

PROJECT ABSTRACT

Project Title: **Texas State Health Access Program**
Applicant Entity: **Texas Health and Human Services Commission**
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Texas is applying for a comprehensive grant to support the successful implementation of the state's Healthy Texas small employer reinsurance program, and to implement and evaluate a Health Care Cost Sharing Account (CSA) model, both of which are designed to reduce the number of uninsured, employed Texans.

Grant funding will be used to support the Healthy Texas reinsurance program -- a comprehensive statewide program using a state-funded reinsurance pool to lower premiums for small employers by an estimated 33 percent. State legislation passed June 1, 2009, created the program and appropriated revenue for the Healthy Texas reinsurance pool, but additional funds are needed for effective implementation. Grant funds will also be used to fund and test the effectiveness of the complimentary CSA model in increasing take-up and improving appropriate use of primary care for low-income employees within three delivery systems: the Healthy Texas small employer market, the TexHealth Coalition three-share programs in six communities, and a large urban safety net hospital-sponsored HMO's commercial small employer product.

CSAs will provide employees a subsidy to cover either a portion of their insurance premium or a share of their deductibles, co-pays or coinsurance. CSAs will be used in this program to address two key obstacles to small employer take-up rates: high premium costs and employee deductibles. Deductibles, which are standard in most employer sponsored plans as a way to keep employer costs lower, create a barrier to care for low-income individuals who want first-dollar coverage allowing them to seek primary care when they need it. Texas focus groups and interviews indicate that deductibles can also significantly limit employee take-up, even when combined with lower cost employee premiums.

Of Texas' estimated three million uninsured employed, this program will target 398,000 uninsured employed Texans who receive annual wages at or below 300 percent FPL across the state.¹ With current funding, it is expected that an estimated 31,000 to 42,000 uninsured working Texans statewide will be enrolled annually. Further, we believe grant funding will serve as a critical catalyst to precipitate additional investments in coverage for Texans.

The grant design will allow for a full evaluation of both programs. We will evaluate the program's ability to increase small employer insurance take-up and enrollment, increase the number of employed individuals receiving coverage, improve access to appropriate primary care, increase continuity of care, and support a sustainable culture of insurance. Claims, enrollment and medical record data, site visits and surveys will be used to evaluate the achievement of program objectives using process and performance measures detailed in the evaluation plan.

¹ U.S. Census Bureau's CPS data – Texas Sample. HHSC Strategic Decision Support Demography Unit.

PROGRAM NARRATIVE

Introduction

Texas is a huge and diverse state: geographically, it is 25 times the size of Massachusetts and 174 times the size of Rhode Island; it is larger and more diverse than most other *countries* with the largest numerical population growth in our country. Texas' uninsured problem is also immense. With almost six million uninsured individuals -- 25 percent of the population--, Texas leads the nation in percentage of uninsured. Context for the magnitude of Texas' challenge in ensuring access to health coverage and medical homes is provided by the fact that 34 states in our country have total populations that are smaller than Texas' uninsured population.²

There are many reasons for this: premium costs are higher than the national average and ability to pay is lower; salaries are lower and Texans are disproportionately poor (21 percent of Texans have incomes below 100 percent of poverty; 43 percent or *almost half of all Texans* have incomes below 200 percent of poverty). Not surprisingly, fewer small employers offer insurance and affordability and access to insurance loom as significant obstacles. Compared to other states, there is less of a union presence; and 36 percent of the population is Hispanic – a group with a statistically significant lower rate of insurance. Reported hospital uncompensated charges doubled from \$5.5 billion to \$11 billion between 2001 and 2006, helping drive the higher overall premiums with Texas having the fifth highest individual and third-highest family premium costs due to costs of care for the uninsured.

With a long history of effort and focus on issues of the uninsured, including and facilitated in part by HRSA planning and pilot grants to the Texas Department of Insurance, Texas' political environment has reached a tipping point. Major legislation from our 2007 Legislative session and the session ending June 1, 2009, provides bold direction for health reform and increasing access to care, including direction to: seek a major 1115 Medicaid reform waiver fundamentally restructuring the indigent care delivery system and financing system, and making insurance available to uninsured Texas adults;³ create and facilitate three-share coverage programs; strengthen performance-based Medicaid and CHIP contracting and payments; support and expand Texas's innovative use of health information technology⁴ and, in legislation passed June 1st, create the "Healthy Texas" program. This reinsurance program is based on New York's successful Healthy New York reinsurance program and marks a significant state commitment and investment in increasing access to affordable insurance through Texas' small employers market.

The Goals and Objectives

The size and multi-dimensional nature of Texas' challenges requires multi-dimensional

² These states are: Missouri, Maryland, Wisconsin, Minnesota, Colorado, Alabama, South Carolina, Louisiana, Kentucky, Oregon, Oklahoma, Connecticut, Iowa, Mississippi, Arkansas, Kansas, Utah, Nevada, New Mexico, West Virginia, Nebraska, Idaho, Maine, New Hampshire, Hawaii, Rhode Island, Montana, Delaware, South Dakota, Alaska, North Dakota, Vermont, District of Columbia, and Wyoming.

³ Texas submitted an 1115 reform waiver April 16, 2008; negotiations stalled with the change in administration and Texas is now positioning itself for federal reform.

⁴ E.g., in the creation of a medical passport for foster children to ensure portable care coordination and continuity of care.

approaches for addressing the many facets contributing to the uninsured dynamics in Texas.

With HRSA funding, Texas will:

- increase the number of previously uninsured individuals enrolled in health care coverage, covering over 42,000 new Texans in year five of the grant.
- increase utilization of primary and preventive care and decrease use of emergency room care,
- increase small business participation in health care plans,
- reduce the cost of health insurance,
- improve employer and employee satisfaction with their health care plan,
- help to establish sustained participation in their health care plans after grant funding ends.
- increase employee take-up rates and help inculcate a “culture of insurance” for a targeted section of the population (those with some ability to contribute to insurance costs)
- improve the continuity of care in medical homes through periods of uninsurance by partnering with safety net providers.

The Obstacles: Texas’ grant program achieves these objectives by addressing the specific key challenges outlined below.

