The Potential Economic Impact of 3-Share Programs in Texas

November 2008

TexHealth Coalition

www.texhealth.org

PRESENTED BY

txp — www.txp.com

rh2 — www.rhtwo.com

MORNINGSIDE RESEARCH AND CONSULTING, INC. — www.morningsideresearch.com

Contents

Executive Summary

Today Texas leads the nation in the number of uninsured with one-in-four residents having no health coverage. This is due, in part, to fewer Texans having health care coverage through their employers. Only 53 percent of Texans have employee health coverage versus 61 percent of all Americans.

This study examines the potential 3-Share programs hold for increasing the availability of employer-based health coverage and measures the potential economic impact of 3-Share programs on Texas communities. If fully implemented, state-wide, 3-Share health coverage plans could provide almost 400,000 more Texas employees and their dependents with healthcare coverage within three years. If Texas has the same experience as some of the established, older 3-Share programs, as many as 700,000 Texans may find healthcare coverage with 3-Share health plans in the next 10 years.[1]

Further, implementing 3-Share programs statewide would result in over $700 million in additional spending in Texas and bring a total increase in annual economic activity of just over $1.7 billion. Broad adoption of 3-Share health plans would create about 16,000 permanent jobs and provide the State with just under $30 million in additional tax revenue.

In 2007 the Texas Legislature passed legislation allowing Texas communities to develop customized, subsidized, low-cost small-business health plans to lower the rate of uninsured in their communities. Five Texas communities included in this report – Galveston County, Harris County, Central Texas, Dallas County, and El Paso County – collaborated in developing the TexHealth Coalition (TexHealth) to create these types of plans. A sixth community -- Brazos Valley – has joined TexHealth since the initiation of this study[2].

TexHealth's subsidized health plans are called 3-Share initiatives. These plans split the cost of health care coverage three ways. The employer, employee and a third party share the cost of the health coverage contributions. This lowers the cost for both the employer and the employee, making health coverage more affordable for both. Shared financial responsibility for the program gives each party – the employer, the employee, and the community a stake in making the program successful.

The programs keep monthly contributions low and improve community health by emphasizing primary and preventative care and wellness while covering a range of other basic services including physician visits, hospitalization, specialty care, and mental health. They further reduce plan contributions for the employer and employee by increasing the flexibility of enrollment qualifications and enlarging the number of employees who can participate in a small business health plan.

In support of their 3-Share initiatives, TexHealth engaged TXP and its partners, RH2 and Morningside Research and Consulting, to measure the economic impact of implementing these initiatives on their communities and the state economy. The study team estimated the total number of additional Texans who would obtain coverage in each of the 3–Share communities if these initiatives were fully implemented. The study used information from other state and community experiences with 3-Share initiatives to inform these estimates.[3]

According to the National Academies of Science, the uninsured are less likely to use health care services than those who have coverage.[4] This study assumes that health spending would increase if Texans enrolled in 3-Share health plans. The research team took previous economic studies on the differences in health spending between those with and without health coverage, updated the data to current values, extrapolated the results to Texas, and then measured the secondary effects to calculate increased health spending and potential impacts resulting from 3-Share enrollment. [5]

Almost 160,000 Texas employees and their dependents could gain health coverage through 3-Share initiatives in TexHealth pilot communities. The total direct and indirect spending that could be generated by 3-Share programs in these communities would exceed $707 million. Total potential enrollment and direct and indirect spending resulting from fully implementing 3-Share programs in these communities and the State of Texas are summarized below.

	Potential Enrollees (Employees and Dependents)	Total Direct and Indirect Spending
Central Texas	30,349	$133,690,099
Dallas County	48,141	$213,599,186
El Paso County	9,981	$43,947,616
Galveston County	3,776	$16,563,033
Harris County	67,679	$299,232,382
Total TexHealth	**159,926**	**$707,032,316**
State Of Texas	386,831	$1,704,945,605

The table above does not include the estimated additional earnings, jobs, and Texas tax revenues generated in these communities by the 3-Share programs.

However, increased healthcare spending doesn't tell the whole story. Numerous studies completed in the past five years have examined the positive impacts of health coverage on health outcomes and increased employee productivity, job participation, and "presenteeism" (being fully present and attentive at work). The lack of health coverage causes roughly 18,000 unnecessary deaths every year in

the United States. [6] The annualized cost of the diminished health and shorter life spans of uninsured Americans is as much as $130 billion for each year of health insurance forgone.

Those with health coverage are likely to be healthier and participate in the workforce in greater numbers than those without coverage. According to a Commonwealth Fund study, the country foregoes $185 billion each year in economic output due to lack of health coverage.[7] Another California study suggests that the state loses $230 million annually due to bad health outcomes from lack of health coverage.[8]

An additional outcome of not having health care coverage is “job lock” or the inability of workers to leave a job because health benefits are not portable. A recent survey by the New York Times/CBS News Poll reported on November 3, 2008 noted that 3 in 10 Americans say they or someone in their household have at some time stayed in a job they wanted to leave mainly to keep the health benefits.[9]

An equally important result of high uninsurance rates is reduced access to and availability of healthcare services and higher costs for the services that are available. Healthcare providers and insurers may shift costs for the uninsured to businesses and individuals or discontinue certain services such as emergency or obstetrical services in an effort to address high levels of uncompensated care.

While 3-Share programs may not be the sole solution to the problem of the high level of uninsured in Texas, 3-Share programs can make a significant contribution to reducing the number and rate of uninsured. If 3-Share programs were implemented throughout Texas, they could enroll a potential 386,831 employees and dependents in a health care coverage plan in as little as three years. If such a reduction in the number of uninsured had occurred in 2006, it would have reduced Texas’ number of uninsured by 6.8 percent.

Chapter One. Project Overview

The Texas Department of Insurance (TDI) estimates the number of uninsured Texans at almost a quarter of the state's population during 2006. Of that number, fully two-thirds of uninsured adults are employed, with 44 percent working at firms that employ less than 25 workers. Texans who work in small businesses and depend on their employment for affordable health insurance for themselves and their families are not getting coverage. Small business employers who depend on health insurance to attract and retain workers are finding it hard to find cost-effective insurance for their employees.

This significant gap in Texas' health insurance coverage impacts the economies of Texas communities as well as the lives of individual Texans. The health of the nation's labor force and its impact on productivity is perhaps the most frequently cited factor in discussions of the relationship between healthcare and the economy. Often lost in this conversation is the fact that spending by patients (and their insurance companies) for the services provided by hospitals, physicians, and other professionals in the healthcare industry constitutes a major economic driver for many communities, employing thousands of people and accounting for millions of dollars on purchases of equipment, supplies, and services.

The TexHealth Coalition (TexHealth) retained Texas Perspectives, Inc. (TXP) and its partners RH2 Consulting and Morningside Research and Consulting to develop an economic impact assessment of reducing the number of uninsured in Texas communities through the implementation of 3-Share programs. The study's purposes are to:

- Identify and describe the successes and barriers faced by 3-Share initiatives operating elsewhere in the country.
- Provide an overview of the 3-Share Initiatives currently pursued in several Texas communities.
- Estimate the potential direct short and long term economic benefits that would accrue to the local communities were 3-Share initiatives similar to the ones being developed by TexHealth members are fully implemented.

This report is structured as follows:

- Executive Summary
- 3-Share Health Plans – Other States
- Profiles of TexHealth's Three-Share Initiatives
- Literature Review
- Economic Impact Measurement of the potential TexHealth's Three-Share Initiatives
- Appendices

Chapter Two. 3-Share Health Plans – Other States

The purpose of this report is to estimate the economic impact for local communities and the State of Texas of fully implementing 3-Share initiatives to facilitate small business access to health coverage. The study looked at other states to see how effective they had been in enrolling employers and employees in their 3-share plans, who they covered, and what barriers they faced in the development of their plans.

Three-Share is a term used to describe a public-private health coverage model that divides premium or coverage costs between three or more parties, usually an employer, an employee, and another party. This third share may be paid for by a not-for-profit group, a philanthropic organization or a public entity such as a county or a state. This cost-sharing approach lowers the amounts the employer and employee must pay to participate in a health plan reducing one of the major barriers to small employer based health coverage.[10]

Although 3-Share health plans are not the only means of increasing affordable small-employer health coverage, this report limits in-depth analysis to a discussion of 3-Share initiatives except for brief mention of some other options other states have implemented at the end of this chapter. For a more detailed discussion of non-3-Share premium subsidy options, the reader should refer to the Texas Department of Health-Texas Health and Human Services Commission study "*Report on Senate Bill 10, Section 31 Eightieth Legislature, Regular Session, 2007: A Study of Health Insurance Premium Assistance Options for Uninsured Texans" published in November 2008*.[11]

While 3-Share programs have been around since the mid-1990's it is only with the past five years that they have gained prominence at the state level. Six 3-Share initiatives are currently operating at the state level and five at the local level. However, two of the local programs had fewer than 100 enrollees and therefore were not included in the report.

State 3-Share Programs

Under the authority of Section 1115(a) of the Social Security Act, states have been able to seek Health Insurance Flexibility and Accountability (HIFA) waivers from the federal government to expand employer sponsored health coverage to certain working parents of children enrolled in the State Children's Health Insurance (SCHIP).

A number of states have taken advantage of federal HIFA waivers by creating 3-Share initiatives in their states. Arkansas, New Mexico, and Oklahoma are among the states that have successfully sought HIFA waivers.

Other states have initiated 3-Share plans using state funds rather than federal HIFA Waiver funds to finance the third share of their health plans. These include Maine, Maryland and Tennessee. Regardless of how these states fund the "3rd share", these states all seek to provide coverage to lower income employees who cannot afford to buy coverage on the private market. Appendix A provides detailed profiles for these statewide programs and the three local programs with more than 100 enrollees.

None of the state sponsored 3-Share initiatives has been operating long. Maine, New Mexico, and Oklahoma all began their programs in 2005. Arkansas started its program in 2006, Tennessee in 2007 and Maryland in October 2008. The percent uninsured in these states, the employer-based coverage levels, and total population for the states with active 3-Share initiatives varies widely.

Table 1 below compares these states by population, uninsured rates, and employer-based coverage.

Table 1. Selected State Comparison Population, Uninsured, Employer-based Coverage

State	Population	Employer-Based Coverage	Uninsured
Arkansas	2,776,920	46.6%	17.5%
Maine	1,309,960	52.5%	9.1%
Maryland	5,565,800	61.0%	13.8%
New Mexico	1,938,090	42.3%	22.8%
Oklahoma	3,491,890	47.9%	18.5%
Tennessee	6,005,630	50.0%	14.1%

Source: State Health Facts, Kaiser Family Foundation

Maryland, New Mexico, Oklahoma and Tennessee regulate their 3-Share plans the same way they regulate other health insurance products in the state. State regulation may include coverage requirements dictating what services or medical conditions must be covered, financial requirements and other stipulations for operation. Maine and Arkansas do not regulate their 3-Share health plans as insurance products.

Eligibility

Business and employee eligibility criteria vary from program to program, but some are more common than others. Eligibility criteria related to businesses include being located within the program area and limitations on their number of full-time equivalent employees. Eligibility related to the health plans subsidy or "third share" almost always requires that the employees make below a certain wage or percent

of the federal poverty level (FPL). The 2008 FPL is $10,400 for a single adult and $21,200 for a family of four.

The Arkansas, Maine, New Mexico, Tennessee and the Winnebago, Illinois programs limit the maximum number of employees in the small business to 50. Oklahoma caps the size of the business at 25 employees and Maine at 9.

The typical employee income range is from 200 to 300 percent of the federal poverty level. However, the programs may also include more complicated stipulations on eligibility, including hourly wage rates, full and part time status, previous coverage, age and citizenship criteria.

Some programs limit the amount of the program cost that an employer must pay. The maximum an employer must pay may be a dollar amount or a percent of the employee's premium.

Programs may allow the owners to enroll and spouses and/or dependents. Fewer states allow participation by those outside the small business employer and employer group. However, Maine permits the self-employed and the unemployed to enroll.

Maine and Tennessee allow workers employed by non-participating employers that would otherwise be eligible to offer the health plan to enroll in the health plan individually. New Mexico and Tennessee allow self-employed persons to enroll in their programs. Arkansas, Oklahoma, and Tennessee may cover spouses; while Maryland and Muskegon, Michigan's programs may cover spouses and dependents.

Table 2 below summarizes each of these programs' eligibility criteria for employer, employees, and other participants.

Table 2. 3-share Program Eligibility Criteria

3-Share Program Eligibility Criteria			
STATE	**Employer**	**Employee**	**Others Covered**
Arkansas	2 to 50 employees; 100% participation of employees below 200% Federal Poverty Level (FPL)	Work for participating employer; Income at or below 200% FPL	Spouses
Maine	2 to 50 employees	At least half time; Premium subsidy only available for incomes at or below 300% FPL	Self-employed and Unemployed residing in Maine
Maryland	2 to 9 FTE employees including owners; income below $50,000; Must establish Section 125 plan within 60 days	Any full-time employee	Spouses and dependents with household incomes below $75,000
New Mexico	Fewer than 50 employees	Aged 19-64 and income at or below 200% FPL	Individuals and Self-employed
Oklahoma	25 or fewer employees	Income at or below 200% FPL	Spouses
Tennessee	Fewer than 50 employees; Income below $43,000; No coverage in past 6 months	US citizen; Over 19 years of age; At least half time; No coverage in past 6 months	Employees of non-participating employers; Spouses
LOCAL			
Winnebago, IL	3 to 50 employees; No coverage in past 6 months	Full or part time; not eligible for other coverage; $12/hour or less	Spouse and dependents
Muskegon, MI	Located in county; Median worker wage below $12/hr; No coverage past 12 months; Must offer to all employees working 15.5/hr/wk or more; Pays at least 50% costs	Permanent employee for at least 13 weeks enrolling: Must be ineligible for public health coverage	Spouse and Dependents
Wayne County, MI	Located in county; 2 or more half time employees; at least half do not make more $14.50/hour to get subsidy	May make more than $14.50/ hour or live outside the county, but not eligible for subsidy	None

Source: Morningside Research and Consulting, September 2008

Enrollment

All the 3-Share programs interviewed provided current enrollment numbers. However, the question "What is the potential employee/employer enrollment in your 3-Share program?" was a difficult one for most of the programs we spoke with. Often the programs had little or no information on the number of small employers failing to offer health coverage. Further only Tennessee and Muskegon were able to say how many of the small businesses in their state or community would likely meet the eligibility established for their program.

