments with internists and family physicians have increased to 52 and 36 days respectively, each an increase of two days over last year. Some providers have tried to compensate for higher demand by increasing their patient load, but some are concerned about the quality of health care decreasing because of overburdened physicians.

Supporters of Massachusetts’ program express optimism, in spite of concerns about costs and provider shortages, that the program is in its early stages and that costs can be addressed and eventually will level off. Supporters say the increase in the number of people covered through employer-sponsored plans is the first in 17 years and that many who did not acquire insurance last year will do so this year because of higher tax penalties for 2008, leading to further reductions in Health Safety Net spending. They say eventually new costs will level off as more of Massachusetts’ previously uninsured population obtains health coverage, allowing former safety net costs to instead pay for the new subsidized coverage initiatives.

Opponents of Massachusetts’ program point to the higher-than-anticipated costs and provider shortages as a reason the changes should not be sustained. They say as health costs continue to rise, the state will have to subsidize more of these increases, reduce subsidies and send people back to emergency rooms, or unfairly demand more contributions from businesses, insurers, and hospitals. Opponents say the core problem with health coverage is the cost of health care and simply covering more people will not address this issue.

— by Carisa Magee

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