Affordability

- 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 \$12,947.⁵ HRSA-funded employer and employee focus groups and surveys, most recently an April 2009 survey of small employers conducted by TDI, show that cost is the major obstacle to offering insurance: 71 percent of uninsured firms reported they want to offer insurance but either they or their workers cannot afford the cost. Of employers who do offer coverage, 17 percent indicated the primary reason why eligible employees do not enroll is because they cannot afford their required premium. Most small businesses cannot afford currently available health coverage costs – 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.⁶
- Employers and employees have different objectives for obtaining insurance: *Employers* often seek insurance to protect their assets in case of significant illness. Lower income *employees* seek first dollar coverage to be able to see a physician when they are sick-- not asset protection.

⁵ Healthy Texas Phase I Report, Texas Department of Insurance, November 2008.

⁶ Texas Department of Insurance Small Employer Survey 2001.

- While some low-income individuals will seek care when they need it and pay significant point of service cost-sharing,⁷ they are less likely to pay up front premiums to buy “potential” access to care or protection from risk. Payment preferences associated with “cash culture” favor point of service payments rather than premium payments. This leads to poor take-up rates when premium-based insurance is offered and utilization of overburdened safety net providers, many of whom fail to offer appropriate medical homes.
- In balancing between breadth of benefit package, premium costs, and employee cost-sharing, small employers often choose smaller benefits and higher cost-sharing (including higher deductibles) to make premiums more affordable. With a \$1000 deductible as the most common level in the Texas market, employees are unlikely to take-up coverage when offered because they are unable to afford deductibles when they need care.⁸ Low-income populations seek first dollar coverage and might be unlikely to purchase insurance, or to seek care, when there is a significant deductible. This would happen *even when premiums are subsidized—if there is also a deductible that users must pay as a condition for seeing a provider*. If individuals do enroll in deductible-based insurance products, but then don’t use the services, payments would be made to insurance companies although little care would actually be provided.

Availability and Administrative Effort

- Few affordable options are available to Texas’s small employers that meet both employer and employee needs.
- A significant administrative burden exists on insurers, agents and employees in securing health insurance, in particular for small businesses
- Texas insurers most commonly require a 75 percent participation rate for small employers. That means that even if some employees would buy insurance, unless 75 percent purchase it, no one will have the chance to do so. Low-income employees in businesses are often those who can’t buy insurance. In the same 2009 TDI study referenced above, uninsured firms were asked if they believe they could meet the current private market requirement that at least 75 percent of eligible employees enroll in an insurance plan in order for the employer to purchase coverage. Sixty-five percent of employers responded they could not meet the 75 percent requirement, largely due to the employee’s contribution requirement.

The Plan: With the SHAP grant, Texas will improve access to coverage to the working uninsured by: 1) supporting implementation of the Healthy Texas small employer program for commercial carriers and three-share programs; and 2) implementing Health Care Cost Sharing Accounts (CSAs).

Healthy Texas

Texas will use grant funds to support the implementation of Healthy Texas, a statewide program to make affordable employer-sponsored insurance available by creating a reinsurance pool to pay for a corridor of high enrollee costs. The 2007 Texas Legislature required recommendations for

⁷ Based on indigent care and safety net hospital interviews for our 1115 waiver application and an External Quality Review Organization’s evaluation of the effects of charging CHIP premiums on CHIP enrollment rates.

⁸ We heard this from several different stakeholders, including a representative of the Service Employees International Union (SEIU) invited to discuss benefit development as part of Texas’ 1115 waiver research.

creation of a program, and the 2009 Legislature provided \$17.5 million in annual reinsurance funding, but only \$17,500 for limited administrative, development and outreach funding for Healthy Texas. Grant funds will be used to help pay for these critical functions, as well as to provide CSAs and a small contribution to the reinsurance payments.

Healthy Texas will create a comprehensive, market-based program to assist commercial carriers and three-share programs in providing affordable health care coverage for lower income, working Texans and their families. With the potential to provide insurance to a significant portion of the 5.9 million uninsured Texans, the program serves as an insurance model, creating a new public/private health insurance initiative to provide lower-cost health insurance to uninsured Texans within in the small employer market.

Healthy Texas is modeled after the highly successful Healthy New York program for uninsured individuals and businesses. While there are some distinct differences, the Texas model builds on the experience of New York and focuses on the uninsured small businesses in Texas. The reinsurance model is based on the fact that a small percentage of people account for most health insurance cost. Reducing private insurer's responsibility for high-cost claims allows them to provide lower cost insurance for the large majority of enrollees who have low health care costs. Like New York, enrollees in Healthy Texas will select from a variety of state-approved private market health plans, including three-share programs. From the enrollee's perspective, the health plan will operate like any private market plan. However, for those individuals who have claims costs of at least \$5,000 a year, the state funded Healthy Texas reinsurance program will pay 80 percent of an individual's total claims between \$5,000 and \$75,000 incurred in a calendar year. The health benefit plan covers 100 percent of claims below the \$5,000 threshold and above \$75,000, up to the annual benefit limit. The benefit plan also covers the remaining 20 percent of costs between the \$5,000 and \$75,000 risk corridor.

By providing reinsurance to reduce the insurer's exposure to high cost claims, Healthy Texas allows for a significant reduction (estimated to a one-third reduction) in premium costs for currently uninsured small businesses and their workers. It will also protect insurers and small employers from the small incidence but ruinous impact of catastrophic illness in small employer businesses. Reinsurance addresses the issue of carriers' risk from adverse selection which is often a factor in high premiums. Another benefit of using reinsurance versus a direct premium subsidy is that state funds are spent only when high-cost claims occur.

Healthy Texas increases both the affordability and the availability of insurance as more insurers are willing and able to offer affordable products to small employers. In addition, Healthy Texas minimum participation requirements have been reduced to 60 percent of eligible employees (rather than the current standard of 75 percent), making it easier for employers to obtain the minimum number of employees needed to offer coverage. Healthy Texas allows the state to leverage both public and private funds and minimizes additional administrative costs by building on the existing employer-based health insurance model and by creating an infrastructure compatible with insurance exchange models. In addition, Healthy Texas fosters economic development within the State. The Program will help small employers attract better employees and will enable them to keep workers healthy by providing access to quality health plans at an affordable price.

Healthy Texas will:

- Enable the health insurance market to lower premium costs for certain small employers by creating a state-funded reinsurance system.
- Make reinsurance supported health insurance products available through other publicly supported programs aimed at lowering health insurance premiums, such as three-share programs and any premium assistance programs that may be created through federal reform or other initiatives.
- Provide a comprehensive, sustainable program that creates a unique public/private partnership of insurers, providers, agents, employers, employees, local governments and the state.