The 3-Share programs were more likely to be able to identify a "targeted" enrollment figure. That is, within available resources, how many they hoped to ultimately enroll in their programs.

Tennessee which launched its program in April 2007 indicates that 34,000 people are potentially eligible under its program. The Tennessee program already has enrolled 45 percent of that population and hopes to have enrolled 93 percent of that population by June 2009. Muskegon, Michigan indicates that 1,200 of 1,300 or 92 percent of eligible individuals are enrolled. Muskegon, however, states that they do not have an enrollment target.

Table 3 below looks at program launch dates, current enrollment and targeted enrollment for the statewide and the three local programs with more than 100 enrollees.

Table 3. State 3-Share Launch Date and Enrollment Information (November 2008)

State	Launch date	Current enrollment (employees/employers)	Targeted enrollment[i]
Arkansas	2006	4,199 / 1,081	No Enrollment Cap
Maine	2005	23,000 / 725	140,000[ii]
Maryland	2008	na	10,000[iii]
New Mexico	2005	35,000 / 700	40,000
Oklahoma	2005	9,923 / 3,270	25,000
Tennessee	2007	15,383 / 6,379	31,500
LOCAL			
Winnebago, IL	2003	300 / na	5,000[iv]
Muskegon, MI	1999	1,200 / 400	na
Wayne County, MI	1994	4,453 / 900	5,000

i Targeted enrollment is expressed in number of lives. Targets for the number of businesses do not exist because the number of employees per business is variable.
ii Prior to the program launching in 2004, Maine had a stated target of 189,500 enrollees by the end of 2009.
iii Maryland launched its program in October 2008. At the time of this report no enrollment figures were available.
iv Enrollment linked to availability of subsidy funding.

While most programs did not identify any specific obstacles to expansion, their enrollment is limited by the resources available to the programs to subsidize the third share. One other program noted lack of marketing dollars to promote the program as a barrier to the program's expansion.

Significant Outcomes

The study team also asked programs contacted about the availability of outcome data. Few programs collected outcome data. However, the data that was available indicated that programs had made significant improvements in insuring small business populations.

Maine prepares an annual report of its program. The Maine report indicated that 36 percent of enrollees were uninsured prior to enrolling, 43 percent of small employers enrolled were uninsured prior to enrolling, and that in 2006, 93 percent of members who were eligible re-enrolled in the program.[12]

Interviews with program officials elicited several other outcomes. New Mexico reported an 11.4 percent decrease in the percent of uninsured since the implementation of its program in 2005.[13] Wayne County, Michigan, program officials say the program is attracting small business to their county. Premium rates for the program have not been raised in three years, while private sector rates have increased every year.

Other Models for Providing Low Cost Coverage to Employers

While it was not the purpose of this chapter to identify or discuss other approaches to reducing premium costs we do briefly mention a few of the many other models for providing low-cost health care for employers and employees that do not involve sharing the premium for a health insurance product.

Texas 3-Share Story: News Service

A small business news service co-owner was diagnosed with breast cancer in 1999. She and her husband had started their business a few years earlier, but could not afford health insurance for themselves or for their employees. While she was able to pay for her care, the treatment created a serious financial burden. "I've gotten excellent care, and my prognosis has always been very good," she said, "but we just can't afford for that to happen again."

This small business owner was interested in the three share program, not only because she and her husband would have coverage, but also because it could help them recruit and retain employees. "We're at a point now where we really would like to keep at least one beat reporter and an editor on staff at all times, but if people are looking for work they're looking for something where they will have some benefits," she said. "That seems to be the most important thing that

The largest program is Healthy NY, a state-wide program in New York that is currently covering nearly 150,000 lives. The state requires that all licensed commercial health care plans offer a low-cost Healthy NY option.[14]

Employers and employees share the premium (employers are required to pay at least 50 percent). The premiums are kept low because the state provides reinsurance for high cost claims. New York State pays 90 percent of the reimbursement for health care claims between $5,000 and $75,000. The state paid $92 million in 2006 for those claims.[15]

The New York program funds an annual report that includes the results of surveys of employers and employees. The report indicates changes in premiums and evaluates enrollment in the various health plans. According to the report, without the program, the percentage of New Yorkers who are uninsured would increase nearly one percentage point to 14.3 percent.[16]

For the third consecutive year, participating employers report that the availability of the program has had a positive impact on their business. Some 91 percent of the employers in the program attribute this positive impact to increased morale and retention.

The Texas Department of Insurance has researched a reinsurance program for Texans called Healthy Texas that may be introduced in the upcoming Legislative Session in January 2009. Similar to New York's program, the Texas approach envisions the state covering a proportion of health care claims above a certain threshold and up to a certain point.[17] Table 4 below lists other non-3-Share, subsidized health care models.

Table 4. Other Non-Share Small Business Coverage Models

Program	Description
West Virginia	Small Business Plan - Private insurers contract with the state and are granted access to the Public Employee Insurance Agency's (PEIA) provider reimbursement rates which average 20-25 percent lower than market rates.[18]
Massachusetts	A health insurance program for Massachusetts residents offering free or low-cost health care through managed care health plans offered by private health insurance companies.
San Francisco, CA	Is not an insurance program, but instead offers medical homes emphasizing access to preventative care. Employers, employees or individuals and the city and county share costs.
Pennsylvania	Uses tobacco settlement and other state funds to keep workers off Medicaid by offering limited health benefit packages to workers through Blue Cross Blue Shield
Michigan	Michigan First is an employer subsidy program that does not include a three-share design. The state will negotiate with private insurers who will offer benefit plans at reduced rates to small businesses and their employees.
Virginia	HB 761 (2006) allows small businesses (fewer than 50 employees) to enter purchasing pools to provide coverage to employees.

Chapter Three: Texas 3-Share Initiative Profiles

Five communities: Galveston, Harris County, Dallas County, Central Texas, and El Paso County embarked on creating 3-Share initiatives. Together these communities formed the TexHealth Coalition (TexHealth).

Galveston has launch their 3-Share initiatives and the other communities are in various stages of development. This chapter provides brief descriptions of TexHealth member's 3-Share program's eligibility requirements, benefits, limitations and costs for each of these communities and their 3-Share efforts.

History

According to the Texas Department of Insurance (TDI) family coverage premiums for small businesses have doubled in the past 10 years; increasing from $5,534 in 1997 to $11,310 in 2006. Although data for 2007 and 2008 is not available, premiums are expected to continue to rise. By the close of 2008 average healthcare premiums are expected to increase around 14 percent bringing the average family coverage premium to $12,947.[19]

Most small businesses cannot handle health coverage costs of this magnitude – or even a portion of the average healthcare coverage cost. In fact, 60 percent of small Texas business owners indicate that if they had to contribute anything over $100/month/employee it would diminish the likelihood they would offer coverage.[20]

In 2007, the 80th Texas Legislature passed Senate Bill 10 (SB10). This omnibus healthcare reform legislation included a number of provisions designed to ease existing state uninsured rates. One of these provisions included creating local and regional health care programs and giving them the flexibility to design flexibility programs that meet their community's health coverage needs.

Under the state's current system of health coverage, insurance companies charge small businesses – those with fewer than 50 employees -- premiums based on a variety of characteristics which may include business type, location, and the number, age, gender and health status of employees. Under SB10, local and regional entities have been given the ability to create health plans where contributions are based on enrollees' specific demographic characteristics like gender and age, but do not consider enrollee's health status, claims experience, or how long they've been enrolled in the health plan.

3-Share approaches to health coverage offer the following advantages:

- Ease of enrollment and lower contribution costs for the employer.
- Inclusion of third party funders which stabilize funding for the health plans and lowers the employee contribution costs.

- Customization of health plans by local and regional organization to help ensure the community's needs considered.

TDI and HHSC Grants

In November 2007, the Texas Department of Insurance and the Texas Health and Human Services Commission awarded approximately $1.6 million in planning grants to develop small business health coverage products under the provisions of SB10.[21] TexHealth proposed to use the grant funds to support program design, development and initial operations of TexHealth and activities at the community level. The objectives of TexHealth included:

- Increasing the number of insured in the member's communities
- Collaboration among the members to support and learn from each other's efforts
- Creating efficiencies related to the purchase of actuarial, marketing and other professional services
- Developing accountability measures that enable an objective evaluation of the 3-Share initiatives around the state.
- Integration and coordination with other state health reform and coverage initiatives

Table 5 below uses the latest population size, uninsured rates (2005) and number of small businesses by size (2006) available for these communities.

Table 5. County Demographics

		Uninsured		Businesses by Size			
3-Share Initiative	**Population**	**#**	**%**	**1 to 4**	**5 to 9**	**10 to 19**	**20-49**
Central Texas*	1,494,212	294,146	19.7%	20,735	7,032	4,961	3,576
Dallas County	2,305,455	642,031	27.8%	32,346	11,274	8,158	6,537
El Paso	721,600	236,775	32.8%	6,450	2,742	1,708	1,218
Galveston	277,566	51,180	18.4%	2,773	1,005	647	436
Harris County	3,693,051	1,115,478	30.2%	46,267	16,490	11,589	8,784
Texas	22,860,324	5,590,477	24.5%	265,059	99,040	67,262	47,674

Source: Census Bureau, Steve Murdoch, TXP

*Central Texas includes Travis, Williamson, Caldwell, Burnet, Bastrop and Hays counties.

Galveston County

Galveston was the first of the five communities to launch its 3-Share initiative. Prior to launching its plans, Galveston conducted community-wide CHAT (Choosing Healthplans All Together), engaged community leaders including the area's Chamber of Commerce, and obtained media coverage to explain the plan's concept and provide contact information for interested businesses.

The Galveston County 3-share program started enrolling participants in July 2008. Employers and employees each pay $60 per month in premium costs for Galveston's 3-Share program. UTMB and the Houston Endowment Fund split the remaining $60 per month equally. Total premium costs are $180 per month.

The target enrollment for Galveston's pilot program is 500 participants. On September 10, 2008 – less than 90 days after launching their 3-Share initiative -- the program had almost reached its target enrollment for the year with 108 businesses and 470 enrollees. Of the companies that enrolled in the Galveston plan 30 percent were retail sales businesses; 18 percent, professional; 17 percent services; and 12 percent, hospitality.

Galveston 3-Share also tracked whether patients enrolled in their plan had been previously seen in the UTMB system. Seventy-eight percent of the enrollees were found to be established patients at UTMB and 85 percent of these enrollees were also found to be uninsured prior to enrolling in the 3-Share plan. These numbers confirm that the 3-Share plan will provide enrollees with better access to healthcare while helping reduce Galveston's uncompensated care costs resulting from the uninsured.

After Hurricane Ike hit on September 13th the program lost only 7 businesses and 55 enrollees. Galveston's Executive Director states that plans to expand the program in 2009 remain in place assuming funding for the 3rd share is available. As he put it: "We consider the 3-Share plans to be an economic development tool and we hope to use it to keep the businesses we have here."

Coverage

Galveston's 3-Share Plan targets small businesses with two to 50 employees that have not offered group health coverage in the last 12 months. For an employer to enroll in the 3-share program the median salary for all employees must be less than $50,000 and 50 percent of eligible employees must elect to enroll in the program, with a minimum of 2 employees enrolling. So far the percent of eligible employees enrolling has run much higher than the 50 percent required with about 70 percent of the eligible employees enrolling. An employee must work on average 20 hours per week and cannot be covered by any government health insurance benefits plan to be eligible for the program.

The Galveston 3-share program uses UTMB's healthcare network to provide physician visits, urgent care clinic, emergency room, outpatient surgery, hospitalization, scans, and outpatient mental health. Outpatient pharmacy benefits are provided by Caremark/CVS network. An HMO model is used to instill the medical home concept. Table 6 below lists Galveston's co-pays and limitations for each of these benefits.

Table 6. Benefit Summary Galveston County 3-Share, 2008

Benefit	Co-pay	Limitations
Physician Visits (Primary/Specialty)	$15/$30	20 Visits/Year
Urgent Care Clinic	$30	Included in 20-visit max for physician visits
Emergency Room (UTMB & Mainland Medical Center only)	$75	No Max
Outpatient or day surgery	$75	No Max
Hospitalization, including inpatient surgery	$200	30 Days/Year or $50,000/Year
Scans (MRI, PET, CT Scans)	$75	No Outpatient Max
Outpatient Mental Health	$30	12 Visits/Year
Outpatient Pharmacy (generic/non-generic)	$25/$50	$1,200/Year

Source: Galveston 3-Share, October 2008.

Texas 3-Share Story: Galveston Café Owner

A Galveston Café owner was among the first businesses to enroll in the 3-share program there. As he explains, he has his "8 folks taking part—had 9, but one person moved away after the storm. We have 13 or 14 full time employees who could be eligible, but most of the ones who didn't enroll have coverage through their spouses. One single grandmother didn't enroll, but I think she will this year."

The owner explained why he had not offered insurance before. "I couldn't afford it. I looked around…, but just couldn't afford it. I know they're (some other policies) more comprehensive, but our folks are local and work long hours so all their care is going to be local. I'm thrilled to be able to offer this for my employees."

He is "literally blown away by the plan". It makes me more competitive and helps me keep my employees. Although my employees are pretty long term, they'd definitely think twice before leaving since we now offer coverage. The employees were very enthusiastic about the product.

He reports that "the plan works seamlessly—everyone took advantage of the free physical and a few folks have gone to the doctor with things like flu".

Galveston's 3-share plan has no deductible, but does have a lifetime maximum benefit of $250,000. There is no pre-existing conditions clause and employers and their employees only may enroll. Galveston uses incentives to establish baseline health status in its enrollees by offering a "free" physical when members join the Plan. Another innovation is a voluntary program where copays are waived for urgent care and emergency room visits when referred after hours by the UTMB Nurse-Line. A disease management program is available to members with designated chronic conditions.