Health Care Cost Sharing Accounts

Texas will create, implement and fund Health Care Cost Sharing Accounts (CSAs): a Texas innovation to help address key coverage obstacles. To make it easier for working low-income Texans to buy or pay for health coverage options, the program will fund CSAs. Individuals eligible to participate in the programs must be: working adults eligible for health care coverage through a participating employer, who are uninsured, and receive annual wages at or below 300 percent of the Federal Poverty Level (FPL). CSA accounts will be funded using a five-year glide path of \$900, \$900, \$750, \$500 and \$500.

These “virtual” accounts⁹ will be used, at the employee’s choice at the time of election, to help pay for monthly premiums or point-of service cost-sharing, including deductibles, coinsurance and co-payments. The accounts will be offered to low-income uninsured workers through their employer plans to provide an incentive to offer and purchase health coverage and to make insurance more affordable. Cost sharing accounts will play a significant role in the state’s and health plans’ ability to reach businesses that employ a high percentage of low wage workers.

Participating health plans for this model include the TexHealth Coalition of three-share health plans, Community First Health Plans, a hospital district sponsored commercial insurance plan, and Healthy Texas, discussed above. Participating individuals will be able to choose their own doctors from among a contracted network of providers, and have a medical home to manage their health issues in a more comfortable and less costly setting. All health plans will require participants to choose a primary care provider, and to receive services within their networks. In addition, TexHealth and Community First program members who exceed their annual benefit limit may continue to receive care from the same network of providers. Community First has designed its commercial product using the same network of providers used for its sponsor’s indigent care program CareLink, thus providing continuity of care and extending the medical home concept throughout episodes of uninsurance. TexHealth programs will offer continued services for individuals who may exceed their annual benefit limit by facilitating enrollment with community safety net providers, also extending the medical home concept by helping to facilitate continuity of care through episodes of non-coverage.

⁹ Funds are paid to the contracted health plans or to Healthy Texas. Neither employees, nor employers own or access the funds.

By significantly lowering the employee's premium contribution amount, the CSAs will enable more workers to enroll. By providing an option to use CSAs to help pay for deductibles and point of service cost-sharing, employees are more likely to see value in and purchase employer-sponsored plans. Furthermore, the program will reduce CSA funds over time to create and test a "glide path" which provides a clear up front incentive to participate in the culture of insurance, and a graduated reduction in assistance as enrollees experience the benefit of participating in the shared community of risk that insurance, at its best, can offer.

Grant funds will not be used to supplant other funds for the program. No other funding is available or otherwise planned to support the CSA accounts that will be funded with the HRSA grant. Grant allocations to Healthy Texas will support CSAs within Healthy Texas and will supplement, but not supplant: 1) the \$75,000 TDI received for statewide implementation and outreach; 2) an estimated \$1 million in reinsurance funds in year one of the grant, with reinsurance pool funding contributions tapering off as small employer insurance enrollments and related CSA accounts increase.

Projected Enrollment: Based on allocated SHAP and match funding, and the current state reinsurance pool funding, the following table shows enrollment projections for the program. It is anticipated that Community First Health Plans and the TexHealth Coalition plans will begin CSA operations in January 2010 and that Healthy Texas will begin operations in June 2010.

Table 1: Texas SHAP Grant Program Enrollment Projections

	Year 1 Sept 2009 – Aug 2010	Year 2 Sept 2010 – Aug 2011	Year 3 Sept 2011 - Aug 2012	Year 4 Sept 2012- Aug 2013	Year 5 Sept 2013- Aug 2014
Healthy Texas	6,000	26,000	28,600	31,460	34,600
Community First Health Plans	667	964	1,118	1,294	1,302
TexHealth Coalition	4,557	4,557	5,439	6,417	6,467
TOTAL	11,224	31,521	35,157	39,171	42,369

Conclusion: With 6 million uninsured Texans, and low-income employees unable to afford premiums and often unable to access care because of deductibles, Texas will improve access to coverage by targeting its state and HRSA funds to where they are most needed and can do the most good: low-income uninsured small business workers. By supporting Healthy Texas implementation and funding for CSAs, HRSA funding will significantly improve the state's ability to provide affordable coverage by making premiums more affordable and making first dollar coverage – what low-income individuals need – available. HRSA funding will enable Texas to help provide health care coverage to thousands of uninsured employees throughout the entire state, will test several unique approaches addressing insurance obstacles that apply nationwide, will test approaches to help create a participative culture of insurance, and will test delivery models that build on public, commercial and private coordination approaches. This funding and these programs will serve as a catalyst and will precipitate additional investments in coverage for Texans.

NEEDS ASSESSMENT

Current status of access to health insurance coverage in the State: Since 1995, the State of Texas has had the highest rate of uninsurance in the nation, with the exception of three years (1995, 1997 and 1998) in which Texas had the second highest rate of uninsurance in the nation.

Table 2: Number and Percentage of Texas' Uninsured Population

Year	Number of Uninsured Texans	Percent of Uninsured Texans	National Uninsured Percentage
1995	4,615,000	24.5%	15.4%
1997	4,836,000	24.5%	15.6%
1999	4,664,000	23.3%	16.1%
2000	4,500,000	21.4%	16.3%
2001	4,960,000	23.5%	15.5%
2002	5,555,598	25.8%	14.0%
2003	5,527,771	24.6%	14.6%
2004	5,583,000	25.0%	15.2%
2005	5,515,677	24.2%	15.6%
2006	5,704,000	24.5%	15.7%
2007	5,962,000	25.5%	15.3%

Source: U.S. Census Bureau, Current Population Survey

In 2007, an estimated 5.9 million state citizens had no insurance throughout the entire year. Based on 2008 population data, Texas' uninsured population was larger than the total population of 34 states.¹⁰

Although the uninsured population is not limited to any one particular demographic group, certain characteristics increase the likelihood that an individual will not have insurance. These include:

- **Age:** Of the 5.9 million uninsured Texans, 4.4 million (74 percent) are adults between age of 18 and 65. Young adults ages 18-24 are at greatest risk of having no health coverage; nearly half (41.7 percent) were uninsured, followed closely by adults ages 25-34 years old (39.5 percent are uninsured). Texas also has the highest uninsured rate of any state for adults over age 65, a population that has grown significantly in recent years. In 2005, an estimated 43,526 adults over 65 were uninsured. By 2007, the number had increased to 100,000. While still representing only 4.1 percent of all adults over 65, the rate has more than doubled since 2005 when only 1.8 percent was uninsured.
- **Race/Ethnicity:** Like other border states, the uninsured in Texas are disproportionately Hispanic. Although Hispanics represent approximately 36 percent of the state's total

¹⁰ Missouri, Maryland, Wisconsin, Minnesota, Colorado, Alabama, South Carolina, Louisiana, Kentucky, Oregon, Oklahoma, Connecticut, Iowa, Mississippi, Arkansas, Kansas, Utah, Nevada, New Mexico, West Virginia, Nebraska, Idaho, Maine, New Hampshire, Hawaii, Rhode Island, Montana, Delaware, South Dakota, Alaska, North Dakota, Vermont, District of Columbia, and Wyoming.

population, they account for nearly 60 percent of the uninsured, followed by 25 percent of non Hispanic white, and 10 percent of African-American. The remaining 4.4 percent include all other individuals.

- **Poverty Status:** Though the uninsured as a group have a wide range of incomes, a majority (almost 60 percent) live in families with incomes below 200 percent FPL. An estimated 27 percent have incomes below 100 percent of poverty (\$21,200 for a family of four in 2008). More than 1.7 million uninsured Texans live in families with incomes above \$50,000.
- **Citizenship:** Contrary to popular perception, a large majority of uninsured Texans are U.S. citizens – almost 75 percent of all uninsured. Out of 75 percent, 6 percent are naturalized citizens. However, non-citizens are much more likely to be uninsured, with an uninsured rate of 60 percent all non-citizens in Texas compared to 20 percent for native citizens and 33 percent for naturalized citizens.
- **Employment Status:** Most uninsured adults (69 percent) are employed. Of the remaining uninsured, only five percent are considered unemployed (i.e., are actively looking for work). The remaining 26 percent are not in the labor force, including parents who are taking care of children, early retirees who no longer work, non-working college students, adults caring for aging parents, individuals who are disabled and unable to work, and other adults who for various reasons are not working or looking for work.
- **Company Size:** Workers in small firms are more likely to be uninsured than employees in firms with 100 or more employees. Nearly one-third (31 percent) of uninsured adults are employed in firms of less than 10 workers; a total of 59 percent work in firms of less than 100 employees. While nearly all large firms offer insurance, it is important to note that a quarter of the uninsured adults are employed in firms with 500 or more workers. Many of these workers are not eligible because they work too few hours or are considered temporary or contract workers.

As in other states, most Texans with insurance have it through their employers; though in Texas, a significantly smaller percentage of the population has employer sponsored insurance: 56.9 percent compared to the national average of 67.5 percent. While most states have experienced declining rates of employer-sponsored coverage in recent years, the decline in Texas is more pronounced. Since 2001, the percentage of Texans with employer coverage has dropped from 58.5 percent to the current rate of 50.4 percent, a 16 percent decrease in 6 years. More recent economic events and tighter financial resources will further exacerbate this trend, putting more pressure on Medicaid¹¹ and safety net programs.

Table 3: Sources of Health Insurance

Note: Numbers may not add up to totals, as some people have more than one type of insurance.

Source of Insurance	Number	Texas Percentage	National Average
Private Insurance	13,490,000	56.9%	67.5%
Employment Based	11,949,000	50.4%	59.3%
Individual Insurance	1,709,000	7.2%	8.9%
Government Insurance	6,086,000	25.7%	27.8%

¹¹ “States See Rising Enrollment in Medicaid as Economy Falters,” Kaiser Family Foundation, September 29, 2008; <http://www.kff.org/newsroom/kcmu092908nr.cfm>.

Source of Insurance	Number	Texas Percentage	National Average
Medicaid	3,015,000	12.7%	13.2%
Also has private insurance	410,000	1.7%	2.3%
Medicare	2,814,000	11.9%	13.8%
Also has private insurance	1,130,000	4.8%	7.1%
Military	1,017,000	4.3%	3.7%
Total Insured	17,742,000	74.8%	84.7%

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.

While Texas Medicaid covers about the same percentage of Texans as the national average, Medicaid eligibility for low-income adults who are not pregnant or disabled is limited (TANF-related Medicaid covers parents up to about 17-20 percent of the FPL). This leaves employment-based insurance as the best coverage opportunity for many uninsured Texans.

Today, many 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. With fully two-thirds of uninsured adults employed, and with 44 percent working at firms that employ less than 25 workers, small employer insurance initiatives represent a key target for a comprehensive insurance initiative. The following table highlights data on Texas' employer sponsored insurance and illustrates the particular challenges for employers in small firms.