Central Texas

The TexHealth Central Texas includes Travis, Williamson, Hays, Bastrop, Caldwell, and Burnet counties. TexHealth hopes to begin enrolling businesses in its health coverage plans in early 2009.

Central Texas plans a three-year enrollment roll-out with 10,000 enrollees at the end of the third year. If the program reaches its target of 10,000 participants, that would cover 8.8% of previously uninsured small business employees.

Central Texas describes its health plans as "basic" coverage – a mid-point between traditional commercial coverage and no coverage. Central Texas will focus on prevention and encourage efficiencies and collaboration in the delivery of services to help keep premium costs low.

Eligibility

While none of the program's specifics have been finalized at this writing, it is anticipated that Central Texas will target businesses with 2 to 49 employees that have not offered healthcare coverage in the past year. Premium subsidies will only be available to employees with incomes at or below 200 percent of the federal poverty level (FPL). Employees with incomes above that level may be eligible to enroll in Central Texas, but they and their employers would be responsible for the full premium amount.

Outreach

Central Texas funded three major outreach efforts – outreach to community groups in outlying counties, a survey of small businesses and a set of focus groups. The purpose of the survey and the focus groups was to obtain feedback on the proposed health plan features and costs. An electronic survey was distributed to area small businesses in the Central Texas area through local chambers of commerce and the Integrated Care Collaboration website. Survey respondents were provided detailed information on the proposed plans and potential premium costs. Over 90 percent of small business owners remained interested in offering the plan even after knowing benefit limitations and the price.

Results from the focus groups were consistent with the survey findings. Participants were interested in the health plan after a detailed review of benefits and costs. Among the things participants liked most was the emphasis on prevention and the fact that the plans would be operated by a non-profit.

Coverage

There will be two types of plans—a low cost and a mid-cost plan. At this time, the plans include outpatient hospital services, hospitalization, X-ray and laboratory services, physician office visits, inpatient and outpatient psychiatric services, drugs, and dental services. The following Table 7 provides a breakdown of benefits, limitations and costs of each proposed Central Texas plan.

Table 7. Benefits Summary (Proposed) Central Texas 3-Share

Benefits	Mid Cost Plan Benefits/Limitations	Low Cost Plan Benefits/Limitations
Monthly Premium	$96- $278	$76- $222
Deductible	$0	$500
Coinsurance	Variable	20%
Out of Pocket Max (including deductible)	$5,000	$5,000
Annual Max Benefit per Person	$50,000 (IP and OP)	$50,000 (IP and OP)
Hospital Benefits		
Inpatient, Outpatient, Emergency Room	$500 co-pay + 20% for IP $500 co-pay + 10% for OP $250 co-pay + 10% for ER	Deductible and 20% Coinsurance for both IP and OP$250 co-pay + deductibleand 20%for ER
Hospital Outpatient Radiology, Pathology, and Diagnostics Tests	10% coinsurance	Deductible and 20% Coinsurance
Maternity	Covered under inpatient hospital	Covered under inpatient hospital
Physician Benefits		
Hospital Inpatient, Outpatient Treatment	10% Coinsurance	Deductible and 20% Coinsurance
Doctor Office Visits	8 visit maximum $20 co-pay PCP $40 co-pay Specialist; pre-auth req. after 1st 2 visits	6 visit maximum $20 co-pay PCP $40 co-pay Specialist; pre-auth req. after 1st 2 visits
Radiology and Pathology (subject to office visit limits)	Non-preventive subject to 10% coinsurance	Non-preventive subject to deductible and 20% coinsurance
Maternity (not subject to office visit limits)	Covered	Covered
Psychiatric and Substance Abuse Services		
Outpatient	$40 co-pay; 10 visit limit	$40 co-pay; 10 visit limit
Inpatient (subject to annual hospital max)	$500 co-pay + 20% Coinsurance	Deductible and 20% Coinsurance
Other Services		
Prescription Drugs	$15/ $35 (non-formulary not covered); $2500 annual max	$15/ $35 (non-formulary not covered); $1000 annual max
Ambulance	10% coinsurance	Deductible and 20% coinsurance

Source: Central Texas 3-Share, November 2008

Harris County

The Harris County 3-share program plans to start enrolling participants in January 2009. Harris County's three-year pilot would serve approximately 5,000 currently uninsured workers by the third year. Like Central Texas, Harris County intends to offer two plans. One plan focuses on primary and preventive care with limited out-of-pocket expenses and limits on hospital coverage. The other plan limits primary

and preventive care and has high deductibles, but provides more extensive catastrophic care coverage.

TDI Sponsored Employer Focus Groups

With funds provided by TDI, Harris County was able to obtain feedback on its proposed health plans from local employers and employees. Harris County focus group participants were overwhelmingly interested in the plans with almost 90 percent indicating that they would be interested in purchasing one of the plans.

Among key focus group findings was that employers really valued the "modified community rating" aspect of the plans and the reduced administrative burden that resulted from the modified rating. Under the normal rating system for small businesses each employee has to complete a voluminous health information form. Each time a new employee is hired rates may change based on the health status of the new employee. The enrollment and underwriting process is much simpler under a "3-Share" system and health plan contributions are not affected by the health status of new employees. Harris County found that employers were more likely to prefer the catastrophic plan while employees favored the primary and prevention focused plan.

Eligibility

Businesses employing 2-49 employees will be eligible if they meet the other criteria. The business must not have previously offered health coverage and their primary place of business must be in Harris County. The third share subsidy will be available for employees whose incomes are below 200 percent of FPL.

Coverage

One of Harris County's goals was to keep premiums below $100 for the employer's portion. Both of the plans listed below achieve this. Harris County also intends to make coverage for dependents available through its 3-Share initiative.

Harris County's 3-share plans have inpatient and outpatient hospital services, physician, substance abuse, psychiatric care, drugs and a variety of other benefits. However, the hospital benefits for the 'basic and prevention' plan are significantly less than for the catastrophic plan. Table 8 below summarizes the benefits, limitations and costs of each plan.

Table 8. Benefits Summary (Proposed) Harris County 3-Share

Benefits	Catastrophic Plan	Basic Benefit and Preventive Care Plan
Monthly premium per adult	$156	$129
Monthly premium per child	$72	$59
Annual Deductible	$1000	$250
Co-insurance	30%	20%
Out-of-pocket max	$11,000	$1250
Annual max. benefit	$300,000	No specific dollar limit
Hospital Benefits		
Inpatient hospital stay	Covered	5 days covered annually
Outpatient hospital surgery	Covered	2 visits covered annually
Hospital outpatient radiology, pathology, and diagnostic tests	Covered	2 surgeries covered annually
Emergency room visits	covered	2 visits covered annually
Physician Benefits		
Inpatient hospital care	Covered	
Outpatient hospital care	Covered	
Doctor office visits and preventive care	First 2 visits have $25 co-pay for adults and first 4 visits have $25 co-pay for children under age 2; all other visits subject to deductible and coinsurance	6 visits covered annually; first 2 visits have $25 co-pay and the remaining 4 are subject to deductible and coinsurance.
Substance abuse and psychiatric care	First 2 visits have $40 co-pay; all other visits subject to deductible and coinsurance	Same as above
Radiology and pathology	covered	Covered annually if part of a covered inpatient, outpatient or office visit service
Prescription Drug Benefits		
Deductible	$500	None
Coinsurance	30%	None
Co-pay	None	$10 for generic, $20 for formulary brand name drugs, and $30 for non-formulary brand name drugs
Annual max benefit	none	$1000
Additional Covered Services		
Ambulance	Covered	Covered

Private duty nursing	Covered	Not covered
Home health care	Covered	Not covered
Durable medical equipment	Covered	Not covered
Prosthetics	Covered	Not covered
Maternity care	Covered	Covered
Inpatient psychiatric care	Covered	Not covered
Inpatient substance abuse treatment	Covered	Not covered
Vision exam	Not covered	Covered
Glasses or contact	Not covered	Not covered
Dental coverage	2 annual preventive visits covered at 100% after $25 co-pay	2 annual preventive visits covered at 100% after $25 co-pay
Chiropractic care	Not covered	Not covered
Podiatrist	Not covered	Not covered

Source: Harris County Alliance November 2008

Dallas County

In 2005, the Dallas County Commissioners Court adopted orders that created a regional healthcare initiative to develop and discuss options for addressing regional health issues. From these orders grew the North Texas 3-Share Plan (now TexHealth North Texas). The first order of business for the new collaboration was to develop a low-cost health coverage product for the "working poor." For the purposes of its 3-Share initiative North Texas defines "working poor" as persons earning less than 200 percent of FPL or under $20,000 per year.

In 2008, North Texas received planning grants totaling $312,000 to help launch its 3-Share initiative. Their goal is to enroll 14,000 persons in their 3-Share plan within three years of their initial start date. However, no start date has been set yet for initial enrollment.

Eligibility

To be eligible employers must have between 2 and 50 employees. Employers must not have offered or dropped coverage within the past 12 months prior to enrollment. Employers must be located within Dallas County and their employee's median income must not exceed $50,000. Further 50% of eligible employees must enroll in the plan.

North Texas estimates premiums for its health plan will be $225 per member/per month. Premiums would be split three ways with the employee, employer and third entity each paying $75. The third share will be paid by public funds if the enrollee makes less than 200 percent FPL. If the enrollee makes over 200 percent FPL then he must pay the additional $75 unless the employer assumes all or part of the cost.

Eligible employees must work an average of 20 hours per week and must not be eligible for or enrolled in any government health benefit plans such as Medicaid.

Coverage

Currently North Texas' proposed 3-share contains inpatient and outpatient hospitalization, emergency room, physician, wellness visits, psychiatric or substance abuse, laboratory and X-ray and drug benefits

Table 9 below lists the proposed benefits, limitations and costs for the Dallas County 3-share:

Table 9. Benefits Summary (Proposed) North Texas 3-Share Plan

Benefits	Co-pay	Limitations
Physician	$15 co-pay for in network primary care physician; 50% co-pay for out-of-network physician	Up to 12 visits per year
Specialty Care Physician	$30 co-pay	included in 12 visit limit, above
Wellness Visit	no co-pay (up to $150/yr)	One visit up to $150 per year
Lab and X-ray	no co-pay	no limit
Outpatient hospital		100% in participating hospital; 50% out-of-network with $500 annual maximum
Inpatient hospital		limited, to be determined
ER	$75 co-pay per visit	$1,200 annual max
Pharmacy	$5/$20 co-pay generic/brand	$1,200 per year limit
Psychiatric or substance abuse therapy	$30 co-pay/visit	12 visits per year

Source: TexHealth North Texas November 2008

El Paso County

The El Paso County 3-Share program started in June 2008 and is still in the early planning stages. El Paso County's proximity to the Mexican border enables about one-third of its uninsured to obtain healthcare in Mexico including general medical and dental services.[22] No decisions regarding eligibility or benefits had been made public at the time this report was written. The program is not expected to start enrolling participants until late 2009.

Target enrollment

Target enrollees are small businesses between 2-49 employees that have not offered health coverage for the last 11 months. El Paso County intends for its 3-Share plan to complement its existing Health Care Options program which is geared to individuals at or below 100 percent of poverty. Individuals with incomes between 100 percent and 200 percent FPL will be eligible to enroll in the county's 3-Share plan.

The benefit package is still in the planning phase. It is their intent to keep cost of the plan at $180 (or $60 per share). The program will utilize the El Paso First Health Plan provider network.

Chapter Four: Literature Review

The study team documented a number of the economic impacts of the uninsured on Texas communities that could not, for a variety of reasons, be included in the economic impact model developed and discussed in Chapter Five of this report. The most common being the lack of detailed economic data, especially at the state and local levels.

Texas 3-Share Story: Real Estate Office

An owner of a real estate office says he is very interested in offering the program to his 23 employees. "In the real estate industry we don't really have a good health product that's available at a reasonable cost," he said. "This was a very exciting thing to me because it looked like something that my realtors could be covered by that would not be prohibitive as far as cost is concerned."

Nonetheless several widely discussed positive economic impacts resulting from increased participation in health coverage must be noted, such as job mobility, reduced mortality and morbidity, increased productivity, increased job participation. A general review of recent studies on these topics is included here to show the myriad positive benefits documented from increased health coverage and to the context for the economic impacts of the potential economic benefits arising from full implementation of 3-Share health plans.

Reduced Mortality and Morbidity

As noted by Davis, et al. "A healthy workforce is one of our most important economic assets as a nation."[23] Simply put, healthy workers are more productive than workers who are similar but not healthy. Numerous studies link investments in health and nutrition of the young to adult wages.[24] Better health also raises per capita income through a number of other channels; for example, decisions about expenditures may be altered, which in turn affect savings over the life cycle. Increased savings substantially boosts investment and economic growth.[25] Berger, et al. state that:

> We propose that health status is one of the important underlying factors in enhancing or maintaining productivity in the labor force. Health status is one of the many factors that determine the quantity (working time) and quality (productivity) of employees. The health status of employees may, in addition, affect the efficient use of capital. For example, work-loss days or reduced productivity at work result in idle physical capital, which may represent a serious loss for the company.[26]

The National Academy of Sciences reported that the majority of costs due to being uninsured result from the poorer health outcomes of uninsured.[27] The uninsured are less likely to use health care services than those who have coverage.