Table 4: Employer Sponsored Insurance: Offer and Participation Data

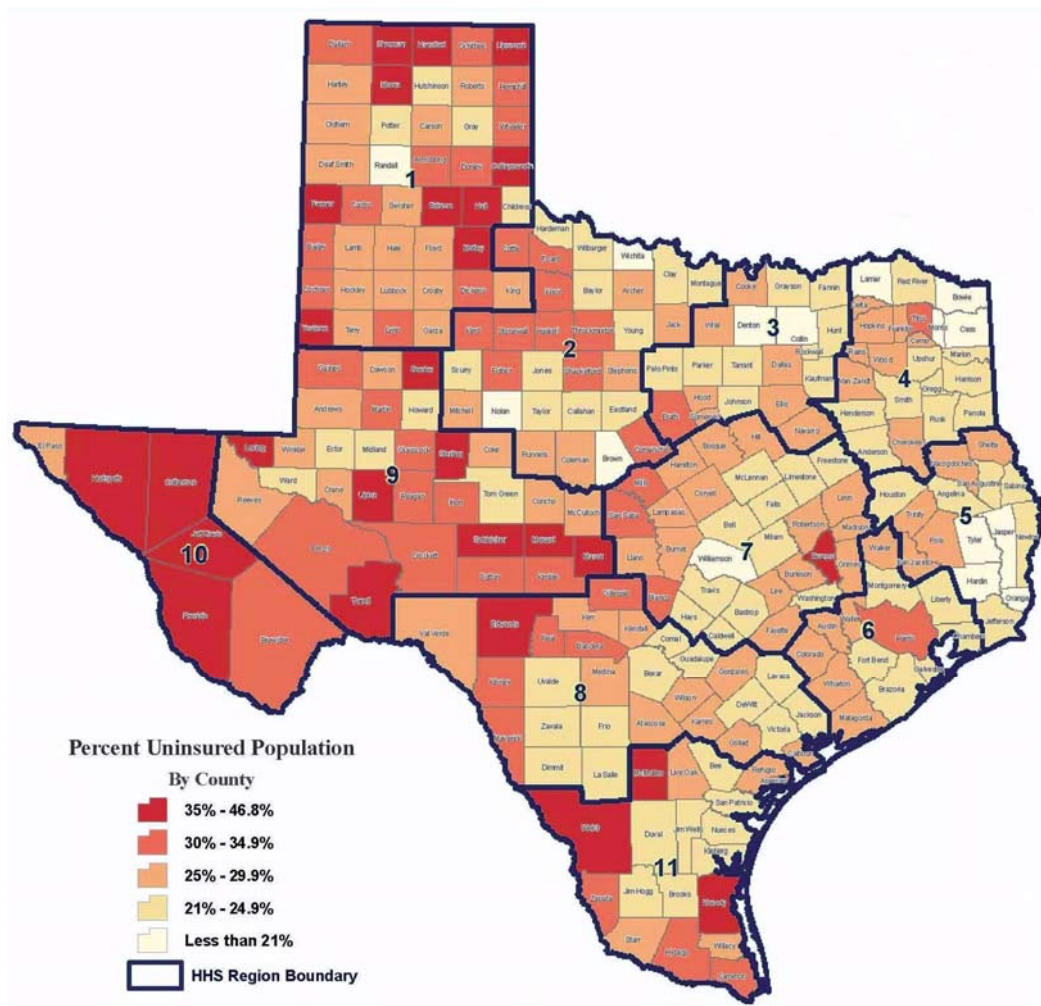
Texas Insurance Enrollment Data	Small Firms	Large Firms
1. Total number of firms	294,072	124,657
2. Total number of employees	1,918,682	6,098,561
3. Percentage of firms that offer insurance	32.2%	88.9%
4. Number of firms that do offer insurance	94,691	110,820
5. Number of firms that do not offer insurance	199,381	13,837
6. Number of employees working in firms that offer insurance	936,316	5,641,168
7. Percentage of employees working in firms that offer insurance	48.8%	92.5
8. Number of employees working in firms that do not offer insurance	982,366	457,393
9. Number of employees eligible for coverage	777,142	4,479,087
10. Number of employees who are enrolled	624,822	3,533,999
11. Percentage of all employees that have employer-sponsored coverage	33%	58%
12. Number of employees who have access to coverage but are not enrolled	152,320	944,088

Texas Insurance Enrollment Data	Small Firms	Large Firms
13. Number of employees who do not have access to coverage	1,141,540	1,619,474

Source: Agency for Healthcare Research and Quality, 2006 Medical Expenditure Panel Survey – Insurance Component.

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 \$12,947.¹²

Chart 1: Texas Uninsured Rates By County



¹² Healthy Texas Phase I Report, Texas Department of Insurance, November 2008.

The map above shows insurance rate variability across the state. While Healthy Texas will be statewide, the other CSA programs will be implemented and tested in seven urban areas of the state.

In Bexar County (San Antonio), where Community First Health Plans (CFHP) will offer insurance and CSAs to eligible uninsured individuals, there are approximately 365,000 uninsured residents (248,000 adults and 117,000 children) representing 24.3 percent of the county population. Total Bexar County population is almost 1.6 million, of whom 57 percent are Hispanic, 32 percent are white non-Hispanics, and 7 percent are African-American. The median household income in Bexar County in 2004 was \$39,694 compared to \$41,759 in the rest of Texas (U.S. Census Bureau, 2004). Literacy and especially health literacy are major community challenges. In Texas, 20 percent of Hispanic and African American students entering the 9th grade will not advance to the 10th grade. In the county as a whole, 18 percent of the population 25 years of age and older have not graduated from high school. Only 7 percent of Hispanics, the community's majority ethnic group, have graduated from a 4 year college (U.S. Census, 2000).

In six other urban areas, members of the TexHealth Coalition will provide three-share coverage and CSAs to eligible uninsured individuals, including several counties with the highest uninsurance rates in the state. Three-share 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 plan. Table 5 shows the number and the corresponding percent of the uninsured residents aged 18-64, in the coalition SHAP coverage areas.

TexHealth Coalition Coverage Area	Total Population	Number Uninsured	Percent Uninsured
Harris County (Houston)	2,376,592	88,097	32.5%
El Paso County	426,898	176,721	40.8%
Dallas County	1,475,760	444,853	29.2%
Galveston County	178,433	43,744	24.7%
Brazos Valley	181,240	41,215	19.9%
Central Texas (Austin)	1,006,183	224,087	22.1%
Total Uninsured Population in TexHealth Coverage Areas	5,645,106	1,718,717	30.4%

Source: TX State Data Center, 2005

The statewide linguistic composition in Texas is provided in Table 6. Of Texas' total population, 16 percent are foreign born. Almost 34 percent of Texans older than five years of age speak a language other than English at home. Approximately 13 percent of the adult population acknowledges that they do not speak English very well. In its program, Texas will fully address the state's linguistic composition, ensuring that program and plan materials and customer service staff are available for both English and Spanish speakers.

Language Spoken at Home in Texas	2002		2007	
Total Population	21,215,494		23,904,380	
Foreign born	3,225,201	15.2%	3,828,904	16.0%
Total Population 5 years and over	19,511,661		21,924,924	
Speak a language other than English	6,138,211	31.5%	7,437,834	33.9%
Speak Spanish	5,340,080	27.4%	6,421,693	29.3%
Speak English "less than very well"	2,359,345	12.0%	2,863,529	13.1%

Source: U.S. Census Bureau, American Community Survey 2002 & 2007

Health issues related to access to care and uninsurance: Having access to a regular source of care and to health insurance have been consistently shown to correlate with better health status. The Institute of Medicine (IOM) reports that the uninsured receive less preventive care, are diagnosed at more advanced stages of disease and, once diagnosed, receive less care than the insured, sometimes leading to premature death. In addition, based on AHRQ analysis, inadequate access to office and clinic-based preventive health care leads to increased utilization of higher cost emergency departments and inpatient facilities for ambulatory care sensitive conditions such as complications from diabetes. A study conducted in Houston, Texas found that approximately 50 percent of emergency room use by the uninsured was for non-emergency conditions.¹³ Table 7 illustrates Texas-specific analyses showing that insured adults are significantly more likely than uninsured adults to receive preventive health care services with the following preventive health disparities between insured and uninsured adults in Texas.¹⁴

Table 7: Health Disparities Between Insured and Uninsured Texas Adults

Preventive Health Care Services	Insured Adults	Uninsured Adults
Adults who reported visiting a doctor for a routine check-up within the past year.	70%	42%
Adults who had a test for high blood sugar or diabetes within the past three years.	58%	46%
Females aged 18 to 64 years with intact cervix who had a pap smear within the past three years,	87%	76%
Females aged 40 to 64 years who reported receiving a mammogram within the past two years	77%	52%
Males age 40 to 64 years who reported receiving a Prostate-Specific Antigen (PSA) Test within the past two years	52%	22%
Males aged 40 to 64 years who received a digital rectal exam within the past five years	61%	32%
Adults aged 50 to 64 who reported having received a sigmoidoscopy or colonoscopy,	55%	26%

According to the Texas Medical Association (TMA), uninsured Texans are up to four times less likely to have a regular source of health care and are more likely to die from health-related

¹³ (Texas Comptroller 2005; Greater Houston Partnership, Public Health Task Force Report, 2005).

¹⁴ 2008 Texas Behavioral Risk Factor Surveillance System (BRFSS).

problems than insured Texans. They are also much less likely to receive needed medical care, even for symptoms that can have serious health consequences if not treated. Nationally, uninsured adults are more likely to report poor or fair health (20 percent of uninsured, versus 12 percent of insured). Based on the information presented by the Texas Hospital Association, uninsured Texans were the highest in the country (27 percent) in reporting their health was poor or fair.

Local data show similar trends and disparities. For example in Bexar County, a 2004 study comparing utilization rates for insured and uninsured patients found that uninsured adult patients ages 45 to 64 years of age with hypertension, mental disorders, acute respiratory infections and cancer, accessed medical care 50 percent or less often than their insured neighbors¹⁵ The community's major health problems include chronic diseases – especially heart disease and diabetes – poor maternal and child health indicators, and prevalence of untreated behavioral health problems. The county's heart disease mortality rate of 223 per 100,000 population compares unfavorably with that of Texas and was significantly higher than the Healthy People 2010 goal of 166 deaths per 100,000. San Antonio's diabetes death rate is second only to that of New Orleans. Obesity and lack of physical activity, increasingly among youth, are community risk factors.¹⁶

To address the state's health needs, Texas delivers health care services through a broad collection of programs and providers including private insurers, public coverage programs such as Medicaid and CHIP, and extensive indigent care programs.

Indigent care overview: Some of the billions of dollars Texas spends to respond to the state's health needs are used to finance a fragmented indigent care patchwork created to meet a state Constitutional requirement to provide indigent care to Texas residents. State law created county indigent health care programs, with requirements for counties, public hospitals and hospital districts to provide programs for low-income, uninsured Texans. Counties are required to provide some care to those under 21% of the poverty level¹⁷, and public hospitals and hospital districts generally cover at higher income levels – up to 200% FPL in larger urban areas. Under these programs, public hospitals carry the largest burden of providing care. Approximately 150 public hospitals in Texas serve as the central and critical access points for uninsured persons seeking care. Public hospitals and hospital districts Sixty percent of the hospital cost for uninsured persons is covered by 45 of these public hospitals. Twelve large Disproportionate Share Hospitals provide most of that care. The large number of uninsured is one component driving uncompensated care costs. Uncompensated care charges in Texas were reported at over \$11 billion in 2006; having doubled over the previous five-year period. Uncompensated care costs increased family premiums in Texas 50 percent higher than the national average in 2005; and related premium increases are estimated to be almost double the national average by 2010: \$2,786 compared to \$1,502. Improving access to insurance through employer sponsored insurance will help “bend the curve” in indigent care expenditures. Initiatives such as

¹⁵ (data analysis Community First Health Plans & the San Antonio Metropolitan Health District; 2008 presentation by Dr. Fernando Guerra, San Antonio Metropolitan Health District Medical Director).

¹⁶ The 2006 Health Profiles (www.healthcollaborative.net).

¹⁷ See the following link for County indigent health care program information and requirements: <http://www.dshs.state.tx.us/cihcp/default.shtm>.

Community First Health Plan's provision of care to the program's enrollees when they lose insurance will also help test an important approach to ensuring continuity through changes in insurance status.

Private insurance market overview: Despite the relatively high number of uninsured residents, Texas is widely recognized as having one of the healthiest commercial insurance markets in the country. In 2006, accident and health insurers and health maintenance organizations (HMOs) reported more than \$23 billion in health insurance premiums written in Texas. Although some small states have experienced a shortage of commercial carriers, Texas has not suffered reductions that other states have reported. In 2007, more than 700 insurers were licensed to offer health insurance coverage. An additional 14 HMOs also provided comprehensive coverage for more than one million Texans covered under fully insured commercial benefit plans.

Like other states, however, Texas' health insurance market is dominated by a few companies. Based on premium information provided in the annual financial statements required of all insurers, the two largest insurers collected 41 percent of total premiums paid in 2006. The top 4 insurers collected more than half (54.9 percent) of premiums, and the largest 12 wrote 70 percent. Similarly, the three largest HMOs collected 70 percent of commercial premiums. The largest five accounted for 85 percent of premiums.

Texas has also continued to maintain a healthy market for small employer insurers. In the years immediately following the federal small employer market reforms under the Health Insurance Portability and Accountability Act (HIPAA), and subsequent state insurance reforms, a number of small employer insurers chose to leave the small employer market. Although the number of carriers is lower than it was 10 years ago when small group reforms were first implemented, this reduction is typical of the market consolidations that have occurred throughout the country. Today, Texas has 46 health insurers and HMOs offering health plans for small businesses.

Many of Texas' licensed insurers and HMOs also administer self-funded plans frequently offered by large employers. Self-funded plans are exempt from state regulation under the federal Employees Retirement and Income Security Act (ERISA). While most insurance plans offered by small employers are fully insured and subject to oversight by the Texas Department of Insurance, many large firms provide self-funded plans. Administrative services provided by licensed insurers for self-funded plans are also exempt from state oversight. Based on various resources, TDI estimates that approximately 60 percent of Texans with employer-sponsored insurance (7.2 million people) were covered under self-funded ERISA plans in 2006.

Health coverage under the grant: The Texas health care coverage program includes two components: the Healthy Texas a reinsurance product for small employers; and a Health Care Cost Sharing Account (CSA) designed to encourage uninsured workers to access health insurance through their employers by providing them with financial assistance to meet their premium or cost-sharing requirements.