According to the National Academies of Science, the lack of health coverage causes roughly 18,000 unnecessary deaths every year in the United States.[28] In addition, acutely ill and chronically ill uninsured Americans have increased morbidity and worse outcomes. All uninsured are less likely to receive preventive and screening services, putting them at greater risk for adverse results. The annualized cost of the diminished health and shorter life spans of uninsured Americans is between $65 and $130 billion for each year of health insurance forgone.[29]

The uninsured are more likely than the insured to report difficulties in getting needed medical care. Almost one fourth of uninsured adults say that they have forgone care in the past year because of its cost compared to 3 percent of adults with private health care coverage. One reason for this is that about half of uninsured adults do not have a regular place to go when they are sick or need medical advice.[30]

The lack of access to care shows up in a variety of ways. The uninsured are less likely than the insured to follow standard treatment plans for injuries or chronic conditions and to obtain all the services that are recommended. After experiencing a health shock, uninsured individuals are less likely to obtain needed medical care and not as likely to receive any follow-up care than the insured. The uninsured had fewer outpatient visits, office-based visits and prescription medicines than the insured. The uninsured were more likely to report not being fully recovered and no longer receiving treatment.[31]

Uninsured colorectal cancer patients are diagnosed in the later stages and die earlier than the insured. [32] Uninsured adults from 51 to 61 are more likely to experience a decline in health or develop problems with mobility over a four year period than insured adults.[33]

Anticipating high medical bills, many of the uninsured do not follow recommended treatments. Uninsured adults were more likely to report that they did not see a physician when needed due to cost. They were more likely not to have routine checkups within the last two years. Deficits in cancer screening, cardiovascular risk reduction and diabetes care were most pronounced among long-term uninsured adults.[34]

One fourth of uninsured adults say they did not fill a drug prescription in the past year because they did not feel they could afford it. [35] The lack of access to medical technology necessary to treat heart attacks, cataracts, and depression provides one example of such costs. One study estimated $1.1 billion per year in lost labor-market productivity and life-expectancy gains for uninsured Americans aged 55 to 64 who did not receive these services.[36]

Increased Productivity

Increasing the number of insured can increase worker productivity in several ways:

- increase number of people who are well enough to participate in the job force
  - having fewer sick days
  - being more aware and present on the job.
- allowing greater employee mobility and reducing the number of employees who are "locked" into a job in order to obtain insurance.

Increased Job Participation

Reducing or preventing serious illness can increase the number of people who participate in the workforce. A Commonwealth Fund estimated that 18 million Americans ages 19 to 64 are not working due to health reasons, including disability and chronic disease.[37] As study authors Davis et al. note:

> Investing in the health of workers and the prevention of disability and serious illness could have an economic payoff. The U.S. labor force would expand, with the potential for a significant increase in the nation's standard of living and economic output. Even valuing lost work-time at the minimum wage, the nation gives up $185 billion each year in economic output because of its workers' health problems.38

One study of the impact of health insurance on California's productivity reported that bad health outcomes caused by a lack of health coverage means 12,000 less Californians work each year. The study also notes that extending the coverage to working age adults might increase annual gross state product by $230 million annually.[39]

Less Sick Days

The health problems of workers and their families constitute a substantial source of lost productivity in days absent from work. In Commonwealth Fund survey data, 29 percent of full and part time workers reported having chronic health problems. Other workers are themselves in good health, but say they miss work days to care for family members who are ill or disabled.[40]

Texas 3-Share Story: Mobile Pet Service

A Mobile Pet Service owner complains, "I am trying to find a way to hire a mother with two children, but I cannot seem to find affordable coverage that can compete with what she gets at a larger company. I am not able to hire some people who need group coverage. I can't give them the same benefits as a larger business can. For example, the most recent quote I received for a potential employee I would like to hire is $750/month for her and her 2 children, one of them with a pre-existing condition [severe ADD], with a $2,000 deductible and less-than-great coverage. The mother is having a hard time leaving her current employer because of the coverage she has there. With this pre-existing condition, no [insurer] is willing to take her child on."

The Commonwealth study estimated that:

- 69 million workers took sick days in 2003, amounting to 407 million lost days of work or a loss of $48 billion of economic output (valuing this as missed time at workers' actual wage rates)
- Nearly two-thirds (64%) of survey respondents said they had missed at least one day of work in the past year because of their own health problems or a family member's health problems. About 20 percent of workers missed six or more days.[41]

Poor health status was found to be the most significant predictor of missed work compared to other factors such as wage rate, sick leave benefits, family structure, and age. Compared with healthier workers, workers with health problems have two-and-a-half times the risk of having six or more sick days during the year, holding other factors constant.[42]

Increased Productivity on the Job

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

A Commonwealth Fund survey found that:

- One-half of respondents reported experiencing at least one day in which they were unable to concentrate at work because they were not feeling well or were worried about a sick family member, with 20 percent reporting six days or more.[43]
- Fifty-six percent of workers with chronic health problems reported one or more days of reduced productivity, compared with 48 percent of healthier workers. The difference between the sicker and healthier workers reporting six or more days at work of reduced productivity was even greater (31% vs. 16%).
- Workers earning $10 to $15 an hour were more likely to report any reduced productivity than workers earning more than $15 per hour or less than $10 per hour, even after adjusting for health status, sick leave benefits, and other factors.
- Younger workers (ages 19 to 29) were more likely than older workers (ages 50 to 64) to report inability to concentrate fully because of health problems, holding constant for health status and other factors.
- Married adults with children were nearly one and one-half times more likely to report reduced productivity than families without children.

The study notes that illness-related presenteeism has a significant impact on the economy. Based on the survey, 55 million workers experience a time when they are unable to concentrate on the job because of a personal or family member's illness. The total number of days per year of reduced productivity due to illness is 478 million. Assuming these workers were working at "half capacity," and based on their average earnings, the economic output not generated during these days would be valued at $27 billion.[44]

Increased Job Mobility

Increasing the ability to obtain health insurance, increases job mobility. It allows more employers to offer health insurance and more individuals to change jobs without losing health insurance. Individuals can create new businesses or work for new companies. They can choose more productive jobs without fear of losing insurance.

A number of studies of this phenomenon have been done since the early 1990s. Authors typically find job lock to reduce job mobility between 20 and 40 percent depending on the study and the demographic group.[45]

"Job lock" is a term used to describe a situation where an employee feels "locked into their job" because of the availability of benefits or job features. A recent survey by the New York Times/CBS News Poll reported on November 3, 2008 noted that three in 10 Americans say they or someone in their household have at some time stayed in a job they wanted to leave mainly to keep the health benefits.[46]

One study by the University of California estimated that 2.3 percent of the California workforce (179,000 workers) with employment based coverage would have made productivity-improving job changes absent job lock in 2002. Job lock led to an estimated $772 million in annual foregone productivity gains in California alone.[47]

The ability to change jobs can be particularly

Texas 3-Share Story: Accounting Service

An Austin Accounting Service owner is interested in health insurance for his start-up business. He currently has three employees. He used to work for a large company with a 1,000 employees who had health insurance companies knocking on the door. He finds himself in the opposite situation now.

This owner hires profession people with college degrees. This group expects health coverage as part of their compensation. His challenge is to provide a benefit that's affordable for his business. Most of their clients are small businesses, and they're looking for the same thing.

All of his employees are currently taking advantage of COBRA from their previous employer at this point. One employee is insured under a spouse's policy. His employees' compensation package includes an amount to cover the COBRA

advantageous for workers who themselves or a family member have a chronic illness. Research at Syracuse University estimated that chronic illness reduced job mobility about 40 percent among the workers in our sample who relied on their employers for coverage as compared to otherwise similar workers who did not rely on their employers for coverage.[48]

Better Community Resources for All

High rates of lack of insurance can imperil the financial stability and viability of health care providers and institutions. Not only may those who lack coverage, but others in their communities, experience reduced access to and availability of primary care, specialty, and hospital services. As noted in the National Academies' study:

> Communities that have higher than average rates of uninsurance are more likely to experience reduced availability of hospital-based services and critical community benefits such as emergency services and advanced trauma care. In addition, population health resources and programs, including disease surveillance, communicable disease control, emergency preparedness, and community immunization levels, have been undermined by the competing demands for public dollars for personal health care services for those without coverage.

The unpaid costs of care for the uninsured in a community may be shifted to businesses in the area through higher health insurance premiums. These premiums may in turn discourage businesses from continuing to provide health insurance to their employees. [49]

Two of the reasons for the exhaustion of community health care services for those communities that have higher levels of uninsured are the tendency of the uninsured to use high cost emergency room care and to be hospitalized for conditions that could have been avoided. The uninsured are more than five times more likely to use the emergency room for primary care. “About 20 percent of the uninsured (vs. 3 percent of those with coverage) say their usual source of care is the emergency room.”[50]

Because uninsured individuals and families are much less likely than are those who have coverage to have a regular health care provider, they are not well-integrated into systems of care. Consequently, population-level disease surveillance and health monitoring is reduced in communities with large uninsured populations.

Increased Quality of Life for Families

As noted in a study by the Institute of Medicine of the National Academies, uninsured individuals and families bear the burden of increased financial risk and

uncertainty as a consequence of being uninsured. Consequently, the psychological and behavioral implications of living with financial and health risks and uncertainty may be significant. Even in families in which all members are insured, the concern about losing coverage remains genuine. Lifecycle events, such as leaving school, retiring, or changing jobs, can cause family members to lose health benefits. Per the study:

> This lack of social and economic security, experienced by virtually all Americans except for those who have gained Medicare coverage on a permanent basis, is truly a hidden cost of our patchwork approach to health coverage. [51]

The study goes on to detail other unintended costs of lack of coverage for American children in particular:

> Uninsured children are at a greater risk than children with health insurance of suffering delays in development that may affect their educational achievements and prospects later in life. Good health and meeting developmental milestones in infancy and childhood affect individuals' educational attainment, earning capacity, and long-term health.[52]

Other Issues Not Included

This review has not included other issues related to the cost of uncompensated health care services to those who provide care which are largely paid by federal, state and local governments and by all taxpayers. The connection to the economic impact on the communities is more indirect.

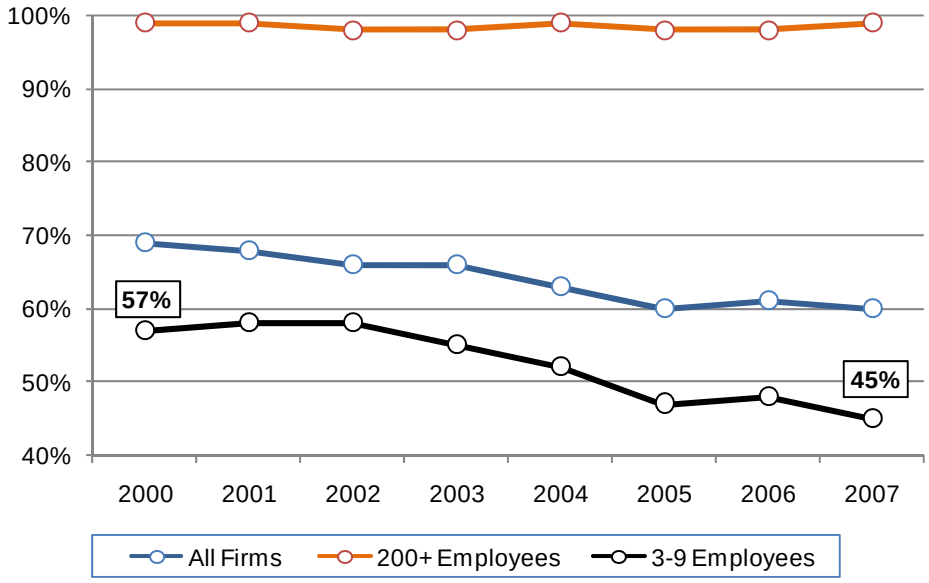
Chapter Five. Economic Impact Analysis:

The Impact of Implementing Texas 3-Share Initiatives on Healthcare Spending

Employers facing a declining economy and rising health premiums have increasingly chosen to not provide health insurance. This has triggered a prolonged decline in employer-sponsored health coverage, especially among small firms.

This trend is particularly evident in Texas. Historically, Texas has had a lower level of employer-sponsored health care than the national average (53 percent of the population versus 61 percent nationally). Texas employers have also increasingly chosen not to provide health care coverage for their employees, dropping even further from an already lower level of employer-sponsored health care. The figure below illustrates these trends.

Figure 1. National Incidence of Health Insurance by Firm Size



Source: Kaiser Family Foundation, TXP

These trends have contributed to some 24.5 percent of the Texas population, or about 5.7 million Texans, lacking health insurance coverage in 2006. Table 10 below shows the health coverage rates and source of coverage for Texans.

Table 10. Texans' Insurance Status - 2007

	Number	Percentage
Total Texas Population	23,704,000	-
Insured Population	17,742,000	74.8%
- Employment-based	11,949,000	50.4%
- Individual	1,709,000	7.2%
- Government-based	6,086,000	25.7%
Uninsured	**5,962,000**	**25.2%**

Source: U.S. Census Bureau, Texas Department of Insurance, TXP

As discussed in Chapter Four, the lower level of health care coverage has significant consequences for job mobility, labor force participation and productivity. What is measured in this chapter are the consequences for Texas communities of lower levels of healthcare spending caused by lower levels of employer-based health insurance.

According to a study referenced in more detail below done by Hadley and Holahan in 2003, the uninsured tend to spend far less for healthcare than those with coverage.[53] Reduced spending by the uninsured translates into less economic activity and fewer jobs across the economy.

When determining the economic impact of the 3-Share program, the first stage is to identify the total estimated number of additional Texans who would obtain coverage in each of the 3–Share communities if these initiatives are fully implemented.

This analysis assumes that 35 percent of businesses in a given area will want to enroll in a 3-Share program and that 75 percent of the employees with an enrolling firm will participate. These assumptions are based on both a survey completed by the Central Texas 3-Share program and actual experience of other states' and communities' 3-Share programs.

The result of this analysis is that approximately one-quarter of the potentially affected small business employee population would enroll in a 3-Share program, assuming that the program could

Texas 3-Share Story: Real Estate, Home Security and Home Theater

One small business employer with a variety of enterprises reports she does not provide benefits because of prohibited costs. She works with 1099 contractors and pays them a bit more instead of employing people and offering them insurance. The biggest impact is that not offering health insurance has prevented her from hiring the best people and has limited her pool of applicants. Recently, she ran an ad for home security and home theater sales positions. The number one question is: is there guaranteed pay and the next question (if not the first) is: do you offer health insurance? She answers no to both questions and that hurts recruitment.

fund the third share for all potentially eligible participating employees. Table 11 below provides estimates on the number of employees who would enroll in Texas 3-Share health plans under these assumptions.

The number of total potential estimated enrollees (both employees and dependents) in 3-Share programs is 30,349 for Central Texas; 48,141 for Dallas; 9,981for El Paso; 3776 for Galveston; and 67,679 for Harris County.

"Texas" figures refer to the potential estimated enrollees of the state as a whole. Tarrant County data is provided because it is used latter in examples of the calculations.

While 3-Share programs are not the sole solution to the problem of the high level of uninsured in Texas, the 3-Share programs can make a significant contribution to reducing the number and rate uninsured. If 3-Share programs were implemented throughout Texas, they could enroll a potential 386,831 employees and dependents in a health care coverage plan. If such a reduction in the number of uninsured had occurred in 2006, it would have reduced Texas number of uninsured by 6.8 percent. It would have changed the overall percentage of uninsured in Texas from 24.5 percent to 22.9 percent, a reduction of almost 1.7 percent.

As noted above in Figure 1, there has been a trend nationally and in Texas toward employers providing lower levels of insurance. If this trend continues, 3-Share programs may play a role in preventing additional erosion in the level of insurance provided by Texas employers.

Table 11. Potential Estimated Enrollees in 3-Share Programs in Texas if There Were No Limit on the Third Share

	Employees	Dependents	Totals
Central Texas	18,957	11,392	30,349
Dallas	30,362	17,779	48,141
El Paso	6,230	3,751	9,981
Galveston	2,345	1,431	3,776
Harris	42,502	25,177	67,679
Tarrant	17,875	10,514	28,389
TEXAS	241,828	145,003	386,831

Source: TXP

Measuring Economic Impacts

An economy can be measured in a number of ways. Three of the most common are "**Output**," which describes total economic activity and is equivalent to a firm's gross sales, "**Employee Earnings**," which corresponds to wages and benefits,

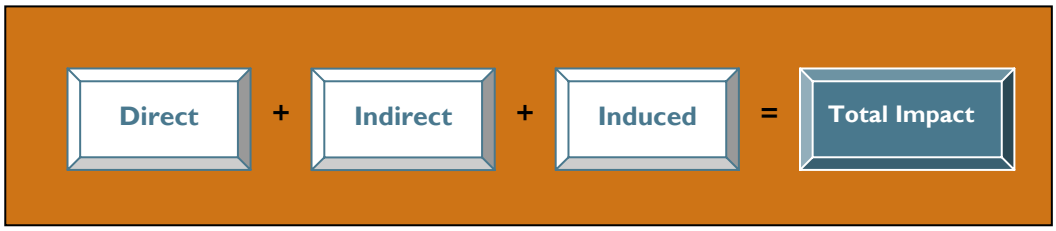
and "**Employment**," which refers to permanent jobs that have been created in the local economy.

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

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

Induced effects (the final ripple) are the changes in regional household spending patterns caused by changes in income generated from the direct and indirect effects. Both the medical supply vendor and its employees experience increased income. Induced effects capture the way in which this income is in turn spent by them in the local economy

Figure 2. The Flow of Economic Impacts



The interdependence between different sectors of the economy is reflected in the concept of a "multiplier." An output multiplier, for example, divides the total (direct, indirect and induced) effects of an initial spending injection by the value of that injection – i.e., the direct effect. The higher the multiplier is, the greater the interdependence among different sectors of the economy. An output multiplier of 1.4, for example, means that for every $1,000 injected into the economy, another $400 in output is produced in all other sectors.

These estimates use the work done by Hadley and Holahan to calculate the differences in health spending between those with and without health coverage. The results of running the increased health care spending levels through the

model are summarized and detailed in the following tables. Note that the allocation between major sub-sectors of health care was based on existing Texas patterns. Also, the estimate of the fiscal impact to the State of Texas is based on the Comptroller's "rule of thumb" of five percent of total personal income ultimately translating into State revenue.

Economic Impact Summary

The estimate above only quantifies one aspect of the economic impacts of increasing health coverage: the incidence of health insurance increases overall medical spending, which in turn has economic implications. This study has taken work done elsewhere on this basic relationship, updated the data to current values, extrapolated the results to Texas, and then measured the secondary effects.

The connection between presence of health insurance and overall health outcomes is both intuitive and well-documented, as it stands to reason that enhanced access to medical resources better enables individuals to manage and protect their overall health. Others have quantified the potential economic costs of lost productivity resulting from lack of coverage and the effects of "job lock" on those who cannot afford to lose the coverage they have. This study does not attempt to quantify those impacts because no Texas specific data for these measures exists. However, the mortality and morbidity and productivity costs of the uninsured and national estimates of their impact are discussed in Chapter Four.

The fact that only the effects of increased health spending are included in these estimates increases their conservatism. The overall finding is that the Texas economy would see a total increase in annual economic activity of just over $1.7 billion if the 3-Share program were implemented state-wide, in the process creating 16,000 permanent jobs and providing the State with just under $30 million in additional revenue.

The total direct and indirect spending generated by 3-Share programs is $134 million for Central Texas, $214 million for Dallas, $44 million for El Paso, $16 million for Galveston, $299 million for Harris County, and $125 million for Tarrant County. This does not include the estimated additional earnings, jobs, and Texas tax revenues generated in every community by the 3-Share program. Detailed results for each community are included in Appendix B.

Table 12. Summary Potential Economic Impact

	Direct Spending	Total Spending	Total Earnings	Total Jobs	Total Texas Tax Revenue
Central	$52,780,280	$133,690,099	$45,921,727	1,265	$2,296,086
Dallas	$84,328,046	$213,599,186	$73,370,008	2,022	$3,668,500
El Paso	$17,350,331	$43,947,616	$15,095,736	416	$754,787
Galveston	$6,539,014	$16,563,033	$5,689,300	157	$284,465
Harris	$118,135,665	$299,232,382	$102,784,485	2,832	$5,139,224
Tarrant	$49,640,169	$125,736,338	$43,189,660	1,190	$2,159,483
TEXAS	$673,105,236	$1,704,945,605	$585,638,339	16,138	$29,281,917

Source: TXP

Table 13. Detailed Texas Potential Economic Impact

TEXAS STATEWIDE	Output	Earnings	Employment
Agriculture, forestry, fishing, and hunting	$11,780,479	$1,645,790	149
Mining	$9,057,911	$1,684,090	19
Utilities	$28,647,738	$5,211,920	63
Construction	$8,236,912	$3,059,311	86
Manufacturing	$153,497,004	$24,569,668	558
Wholesale trade	$53,188,586	$16,898,923	311
Retail trade	$71,199,934	$23,991,556	1,015
Transportation and warehousing*	$49,297,659	$17,119,247	436
Information	$50,496,734	$13,051,795	254
Finance and insurance	$95,452,959	$25,063,216	496
Real estate and rental and leasing	$164,023,042	$11,797,734	386
Professional, scientific, and technical services	$69,794,756	$33,452,193	595
Management of companies and enterprises	$8,364,897	$4,064,987	75
Administrative and waste management services	$61,469,677	$26,643,401	1,193
Educational services	$13,076,633	$5,882,371	254
Health care and social assistance	$768,612,612	$339,574,576	8,416
Arts, entertainment, and recreation	$7,269,537	$2,961,663	174
Accommodation and food services	$41,617,623	$16,014,596	1,111
Other services	$39,860,913	$12,951,303	547
Total	**$1,704,945,605**	**$585,638,339**	**16,138**

The steps used to develop these estimates are described in great detail below.

Detailed Economic Impact Methodology

The following methodology is used to estimate the total economic impact for individual communities and Texas as a whole of declining levels of employer-based health insurance.

Step 1: *Identify health insurance coverage percentages by firm size*.

National data on the percentage of employees with health insurance through their employer by firm size was crossed with more aggregate Texas-specific data to create estimates of the percentage of workers (and their dependents) in different sizes of small firms who receive health insurance coverage from their employers. The following table provides the results.

Table 14. Percent of Employees Receiving Health Insurance Coverage From Their Employer in Their Own Name or as a Dependent by Firm Size - 2007

	All	Employer	Insurance in Employee's Name	Dependent Insurance
All Workers	100%	70.2%	52.8%	17.4%
All Private Sector	100%	69.8%	52.7%	17.2%
under 10	100%	**41.5%**	*22.4%*	*19.1%*
10 to 24	100%	**50.4%**	*31.8%*	*18.6%*
25 to 99	100%	**58.9%**	*43.5%*	*15.4%*

Source: Employee Benefits Research Institute, TXP

Step 2: *Estimate the universe of potential participating firms and employees based on existing employment profiles by size of firm for each community participating in the 3-share program.*

County-level data was extracted from "County Business Patterns," data set maintained by TXP. Tarrant County data is provided in the table below as an example. Tarrant County is currently not one of the TexHealth 3-Share communities.

Table 15. Tarrant County Employment Profile by Firm Size - 2007

Firm Size (Number of Employees)	1 to 4	5 to 9	10 to 19	20-49
Number of Firms	18,205	6,939	4,946	3,756
Total Number of Employees	36,410	48,573	69,244	112,680

Source: County Business Patterns, TXP

Step 3: *Combine the data from Steps 1 and 2 to create initial estimates of the universe of potential participants if health coverage were expanded without constraints on the availability of the 3rd share and all the employers and employees wanting to enroll had the resources to do so*.

Tarrant County data is provided in the table below showing the potential number of employees by firm size that could be covered by a 3-Share plan with those who would get the coverage in their own names split from dependents that would be covered under the plan.

Tarrant County data is provided in the table below as an example.

Table 16. Tarrant County Potential Universe of Employees to be Covered

Firm Size (Number of Employees)	Total	Own Name	Dependent
under 10	49,731	26,892	22,839
10 to 24	34,350	21,692	12,658
25 to 99	46,296	34,180	12,115
TOTALS	**130,377**	**82,765**	**47,612**

Source: TXP

Step 4: *Reduce the universe of potential participants from every potential employee to a reasonable "market capture" rate*.

This analysis assumes that within the first three years of operation 35 percent of uninsured small businesses in a given area will want to enroll in a 3-Share program and that 75 percent of the employees with an enrolling firm will participate. Thirty-five percent mirrors Muskegon, Michigan's initial enrollment experience and is slightly more conservative that the 43 percent enrollment experienced in Tennessee in its first two years of operation. Muskegon operates one of the longest running 3-Share programs in the country.

When this estimated percentage is run against spreadsheets describing the distribution of small firms, employees and dependents the net finding of this analysis is that approximately one-quarter of the potentially affected small business employee population would enroll in a 3-Share program, if the program could fund the third share for all potential participating employees.

Table 17. Tarrant County Potential Estimated Market Capture

Firm Size (Number of Employees)	Total	Own Name	Dependent
under 10	13,054	7,059	5,995
10 to 24	9,017	5,694	3,323
25 to 99	12,153	8,972	3,180
TOTALS	**34,224**	**21,726**	**12,498**

Source: TXP

Step 5: *Estimate the differences in annual levels of healthcare spending between those who do and do not have health insurance*.

The following section details how these estimates were derived based on a research study on health care spending patterns of the insured and uninsured. The authors calculate increasing health coverage would add approximately 15 percent to the estimated baseline per capita spending by people uninsured any part of the year

Hadley & Holahan 2003 Study

Hadley and Holahan in a 2003 study attempted to quantify the impact health insurance would have on patterns of medical spending by the currently uninsured. Their analysis estimated the cost of increased medical care used by the uninsured under two alternative assumptions: The newly insured's spending would be similar to that of either lower- or middle-income people covered by (1) the "average" private health insurance policy, or (2) the "average" public insurance policy (primarily Medicaid and the State Children's Health Insurance Program).[54]

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

- Differences in the effects of each type of insurance coverage on medical spending. Private insurance generally incorporates cost sharing through deductibles, coinsurance and co-payments; offers a range of covered services; and provides access to a broad set of providers under varying payment rates. Public insurance typically incorporates very little patient cost sharing and covers a broad range of services but limits access to a more narrow set of providers who are willing to accept lower payment rates.

- Differences in the characteristics of the uninsured relative to people with full-year private or public insurance. There are likely differences in care-seeking behavior attributable to socio-demographic differences between the uninsured and the insured populations.[55]

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

The end result of the study is that the authors estimate that increasing health insurance would add approximately 15 percent to the estimate of baseline per capita spending by people uninsured any part of the year.[56]

Appendix A. Other States and Local 3-Share Programs

State Premium Subsidy Programs

New Mexico	
Name of Program	New Mexico State Coverage Initiative – A HIFA Waiver Program.[57]
Date of Implementation	July 2005
Authorizing Legislation	None. The program is an initiative of Governor Bill Richardson and is being implemented by the New Mexico Human Services Department.
Regulated insurance product?	Yes. Participants chose from three commercial carriers offering Medicaid managed care coverage.
Current Enrollment	September 2008: ▪ 35,000 lives[58] ▪ 700 small businesses ▪ Enrollment approaching capacity as of 9/30/08. New enrollment is currently being managed through a registration process.[59]
Enrollment Target	40,000 lives by 2010[60]
Potential Enrollees	Unknown
Eligibility for Employers	Must have fewer than 50 employees.
Eligibility for Employees	Must be between the ages of 19 and 64 and at or below 200 percent of the FPL.
Eligibility for others	Individuals and the self-employed must pay both employer and employee share of the premium, though out of pocket payments are not to exceed 5 percent of an enrollee's family annual income.
Premium Shares	▪ Employer: pays $75 ▪ Employee: pays $0-$35 ▪ Individual enrollees: $75 + $0-$35 ▪ State: pays the balance using unspent SCHIP funds and state funds[61]
Funding Mechanism	The program is made possible by a HIFA waiver, which was approved in 2002. In addition to employer and employee premium contributions, unspent federal SCHIP funds and state funds are used. The State Coverage Initiative has received a Robert Wood Johnson grant to survey employers.
Services Provided	The state contracts with managed care organizations to offer a unique model of a subsidized commercial product. Comprehensive benefits with an annual benefit limit of $100,000 per enrollee include: primary and specialty care; inpatient and outpatient hospitalization; prescription drugs; lab; x-ray; physical, occupational and speech therapy; and behavioral health and substance abuse services.
Exclusions or Limitations	Employers must not have dropped commercial insurance in the previous 12 months. Individuals seeking coverage must not have dropped coverage in the previous six months. Benefits not included are vision, dental, hearing aids, long-term nursing services, pulmonary rehabilitation, non-emergency transportation and hospice care.
Obstacles to Expansion	The HIFA waiver is a demonstration project which will expire in 2010.
Outcome data	The program director reports that since implementation of the program, there has been an 11.4% decrease in uninsurance in New Mexico.[62]
Looking Ahead	