Healthy Texas has the potential to provide insurance to a large number of uninsured, employed Texans. Based on current estimates, the program will enroll 26,000 individuals during its second

year. Future growth will depend on the level of funding in state appropriations for the reinsurance pool.

Community First Health Plans will offer a commercial benefit package to small businesses in Bexar County (San Antonio) that currently do not provide insurance, and the TexHealth Coalition's three-share programs and CSAs will be implemented in six diverse communities across the state.

Under the TexHealth Coalition component, almost 160,000 Texas employees and their dependents could gain health coverage through three-share initiatives in TexHealth pilot communities. If fully implemented, statewide, three-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 three-share programs that number could be as high as 700,000 Texans finding healthcare coverage with three-share health plans in the next 10 years.¹⁸

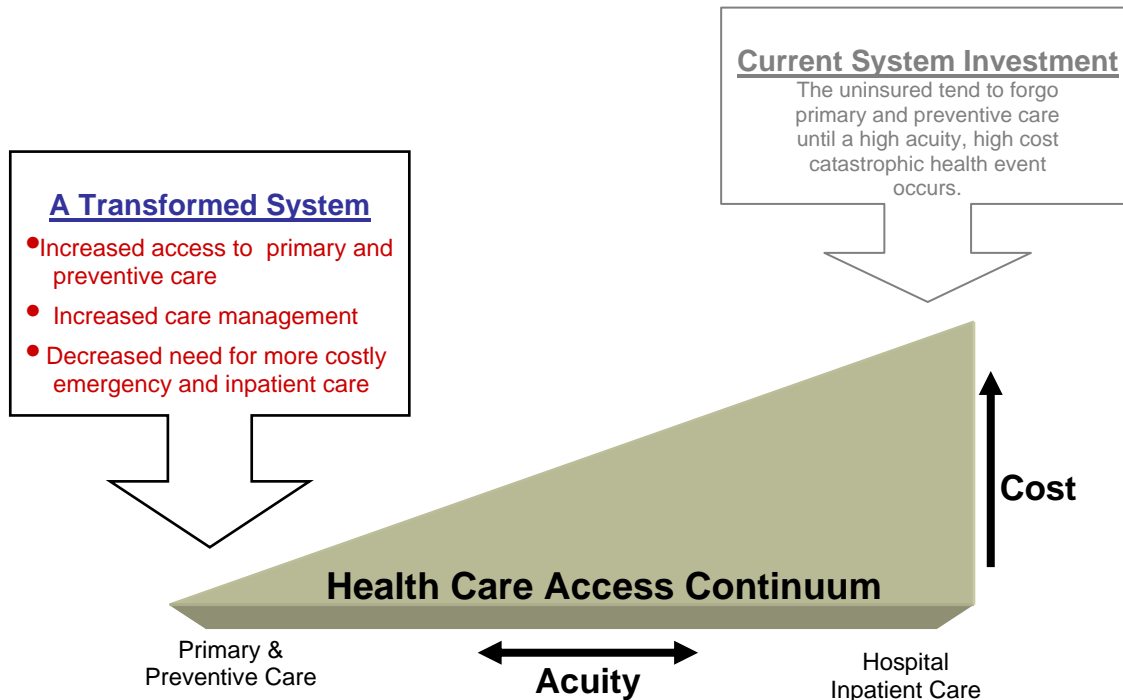
Based on available HRSA funding, enrollment projections for Texas State Health Access Program are found in Table 1 of the narrative section of the grant proposal. These estimates are based on available grant funding; with additional funding enrollment could increase. If approved, these funds will enable Texas to provide health insurance coverage to thousands of uninsured people throughout the entire state, and will have a much broader impact by serving as a catalyst to precipitate additional investments in coverage for Texans.

Need for program and use of medical homes: Texas' ranking as the state with the highest percent of uninsured, now nearly 6 million Texans; data showing lower levels of employment-based coverage in Texas compared to national employment-based coverage and additional data and information provided previously in this document show the critical need for the SHAP-funded program. Extensive research of published and unpublished data helped refine our scope to address the state's uninsured needs. Research ranged from the "2008 Texas Behavioral Risk Factor Surveillance System (BRFSS) Data" by the Center for Health Statistics, Texas Department of State Health Services, to "Latinos' Access to Employment-Based Health Insurance" in *Latinos: Remaking America, 2002*, to the Greater Houston Partnership's "Public Health Task Force Report" from 2005, among others. Please see Attachment 8 for a detailed list of references.

Medical homes play a central role in the coverage program. Compared to care received outside a medical home, in emergency rooms or ad hoc visits, Texas believes that providing access to appropriate primary care increases quality of care, health status and is a more efficient approach to investing in health care. In our Texas Health Opportunity, Coverage and Reform 1115 waiver application, providing medical homes was a key component in system reform, with the following graphic consistently used to emphasize this critical feature.

¹⁸ 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 as cited in *(3-share Economic Impact Study Executive Summary)*.

Chart 2: Health Care Access Continuum



Our commitment to medical homes continues in this SHAP application, for the same sets of reasons: quality of care, improved health status, and best use of scarce healthcare dollars. We know that uninsured people without medical homes often use emergency rooms for their healthcare needs. A study conducted in Houston, Texas found that approximately 50 percent of emergency room use by the uninsured was for non-emergency conditions.¹⁹ Under the SHAP program, all participants will be required to select a medical home. The schedule of benefits and the availability of the CSA will encourage individuals to access appropriate primary care within their medical homes.

Medical homes and continuity of care within the medical homes are such important objectives that Community First Health Plans will work with members who exceed their annual benefit limits, and who qualify, to provide ongoing care and a medical home using the same network of providers used for the CareLink program. The TexHealth Coalition three-share programs are committed to ensuring that members are connected to safety net providers and programs when they exhaust plan benefits and will work to enroll them in local programs for the uninsured such as the Travis County medical assistance program.

The role of safety net provides in the coverage programs: Safety net providers play key roles in the SHAP program. Community First, the HMO affiliated with the public hospital district for Bexar County, is offering a new commercial small employer product with the CSA made possible through the SHAP program. The TexHealth three-share coalition includes the indigent

¹⁹ Texas Comptroller 2005; Greater Houston Partnership, Public Health Task Force Report, 2005.

care networks in the other major urban areas of the state. These networks include hospital districts, public hospitals, FQHCs and other safety net providers.