Maine	
Name of Program	DirigoChoice
Date of Implementation	2005
Authorizing Legislation	Legislative Document 1611/House Paper 1187
Regulated insurance product?	No. The state works with private insurers to voluntarily keep costs down.[63]
Current Enrollment	2008 ▪ 23,000 lives (of these, 48% are small business employees, 30% are sole proprietors, and 22% are individuals) ▪ 725 small businesses
Enrollment Target	189,500 lives at the end of 5 years (2009)[64]
Potential Enrollees	Program officials did not respond to our emails and phone calls regarding this question. This data was not uncovered in our research.
Eligibility for Employers	Must employ at least 2 but not more than 50 eligible employees. The majority of employees must be employed in the state.
Eligibility for Employees	Must work at least 20 hours per week (not including temporary or substitute work). While any employee of an eligible business can enroll, premium subsidies are only available to those at 300% of FPL and below. A worker who is employed in a DirigoChoice-eligible business that is not offering DirigoChoice coverage may be eligible for the program.
Eligibility for others	Sole proprietors who work and reside in Maine are eligible as are unemployed persons who reside in the state.
Premium Shares	▪ Divided among employer (60%), employee (sliding scale based on income), and the state ▪ Total average cost is $300/month ▪ Subsidies available to employees at 300% FPL and below o Monthly premium for workers below 200% FPL:$24-$48 o Monthly premium for workers between 200% and 300% FPL:$72-$96
Funding Mechanism	The state subsidizes premiums for low-income workers and qualifying unemployed persons through creation of a new health insurance product.
Services Provided	Comprehensive coverage plan with deductibles ranging from $500-$1,750
Exclusions or Limitations	
Obstacles to Expansion	As of September 2008, enrollment is frozen due to lack of funds.[65] Criticisms of the program include low enrollment, high costs and little effect on the number of uninsured.[66] One architect of the program charges that a central problem is a missed opportunity to secure new federal matching funds.[67]
Outcome data	▪ 36% of DirigoChoice members where uninsured prior to enrolling.[68] ▪ 43% of small employers enrolled were uninsured prior to enrolling.[69] ▪ In 2006, the program experienced a 93% monthly persistency rate, meaning that 93% of members eligible to renew did so.
Looking Ahead	In 2008, Governor Baldacci signed into law changes in the programs' funding mechanism, including new sales taxes on beer, soda, wine, and a surcharge on insurers. Some say this new mechanism will provide more stable funding for the program, but it is already a target for repeal. Other changes to the program in 2008 are the governor's effort to lower individual premiums through a reinsurance mechanism and the passage of legislation to allow DirigoChoice to be self-administered.[70]

Tennessee		
Name of Program	CoverTN	
Date of Implementation	April 2007	
Authorizing Legislation	Tennessee Code Annotated 56-7-3001 et. seq.	
Regulated insurance product?	Yes.	
Current Enrollment[71]	September 2008: ▪ 15,383 lives ▪ 6,379 employers	
Enrollment Target	31,500 by June 30, 2009[72]	
Potential Enrollees	34,000 lives[73]	
Eligibility for Employers	▪ Must be located in Tennessee ▪ 50 or fewer full-time equivalent employees ▪ 50% of employees earn $43,000 or less ▪ Business offers plan to all employees ▪ Business has not offered employee-sponsored insurance for six months or if offered, employer has not paid 50% or more of employee premiums	
Eligibility for Employees	▪ U.S. Citizen or qualified legal alien ▪ 19-years-old or older ▪ Works at least 20 hours per week, on average ▪ Did not drop health insurance in the previous 6 months ▪ Must be at or below 250% of the FPL	
Eligibility for others	Self-employed: ▪ Must live in Tennessee (6 months) ▪ U.S. Citizen or qualified legal alien ▪ 19-years-old or older ▪ Works at least 20 hours per week, on average ▪ Earns $43,000 or less a year ▪ Did not drop health insurance in the last 6 months	Employees of non-participating employers: ▪ Employer cannot offer employer-sponsored health insurance or CoverTN ▪ Must live in Tennessee (at least 6 months) ▪ U.S. Citizen or qualified legal alien ▪ 19-years-old or older ▪ Works at least 20 hours per week, on average ▪ Earns $43,000 or less a year ▪ Did not drop health insurance in the last 6 months Spouses of participating employees may also be eligible.
Premium Shares	The state, employers and employees agree to each pay 1/3 of the monthly premium. Employees at non-participating employers and self-employed individuals must pay 2/3 of their premiums. Monthly premium shares range from $37 to $109 and depend on the age of the enrollee and whether the eligible person uses tobacco use and is at a healthy weight.	
Funding Mechanism	The source of state funds is unknown. We have requested this information from state officials.	
Services Provided	The state contracts with two carriers to offer two plans that include doctor visits, emergency care, inpatient and outpatient care, prescription drugs, outpatient care and limited durable medical equipment. The benefits are portable. Enrollees can stay in the program as long as they pay their share of the deductible, regardless of where they are employed. There are no deductibles and there is no catastrophic coverage.	
Exclusions or Limitations	There is a 12 month waiting period for benefits for pre-existing conditions.	
Obstacles to Expansion	None were identified.	

Tennessee	
Outcome data	There is no outcome data available.[74]
Looking Ahead	Cover TN is expanding. Last year the program was re-designed amid budget cuts. Enrollment has been slow to grow since implementation, though it has picked up in recent months.[75] Recently, coverage was expanded to Tennesseans who are between jobs.[76]

Oklahoma	
Name of Program	Insure Oklahoma: Employee Sponsored Insurance – A HIFA Waiver Program[77]
Date of Implementation	November 2005
Authorizing Legislation	Senate Bill 1546
Regulated insurance product?	Yes. The coverage is a Medicaid product offered through twenty different carriers.
Current Enrollment[78]	September 2008: ▪ 9,923 lives ▪ 3,270 employers
Enrollment Target	The program's capacity is set at 25,000 lives.[79]
Potential Enrollees	Unknown.
Eligibility for Employers	Employers with 25 or fewer employees are eligible.
Eligibility for Employees	Covers those up to 200% of FPL.
Eligibility for others	Spouses of employees receive a reduced subsidy for their premiums.
Premium Shares	▪ Employer: pays at least 25% of premium ▪ Employee: pays lesser of 15% of premium or 3% of gross income ▪ State pays balance of premium (about 60%); 85% of spouses' premium
Funding Mechanism	This is a HIFA Waiver program approved in 2005. The program is a state-sponsored health plan operated under the state Medicaid program. The state portion of the premium is funded through increased taxes on tobacco products and Medicaid matching dollars.
Services Provided	Benefits are dependent upon provider selected by employer group or individual enrollee. All plans must cover doctor care, pharmacy services, hospitalization, x-ray, lab, and hospital. The maximum out of pocket total is $3,000, the maximum co-pay is $50 and the maximum pharmacy annual deductible is $500. There are currently 20 different carriers offering 244 different plans.
Exclusions or Limitations	See above.
Obstacles to Expansion	None were identified.
Outcome data	There is no outcome data available to date.[80]
Looking Ahead	

Arkansas	
Name of Program	ARHealthNetworks or Arkansas Safety Net Benefit Program – A HIFA Waiver Program[81]
Date of Implementation	2006
Authorizing Legislation	Initiated Act 1 of 2000: The Tobacco Settlement Proceeds Act
Regulated insurance product?	No.
Current Enrollment[82]	October 2008: ▪ 4,199 lives ▪ 1,081 employers
Enrollment Target	Program officials state that no targets are set.[83] The program does not have enrollment caps.
Potential Enrollees	State officials estimate that more than 70% of small businesses do not offer health insurance and that nearly 400,000 adults in Arkansas are uninsured.[84]
Eligibility for Employers	Must have 2 to 500 employees. If a qualifying business chooses to participate, all employees that are under 200% FPL must participate unless they provide evidence of other individual or group coverage.
Eligibility for Employees	Must be at or below 200% of the FPL. There are two populations in the program: Adults with children and single adults.
Eligibility for others	Benefits are not available for unemployed individuals or individuals who are employed by a non-participating employer, but spouses of participating employees may be eligible.
Premium Shares	Adults with children: 81% Title XXI (SCHIP funds), 9.5% State tobacco funds, and the employer and employee split the remaining 9.5% Single Adults: 73% Title XIX (Medicaid funds), 13.5% State tobacco funds, and the employer and employee split the remaining 13.5%[85]
Funding Mechanism	This program is under a HIFA waiver, approved in 2006. The program operates like a Medicaid fee-for-service program with two funding streams to cover two separate populations: adults with children and single adults.
Services Provided	Coverage is administered through Novasys, the third party administrator. The plan is a limited benefit health plan.
Exclusions or Limitations	Employers must not have offered group coverage in the last 12 months.
Obstacles to Expansion	None were identified.
Outcome data	Program officials were unable to provide us with outcome data.[86]
Looking Ahead	The HIFA waiver will expire in 2011. State officials say if the program is successful, they will apply for a renewal.

Maryland[87]	
Name of Program	Maryland Health Insurance Partnership
Date of Implementation	October 2008
Authorizing Legislation	Working Families and Small Business Health Coverage Act of 2007, Senate Bill 6 (special session)
Regulated insurance product?	Yes. A copy of the Partnership regulations (COMAR 10.25.01) can be found at http://www.dsd.state.md.us
Current Enrollment	Enrollment began in September 2008.
Enrollment Target	10,000 lives within 1,500 businesses in its first year[88]
Potential Enrollees	Unknown
Eligibility for Employers	▪ The business must employ at least 2 and no more than 9 full-time employees both at the time of initial application and on at least 50% of its working days during the past calendar quarter. o Any individual who is not a temporary, seasonal, or substitute employee and works 30 hours or more per week count as full-time employees. o Owners and partners working more than 30 hours per week at the business count as full-time employees. ▪ The average wage of the full-time employees is below $50,000. ▪ The employer must establish a Section 125 plan within 60 days of enrollment in the Health Insurance Partnership Program.
Eligibility for Employees	Any full-time employee who obtains health insurance through an eligible small employer's plan may receive a subsidy toward the cost of employee-only coverage. A full-time employee seeking an additional subsidy for dependent coverage (spouse and/or children) must have a family income of less than $75,000.
Eligibility for others	Coverage can be extended to spouses and dependents.
Premium Shares	The State gives a premium subsidy to be divided between the employer and employee. How the subsidy is split is based on the contribution each makes toward the cost of coverage. The employer will determine the employer contribution to the employees' premium. If the health plan includes a Health Savings Account, the employer also determines the amount of the employer contribution. The subsidy per employee depends on the health insurance coverage chosen and the average annual wage for the business. The premium subsidy is up to 50% of the premium for each participating employee. Annual subsidies range from $77 for a single employee whose annual wage is $49,001-$50,000 to $5,000 for an employee + family whose salary is less than $25,000. http://mhcc.maryland.gov/partnership/SubsidyTable.aspx
Funding Mechanism	The public portion of the program comes from general funds and the Health Coverage Fund within the state budget. Spending cap is $15 million.[89]
Services Provided	The Partnership's participating carriers offer a "standard, comprehensive set of covered services." Plan choices include PPO and HMO plans.
Exclusions or Limitations	▪ The business has not offered insurance to its employees in the most recent 12 months. ▪ Part-time, temporary, and seasonal employees do not qualify for a subsidy.
Obstacles to Expansion	None were identified.
Outcome data	Outcome data will be reported by January 1, 2009 and annually thereafter at http://mhcc.maryland.gov/partnership
Looking Ahead	

Another Statewide Model for Providing Low Cost Insurance to Employers: New York

We have included information on the New York program because of its size and success. The employer and employee share the cost of the premium, but the costs are kept low because the state pays 90 percent of the claims between $5,000 and $75,000.

New York	
Name of Program	Healthy NY
Date of Implementation	January 2001
Authorizing Legislation	Health Care Reform Act of 2000
Regulated insurance product?	Yes. The state requires all commercial plans to offer the Healthy NY option.
Current Enrollment	October 2007: ▪ Nearly 150,000 lives ▪ Of these, 53% are individuals, 16% are sole proprietors, and 31% are small businesses[90].
Enrollment Target	We were unable to identify any current enrollment targets.
Potential Enrollees	Program officials report that this information is not available. [91]
Eligibility for Employers	▪ Must have fewer than 50 employees ▪ Must be located in New York state ▪ Must be willing to contribute at least 50% of the individual premium for its employees ▪ 30% of workers must earn less than $36,500 annually ▪ Must certify that 50% of eligible employees will participate or already have health coverage through a spouse or another government program, and at least one participant earns at least $36,500 per year.
Eligibility for Employees	Employees must have been uninsured for at least 12 months prior to enrollment must be at or below 250% of the FPL.
Eligibility for others	Sole proprietors and individuals whose employers do not offer health insurance coverage must have been uninsured or have lost insurance in the 12 months prior to enrollment and must be at or below 250% of the FPL. They must also be New York state residents and must currently be employed or have been employed within the previous 12 months. Sole proprietors and individuals must not be eligible for Medicaid to be eligible for Healthy NY. Dependents and spouses of enrollees, as well as part-time workers may also be eligible for coverage, but are not entitled to an employer contribution to their premiums.
Premium Shares	▪ Total premium cost varies from $186-$288/month: employers are required to pay at least 50% of the individual premium but can pay more ▪ State reimburses health plans for 90% of their claims between $5,000 and $75,000 on behalf of member
Funding Mechanism	This program is a reinsurance program wherein the state makes “stop-loss” reimbursement payments to health plans that cover 90 percent of all claims between $5,000 and $75,000 per enrollee. Total stop-loss reimbursements from the state to the health plans for 2006 were just over

New York	
	$92 million.[92]
Services Provided	17 health plans are offered. Comprehensive coverage is offered: inpatient, outpatient, preventative health, lab and radiology, maternity, and emergency room.
Exclusions or Limitations	▪ Employers must not have provided health insurance coverage to workers in the last 12 months. ▪ Some pre-existing conditions are excluded and subject to a 12 month waiting period ▪ Mental health, dental, vision, prescriptions, alcohol and substance abuse treatment, chiropractic services, hospice care, ambulance services and durable medical equipment are excluded.
Obstacles to Expansion	Premium increases are a concern for participating employers.[93]
Outcome data	▪ Without Healthy NY, the percentage of uninsured New Yorkers would increase nearly one full percentage point to 14.3 percent.[94] ▪ For the third consecutive year, participating employers report that the availability of Healthy NY has had a positive impact on their business and attribute this positive impact to increased morale and retention. (91% of participating employers responded this way in 2007.)[95]
Looking Ahead	

Local Three-Share Programs

Winnebago County, IL	
Name of Program	Health Access Plan
Date of Implementation	July 2003
Authorizing Legislation	Unknown
Regulated insurance product?	No. The plan is not an HMO or a traditional insurance product.
Current Enrollment[96]	300 lives
Enrollment Target	5000 lives in 500 Winnebago County businesses.[97]
Potential Enrollees	Enrollment is linked to available subsidy funding.
Eligibility for Employers	▪ Employers with 3 to 25 employees in Winnebago County ▪ Employers must not have offered insurance to employees in the previous six months ▪ Median wage of employees must be $12/hr or less
Eligibility for Employees	Must be a full or part time employee at an eligible business and must not have or be eligible for other health insurance.
Eligibility for others	Dependent coverage is available.
Premium Shares	The cost of coverage, $150 per month, is to be split into three equal shares among the employee, the employer, and the community. The community match is comprised of federal funds and local government, community, and foundation funds.
Funding Mechanism	The program has received support from a Community Access Program Grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, awarded in September, 2001.
Services Provided	The plan provides “modest health coverage” toward physician services, ER visits, inpatient hospital services, surgical services, intensive care, skilled nursing services, in-patient mental health care, wellness care, prescription drugs, diagnostic lab and x-ray.
Exclusions or Limitations	The program does cover services received outside of Winnebago County. Seasonal and temporary workers cannot receive benefits. Individuals are not excluded because of pre-existing conditions.
Obstacles to Expansion	
Outcome data	
Looking Ahead	

Wayne County, MI		
Name of Program	Wayne County Health Choice	
Date of Implementation	1994	
Authorizing Legislation	Municipal Health Facilities Act of 1987	
Regulated insurance product?	No. The program is able to maintain low premiums that are not necessarily based on the market value.	
Current Enrollment[98]	End of September 2008: ▪ 4,453 ▪ 900+ employers	
Enrollment Target	5,000 members	
Potential Enrollees	Program officials estimate that the potential is into the thousands. The county has between 250,000-350,000 uninsured or underinsured (could include Medicaid and those who are working). In the current budget, they could enroll as many as 7,000.	
Eligibility for Employers	Business must be located in Wayne County, have at least two employees working 20 hours a week or more and have more than half their employees earning $14.50 or less, and may not have provided health benefits in the previous 3 months.	
Eligibility for Employees	An employee can work in Wayne County but live outside the county, but will not be eligible for a subsidy. If an employee makes over $14.50/hour and is eligible for the plan, they will not get a subsidy.	
Eligibility for others		
Premium Shares	▪ $58/employer ▪ $58/employee ▪ $67/Wayne County HealthChoice subsidy ▪ Premium is determined by the hourly wage	
Funding Mechanism	The subsidy is funded through an adult benefit waiver which is the result of a unique relationship between the state and federal government. Wayne County matches state funds to pay into the subsidy.[99]	
Services Provided	Basic Medical: ▪ Physician services ▪ Home health care ▪ Inpatient hospital services ▪ Outpatient services ▪ Emergency health services ▪ Out-of-area emergency health services ▪ Diagnostic lab and x-rays ▪ Prescription drugs	▪ Supplemental “rider” benefits: ▪ Outpatient physical therapy ▪ Durable medical equipment ▪ Vision exams and glasses ▪ Dental care ▪ Substance abuse treatment ▪ Additional inpatient hospital days
Exclusions or Limitations		
Obstacles to Expansion	Lack of marketing funds has limited enrollment.	
Outcome data	Program officials say the program is attracting small businesses to Wayne County. HealthChoice rates have not been raised for the last three years, while private sector rates have increased every year.	
Looking Ahead		

Muskegon, MI	
Name of Program	Access Health
Date of Implementation	1999
Authorizing Legislation	State Law 260 and Act 230 – the Municipal Health Facilities Corporations Act
Regulated insurance product?	No.
Current Enrollment[100]	▪ over 1200 lives ▪ 400 employers
Enrollment Target	Unknown
Potential Enrollees	1300 lives[101]
Eligibility for Employers	▪ Businesses must located in the county ▪ Median worker wage $12.00/hour or below ▪ Employer must have gone previous 12 months without offering coverage ▪ The business must offer coverage to all uninsured permanent employees who work and are paid for an average of 15.5 hours or more per week for the most recent 13 calendar weeks. ▪ The employer must pay at least 50% of the monthly cost of the Access Health program, including dependents if coverage is extended to dependents.
Eligibility for Employees	▪ Be permanent employee to whom the employer issues a W-2Have been continuously and actively employed as a permanent employee for at least 13 weeks before the effective date of his/her application for the Access Health plan. ▪ Must be ineligible for any type of federal, state or business-sponsored ongoing health insurance, health benefit plan or program of health benefits, including but not limited to Medicare, Medicaid, Healthy Kids/MIChild, Veterans Benefits, Indian Health Services or any ongoing employer or association sponsored health benefit program.
Eligibility for others	Dependents of enrollees may be eligible.
Premium Shares	Employee: $46 Employer: $46 Community: $56
Funding Mechanism	A contract with the local hospital system makes up the community portion of the funding for the program.[102]
Services Provided	The program offers comprehensive coverage, including inpatient, outpatient, prescription drugs, and home health.
Exclusions or Limitations	▪ The plan does not cover services outside the county. ▪ No coverage is offered for independent contractors, temporary workers, or seasonal workers or retirees. ▪ Members may not cancel coverage to enroll on the Access Health Plan.
Obstacles to Expansion	Program officials point to the poor state of the Michigan economy.[103]
Outcome data	The program is reported to have saved tax dollars by moving low-income workers out of Medicaid and other safety net programs, expanded health insurance coverage, achieved better health status for the local population, reduced personal bankruptcy, and strengthened the local small business market.[104]
Looking Ahead	

Appendix B. Detailed Economic Impact Result by Community/ Region

CENTRAL TEXAS	Output	Earnings	Employment
Agriculture, forestry, fishing, and hunting	$923,744	$129,052	12
Mining	$710,259	$132,055	1
Utilities	$2,246,358	$408,683	5
Construction	$645,882	$239,890	7
Manufacturing	$12,036,178	$1,926,584	44
Wholesale trade	$4,170,683	$1,325,097	24
Retail trade	$5,583,009	$1,881,253	80
Transportation and warehousing*	$3,865,583	$1,342,373	34
Information	$3,959,606	$1,023,432	20
Finance and insurance	$7,484,764	$1,965,285	39
Real estate and rental and leasing	$12,861,558	$925,097	30
Professional, scientific, and technical services	$5,472,824	$2,623,091	47
Management of companies and enterprises	$655,918	$318,748	6
Administrative and waste management services	$4,820,029	$2,089,192	94
Educational services	$1,025,380	$461,255	20
Health care and social assistance	$60,269,311	$26,627,101	660
Arts, entertainment, and recreation	$570,027	$232,233	14
Accommodation and food services	$3,263,368	$1,255,754	87
Other services	$3,125,618	$1,015,552	43
Total	$133,690,099	$45,921,727	1,265

DALLAS COUNTY	Output	Earnings	Employment
Agriculture, forestry, fishing, and hunting	$1,475,883	$206,188	19
Mining	$1,134,794	$210,986	2
Utilities	$3,589,049	$652,960	8
Construction	$1,031,938	$383,277	11
Manufacturing	$19,230,429	$3,078,140	70
Wholesale trade	$6,663,578	$2,117,133	39
Retail trade	$8,920,078	$3,005,713	127
Transportation and warehousing*	$6,176,115	$2,144,735	55
Information	$6,326,337	$1,635,156	32
Finance and insurance	$11,958,548	$3,139,973	62
Real estate and rental and leasing	$20,549,153	$1,478,045	48
Professional, scientific, and technical services	$8,744,034	$4,190,961	75
Management of companies and enterprises	$1,047,972	$509,270	9
Administrative and waste management services	$7,701,051	$3,337,942	149
Educational services	$1,638,268	$736,956	32
Health care and social assistance	$96,293,411	$42,542,620	1,054
Arts, entertainment, and recreation	$910,743	$371,043	22
Accommodation and food services	$5,213,944	$2,006,342	139
Other services	$4,993,859	$1,622,567	68
Total	$213,599,186	$73,370,008	2,022

El PASO COUNTY	Output	Earnings	Employment
Agriculture, forestry, fishing, and hunting	$303,660	$42,423	4
Mining	$233,482	$43,410	0
Utilities	$738,440	$134,345	2
Construction	$212,319	$78,858	2
Manufacturing	$3,956,623	$633,321	14
Wholesale trade	$1,371,018	$435,596	8
Retail trade	$1,835,289	$618,420	26
Transportation and warehousing*	$1,270,724	$441,275	11
Information	$1,301,632	$336,430	7
Finance and insurance	$2,460,448	$646,043	13
Real estate and rental and leasing	$4,227,948	$304,105	10
Professional, scientific, and technical services	$1,799,068	$862,282	15
Management of companies and enterprises	$215,618	$104,781	2
Administrative and waste management services	$1,584,476	$686,775	31
Educational services	$337,070	$151,627	7
Health care and social assistance	$19,812,182	$8,753,061	217
Arts, entertainment, and recreation	$187,384	$76,341	4
Accommodation and food services	$1,072,759	$412,801	29
Other services	$1,027,477	$333,840	14
Total	**$43,947,616**	**$15,095,736**	**416**

GALVESTON COUNTY	Output	Earnings	Employment
Agriculture, forestry, fishing, and hunting	$114,444	$15,988	1
Mining	$87,995	$16,360	0
Utilities	$278,304	$50,632	1
Construction	$80,019	$29,720	1
Manufacturing	$1,491,177	$238,687	5
Wholesale trade	$516,711	$164,168	3
Retail trade	$691,686	$233,071	10
Transportation and warehousing*	$478,912	$166,308	4
Information	$490,561	$126,794	2
Finance and insurance	$927,297	$243,482	5
Real estate and rental and leasing	$1,593,434	$114,611	4
Professional, scientific, and technical services	$678,035	$324,978	6
Management of companies and enterprises	$81,262	$39,490	1
Administrative and waste management services	$597,159	$258,833	12
Educational services	$127,036	$57,145	2
Health care and social assistance	$7,466,840	$3,298,865	82
Arts, entertainment, and recreation	$70,621	$28,772	2
Accommodation and food services	$404,303	$155,577	11
Other services	$387,237	$125,818	5
Total	$16,563,033	$5,689,300	157

HARRIS COUNTY	Output	Earnings	Employment
Agriculture, forestry, fishing, and hunting	$2,067,574	$288,850	26
Mining	$1,589,740	$295,572	3
Utilities	$5,027,920	$914,736	11

Construction	$1,445,648	$536,935	15
Manufacturing	$26,940,023	$4,312,185	98
Wholesale trade	$9,335,047	$2,965,904	55
Retail trade	$12,496,191	$4,210,721	178
Transportation and warehousing*	$8,652,156	$3,004,573	77
Information	$8,862,604	$2,290,700	44
Finance and insurance	$16,752,802	$4,398,806	87
Real estate and rental and leasing	$28,787,432	$2,070,602	68
Professional, scientific, and technical services	$12,249,570	$5,871,143	104
Management of companies and enterprises	$1,468,110	$713,440	13
Administrative and waste management services	$10,788,448	$4,676,142	209
Educational services	$2,295,060	$1,032,406	45
Health care and social assistance	$134,898,018	$59,598,212	1,477
Arts, entertainment, and recreation	$1,275,865	$519,797	31
Accommodation and food services	$7,304,245	$2,810,697	195
Other services	$6,995,928	$2,273,063	96
Total	**$299,232,382**	**$102,784,485**	**2,832**

TARRANT COUNTY	**Output**	**Earnings**	**Employment**
Agriculture, forestry, fishing, and hunting	$2,067,574	$288,850	26
Mining	$1,589,740	$295,572	3
Utilities	$5,027,920	$914,736	11
Construction	$1,445,648	$536,935	15
Manufacturing	$26,940,023	$4,312,185	98
Wholesale trade	$9,335,047	$2,965,904	55
Retail trade	$12,496,191	$4,210,721	178
Transportation and warehousing*	$8,652,156	$3,004,573	77
Information	$8,862,604	$2,290,700	44
Finance and insurance	$16,752,802	$4,398,806	87
Real estate and rental and leasing	$28,787,432	$2,070,602	68
Professional, scientific, and technical services	$12,249,570	$5,871,143	104
Management of companies and enterprises	$1,468,110	$713,440	13
Administrative and waste management services	$10,788,448	$4,676,142	209
Educational services	$2,295,060	$1,032,406	45
Health care and social assistance	$134,898,018	$59,598,212	1,477
Arts, entertainment, and recreation	$1,275,865	$519,797	31
Accommodation and food services	$7,304,245	$2,810,697	195
Other services	$6,995,928	$2,273,063	96
Total	**$299,232,382**	**$102,784,485**	**2,832**

1 Community Health Ventures: An Overview of Community Sponsored Multi-Share Health Coverage Initiatives Modeled on Access Health of Muskegon, Muskegon, Michigan, 2006 and Muskegon Community Health Project: An Overview of Community Sponsored Multi-Share Health Coverage Initiatives Modeled on Access Health of Muskegon

2 Note: Brazos Valley is not profiled in this report because they joined TexHealth after the study had been initiated.

3 Note: For a review of non-3-Share premium subsidy programs see, Report on Senate Bill 10, Section 31 Eightieth Legislature, Regular Session, 2007: A Study of Health Insurance Premium Assistance Options for Uninsured Texans, the Texas Department of Insurance and the Texas Health and Human Services Commission, published November 2008

4 Institute of Medicine of the National Academies of Sciences, Hidden Costs, Value Lost: Uninsurance in America, 2003, p.4. http://www.iom.edu/CMS/3809/4660/12313.aspx (Last visited November 22, 2008)

5 Jack Hadley and John Holahan, Covering the Uninsured: How Much Would It Cost," Health Affairs, June 2003. http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.250v1/DC1

6 Ibid., p.5. http://www.nap.edu/cataglog/10719.html (Last visited November 15, 2006)

7 Karen Davis, Sara R. Collins, ,Michelle M. Doty, Alice., Ho, , and Alyssa L. Holmgren, Alyssa L. (2005, August). Health and Productivity Among U.S. Workers. The Commonwealth Fund http://www.illinoiscovered.com/assets/cover_865_davis_hlt_productivity_usworkers.pdf (Last visited November 22, 2008).

8 Arindrajit Dube, "Productivity Impact of Health Care Reform in California," Institute for Labor and Employment, University of California, Berkley, August 2003, p. 1. http://laborcenter.berkeley.edu/healthcare/productivity_healthcare03.pdf (Last visited November 15,2008)

9 Erick Eckholm, "Health Benefits Found to Deter Switches in Jobs," The New York Times, November 3, 2008. http://query.nytimes.com/gst/fullpage.html?res=9D0CEEDD123BF935A1575AC0A967958260&sec=health&spon=&pagewanted=all (Last visited November 14, 2008)

10 A Vision For Change: Policy Solutions For Addressing Health Coverage In Texas , Texas Health Institute, January 2007

11 *Report on Senate Bill 10, Section 31 Eightieth Legislature, Regular Session, 2007: A Study of Health Insurance Premium Assistance Options for Uninsured Texans*, the Texas Department of Insurance and the Texas Health and Human Services Commission, November 2008

12 Henry J. Kaiser Foundation, "States Moving Towards Comprehensive Health Care Reform- Maine," 6/2/08, http://www.kff.org/uninsured/statehealthreform/me.cfm, accessed 9/12/08

13 Email correspondence with Mari Spaulding-Bynon, Program Director of Insure New Mexico, 9/19/08.

14 E&P Consulting, "2007 Annual Report on HealthyNY," January 2008, p. II-8

15 Ibid, p. I-5

16 Ibid, p. II-23

17 Healthy Texas – Premium Stabilization Fund* A Private/Public Health Insurance Expansion Model, Texas Department of Insurance, October 2008.

18 West Virginia Small Business Plan, http://www.wvsbp.org/backgroundhistory.html, accessed 10/3/08.

19 Healthy Texas Phase I Report, Texas Department of Insurance, November 2008

20 Texas Department of Insurance Small Employer Survey

21 Ann Kitchen, Executive Director Integrated Care Collaboration and Donald Spies, Chief Executive Officer, TexHealth North Texas, December 11, 2008

22 Luna, M.D., Jose, email correspondence, December 1, 2008.

23 Karen Davis, , Sara R. Collins, ,Michelle M. Doty, Alice., Ho, , and Alyssa L. Holmgren, Alyssa L. (2005, August). Health and Productivity Among U.S. Workers. The Commonwealth Fund http://www.illinoiscovered.com/assets/cover_865_davis_hlt_productivity_usworkers.pdf (Last visited November 22, 2008)

24 J. Strauss and D. Thomas, D. (1998). "Health, Nutrition, and Economic Development," Journal of Economic Literature , 36: 766-817.

25 Dean T. Jamison, , “Investing in Health,” Disease Control Priorities in Developing Countries(2nd Edition),ed., 3-36, New York: Oxford University Press., p. 7s. http://files.dcp2.org/pdf/DCP/DCP01.pdf (Last visited November 22, 2008).

26 Marc L. Berger., James F. Murray, Judy Xu, and Mark Pauly, (2001, January). “Alternative Valuations of Work Loss and Productivity.” Journal of Occupational and Environmental Medicine 43:1, p. 5.. http://www.acoem.org/health_right.aspx?id=1340.(Last visited November 21, 2008)

27 Institute of Medicine of the National Academies of Sciences, Hidden Costs, Value Lost: Uninsurance in America, 2003, p. 2. http://www.nap.edu/cataglog/10719.html (Last visited November 15, 2008)

28 Ibid., p.5. http://www.nap.edu/cataglog/10719.html (Last visited November 15, 2006)

29 Ibid., p.4. http://www.nap.edu/cataglog/10719.html (Last visited November 15, 2006)

30 The Henry J. Kaiser Family Foundation ,“The Uninsured: A Primer, Key Facts about Americans without Health Insurance,”, October 2008, p.7 http://www.kff.org/uninsured/upload/y451-04.pdf. (Last visited November 21, 2008)

31 J. Hadley, “Insurance coverage, Medical Care Use, and Short term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition,” JAMA 297 (10):1073-84. http://jama.ama-assn.org/cgi/content/full/297/10/1073 (Last visited November 19,2008)

32 R. Roetzheim et. al., “Effects of health Insurance and Race on colorectal cancer treatments and Outcomes.” American Journal of Public Health, 90(11):1746-54. http://www.ajph.org/cgi/content/abstract/90/11/1746 (Last visited November 19, 2008)

33 D. Baker et al., Lack of Health Insurance and Decline in Overall Health in Late Middle Age,” New England Journal of Medicine, 345(15):1106-12. http://content.nejm.org/cgi/content/abstract/345/15/1106 (Last visited, November 21, 2006)

34 J. Ayanian et. al. “Unmet Health Needs of Uninsured Adults in the United States.” JAMA 284 (16):2061-9.2000. http://jama.ama-assn.org/cgi/content/abstract/284/16/2061 (Last visited November 19, 2008)

35 The Henry J. Kaiser Family Foundation, op. cit., 2008, p. 7..

36 Sherry Glied and Sarah E. Little, “The Uninsured and the Benefits of Medical Progress,” Health Affairs, 22, no. 4, 2003, pp. 210-219 http://content.healthaffairs.org/cgi/content/full/22/4/210?ck=nck (Last visited November 15, 2008)

37 Karen Davis, op. cit. p. e

38 Ibid.

39 Arindrajit Dube, “Productivity Impact of Health Care Reform in California,” Institute for Labor and Employment, University of California, Berkley, August 2003, p. 1. http://laborcenter.berkeley.edu/healthcare/productivity_healthcare03.pdf (Last visited November 15,2008)

40 Ibid.

41 Ibid.

42 Dube, op. cit., p. 3.

43 Karen Davis, op.cit., p. 3.

44 Ibid.

45 Ibid.

46 Erick Eckholm, “Health Benefits Found to Deter Switches in Jobs,” The New York Times, November 3, 2008. http://query.nytimes.com/gst/fullpage.html?res=9D0CEEDD123BF935A1575AC0A967958260&sec=health&spon=&pagewanted=all (Last visited November 14, 2008)

47 Dube, op. cit., p. 4.,

48 Kevin T. Stroupe, Eleanor D. Kinney, and Thomas J. Kniesner, “Chronic Illness and Health Insurance-Related Job Lock,” Center for Policy Research, Maxwell School, Syracuse University, August 2000, p. 1.http://ideas.repec.org/p/max/cprwps/19.html (Last visited November 15,2008)

49 The Texas Comptroller’s Office, The Uninsured: A Hidden Burden on Texas Employers and Communities, April 2005, pp. 10-11. http://www.window.state.tx.us/specialrpt/uninsured05/ (Last visited November 21, 2008)

50 The Henry J. Kaiser Family Foundation ,“The Uninsured: A Primer, Key Facts about Americans without Health Insurance,”, October 2006. http://www.illinoiscovered.com/assets/cover_7451.pdf (Last visited November 17,2008)

51 Institute of Medicine of the National Academies of Sciences, op. cit., pp. 6-7.

52 Institute of Medicine of the National Academies of Sciences, op. cit., p. 7.Institue, p.7

53 Jack Hadley and John Holahan, Covering the Uninsured: How Much Would It Cost," Health Affairs, June 2003. http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.250v1/DC1

54 Ibid., p. 2 http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.250v1/DC1 (Last visited November 21, 2008)

55 Ibid.

56 Hadley, op. cit., p. 5.

57 A Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver is designed to expand insurance coverage within currently available Medicaid and State Children's Health Insurance Program (SCHIP) resources and targets populations below 200 percent FPL. The HIFA program allows states to shift Medicaid money into new public insurance programs.

58 Email Communication with Mari Spaulding-Bynon, Insure New Mexico! Program Director, 9/19/08.

59 Insure New Mexico Site, http://www.insurenewmexico.state.nm.us/SCIHome.htm, accessed 9/30/08.

60 Robert Wood Johnson Foundation, "Medicaid HIFA Waiver Comparison Chart", State Coverage Initiative Site, http://www.statecoverage.net/waivers.htm, accessed 9/18/08.

61 Program officials did not respond to our request for more detailed information on the kind of state funds used and we were unable to find further information regarding the nature of these state funds in our research.

62 Email correspondence with Mari Spaulding-Bynon, Program Director of Insure New Mexico, 9/19/08.

63 In negotiations with the insurer, the Dirigo Health Agency established an experience modification program to share risks with the insurance company in order to keep costs low. This program acts as a reserve to provide funding should Anthem's costs exceed agreed-upon targets. Source: Robert Wood Johnson State Coverage Initiatives: Maine, http://www.statecoverage.net/maineprofile.htm, accessed 10/7/08.

64 Silow-Carroll, Sharon and Tanya Alteras, "Stretching State Health Care Dollars: Building on Employer-Based Coverage", The Commonwealth Fund, October 2004.

65 DirigoChoice Website, http://www.dirigohealth.maine.gov/, accessed 9/29/08.

66 Henry J. Kaiser Family Foundation, "States Moving Toward Comprehensive Health Care Reform - Maine",6/2/08, http://www.kff.org/uninsured/statehealthreform/me.cfm, accessed 9/12/08.

67 Dunne, Tom, "Dirigo: Fix it up or shut it down", Portland Press Herald, 5/9/08.

68 Dirigo Health Agency, DirigoChoice Annual Report 2006, p. 26.

69 Ibid.

70 Henry J. Kaiser Family Foundation, "States Moving Toward Comprehensive Health Care Reform - Maine", 6/2/08, http://www.kff.org/uninsured/statehealthreform/me.cfm, accessed 9/12/08.

71 State of Tennessee, Department of Finance and Administration, "Cover Tennessee Opens New Eligibility Category in Program Expansion": Press Release, 9/12/08.

72 Daniel Connolly, "New CoverTN program expands eligibility", Memphis Commercial Appeal, 1/18/08, http://www.commercialappeal.com/news/2008/jan/18/new-covertn-insurance-program-expands/, accessed 10/2/08.

73 Email communication with Dean Flener, Public Information Officer, Cover TN, 9/30/08.

74 Ibid.

75 "Official: Cover Tennesse enrollment picking up", 6WATE.com, August 31, 2008, http://www.wate.com/global/story.asp?s=8930042&ClientType=Printable, accessed 9/12/08.

76 State of Tennessee, "Cover TN Plans Eligibility Expansion", press release 9/10/08.

77 A Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver is designed to expand insurance coverage within currently available Medicaid and State Children's Health Insurance Program (SCHIP) resources and targets populations below 200 percent FPL. The HIFA program allows states to shift Medicaid money into new public insurance programs.

78 Insure Oklahoma, "Fact Facts: September 2008", 9/10/08.

79 Insure Oklahoma, "Fact Facts: September 2008", 9/10/08.

80 Email communication with Dene Alford of Insure Oklahoma Specialist, 9/25/08.

81 A Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver is designed to expand insurance coverage within currently available Medicaid and State Children's Health Insurance Program (SCHIP) resources and targets populations below 200 percent FPL. The HIFA program allows states to shift Medicaid money into new public insurance programs.

82 Email communication with Dan Adams, Program Director for the Department of Human Services, Division of Medical Services, 9/30/08.

83 Conversation with Dan Adams, Program Director for the Department of Human Services, Division of Medical Services 9/30/08.

84 Email communication with Suzanne McCarthy of the Arkansas Center for Health Improvement, 9/30/08.

85 Arkansas Center for Health Improvement, "ARHealthNetworks Funding Sources", http://www.achi.net/HCFDocs/071001ARHealthNetFundingDiagram.pdf September 2007.

86 Email communication with Dan Adams, Program Director for the Department of Human Services, Division of Medical Services 9/30/08.

87 All of the information for Maryland, except where noted otherwise, is based on a conversation with Janet Ennis, Chief of Small Group Market, Maryland Health Insurance Partnership, 10/2/08.

88 Office of the Governor, "Governor O'Malley Unveils Health Insurance Partnership for Small Business": Press Release, 6/23/08.

89 Ibid.

90 E&P Consulting, "2007 Annual Report on HealthyNY", January 2008, p.II-8.

91 Email communication with Renee Greer, State of New York Department of Insurance, 9/23/08.

92 E&P Consulting, "2007 Annual Report on HealthyNY", January 2008, p.I-5.

93 Ibid, p.V-25.

94 Ibid, p.II-23.

95 Ibid, p.V-25.

96 Rockford Health Council, "Health Access Plan", http://www.rockfordhealth.org/HAP.html, accessed 9/24/08.

97 Health Management Associates, Excerpt from Illinois State Planning Grant RFP, p. 39, 1/30/2003.

98 Conversation with Lorenzo Lopez, Deputy Director, 9/27/08.

99 Ibid. We requested more information on this funding mechanism from program officials but did not receive a response.

100 Conversation with Jeff Fortenbacher, Executive Director of Access Health, 10/6/08.

101 Ibid.

102 Ibid.

103 Ibid.

104 Muskegon Community Health Project, "Access Health", PowerPoint Presentation. http://www.naco.org/Content/ContentGroups/Programs_and_Projects/Health_Care/MuskegonHealthAccessModel.ppt, accessed 9/18/08.