Safety-net providers have also played an important role in the formation of the TexHealth Coalition and design of three-share programs. The Muskegon Program, which is a model program, is made up exclusively of safety net providers for its network. In the case of the Galveston Plan, UTMB, known to be the largest provider of specialty care to the working uninsured population in Texas uses its network of specialty providers in the Galveston plan.

Three-share programs are being developed in Texas as an approach to make affordable small employer-sponsored coverage available, as well as to offset safety net care providers' indigent care costs. Three-share programs create a coverage vehicle to generate some level of premium revenue for safety net providers. They also reduce indigent care costs by providing a medical home in which enrollees can see their regular primary care providers without the waits often otherwise associated with indigent care clinics. Further, these programs, such as the Central Texas three-share (Austin area), will use health information technology to create a virtual medical record to help identify patient level disease trends, and utilization patterns to trigger disease management programs and care utilization interventions.²⁰

A unique attribute for safety net providers in the Texas SHAP grant is that, as part of the grant and use of CSA funds, Community First and TexHealth three-share programs will provide or facilitate ongoing care within a medical home for their enrollees, even if the enrollees lose their employer sponsored insurance. At Community First, enrollees who lose insurance, and who are eligible, will be transferred to the hospital district's CareLink program,²¹ and will have continued care through the same network of providers used in the Community First commercial product. This "vertical (job change or loss) and horizontal (income change)" continuity of health care is a unique option made possible by partnering with the public and commercial (e.g., commercial insurance) systems managed within the public sector. Similarly, the TexHealth Coalition will, as a component of the SHAP program, facilitate enrollment in local safety net provider programs to promote continuity within a medical home for their enrollees.

This continuity helps to address what Massachusetts' Connector architect Ed Haislmaier identifies as one of the key issues associated with insurance loss: how well insurance "sticks" to people through life and employment changes.²² As part of its evaluation, Texas will assess this program component to provide information on health care delivery service models and structures to improve access to health coverage.

Barriers or shortcomings with existing infrastructure: A description of the barriers and shortcomings with the existing infrastructure that the program aims to overcome are covered in detail in the introduction to this document. This includes the important role small employers can play in providing insurance if available, affordable options are created, and if employers and employees have incentives to purchase employer sponsored health insurance. Barriers in Texas

²⁰See: <http://www.icc-centex.org/>.

²¹ <http://www.universityhealthsystem.com/CareLink/what-is-carelink.shtml>.

²² <http://www.heritage.org/about/staff/edmundhaislmaier.cfm>.

such as higher premium costs, lower wages, higher poverty levels, fewer employers offering health insurance are also detailed and discussed in the introduction.

Past efforts to reduce the number of uninsured: Legislative and policy directives in Texas reflect and build on a history of programs and initiatives created an effort to address the problems of the uninsured. A chronology of key state legislative and executive efforts follows.

Nearly 15 years ago the Texas Legislature authorized the Texas Health Policy Task Force to conduct a comprehensive, well-documented study and to make recommendations for providing all Texans access to health care. Following a twelve-month study involving hundreds of various participants, the Task Force issued a lengthy report that included more than 80 specific recommendations. Over the next few years, many of the recommendations were adopted in the form of legislation or regulatory changes. In 1995, the State of Texas submitted a Medicaid 1115 waiver to expand Medicaid enrollment to more low-income children using Disproportionate Share Hospital (DSH) funds through a hospital district-based delivery system. HCFA pended the waiver application which was never approved. Many of the state's indigent care and insurance initiatives build on the relationships and shared goals developed with key hospital districts during that time.

The Texas Healthy Kids Corporation was established in 1997 with legislative and executive support to increase access to affordable health insurance for children. The Texas Healthy Kids Corporation (THKC) was created as a non-profit corporation to administer a program through which families could purchase health insurance from several health insurers and HMOs participating in the program. Healthy Kids program was ultimately eclipsed with the implementation of the CHIP program.

Enactment of the Texas Children's Health Insurance Plan (CHIP) represented a significant milestone for Texas policymakers in reaching consensus on providing coverage for uninsured children up to 200% of poverty. After just two months of implementation, a total of 17,344 children had received coverage in CHIP and 122,020 children were referred to Medicaid via CHIP applications. In its first year, Texas CHIP had the fastest enrollment growth of any state.

With over two-thirds of adults employed, and as many as 80 percent of uninsured children residing in families with at least one worker, the state implemented a series of reforms targeting small employer insurance between 1993 and 1997. The Texas Legislature in 1993 adopted the Small Employer Health Insurance Availability Act, amending and revising the law in 1995 and 1997 improving the availability and affordability of health insurance for small employers. Within five years of reform implementation, the number of small employers with health insurance more than doubled in five years from 36,952 to 86,106 in 1998; and from 10.6 percent of small employers to more than 23 percent.

The Texas Health Insurance Risk Pool (THIRP) became operational in 1997 to provide access to quality health care for those individuals who could afford insurance but could not obtain coverage.

The 76th Texas Legislature (1999) authorized creation of the Blue Ribbon Task Force on Uninsured Texans in 1999 - 2000. One of the challenges identified by this task force – and

subsequently addressed with HRSA funding through grants awarded to the Texas Department of Insurance-- was a lack of detailed Texas data needed to support policy analysis, program development.

The Texas Department of Insurance applied for and received a series of TDI Planning Grants, producing critical Texas employer survey and other data to inform Texas policy on the uninsured.²³ Among other things, these data detailed cost as a critical obstacle to employers offering insurance, attitudes towards insurance and the amounts, if any, that employers would be willing to pay. Planning grants also funded development of a Houston pilot. From this work, Texas learned about the differing objectives of employers and employee in purchasing insurance. Texas also learned that insurance carriers were hesitant to participate in a program targeting previously uninsured adult if the carriers could not underwrite or base rates in part on health status. Reinsurance emerged as one option to address carrier concerns and to help make premiums in a coverage program more affordable.

With a long history of effort and focus on issues of the uninsured, Texas' political environment reached a tipping point in 2007. Major legislation passed in that year and in the session that ended June 1, 2009 providing bold direction for health reform and increasing access to care. In 2007, Senate Bill 10 (SB10)'s omnibus healthcare reform legislation had a number of provisions designed to ease existing state uninsured rates, including direction to the Health and Human Services Commission to pursue an 1115 Medicaid reform waiver.²⁴ The waiver was designed to fundamentally restructure the state's financing structure and leverage existing health care investments to make affordable insurance available to uninsured adults.²⁵ In anticipation of reform legislation, Texas began waiver research activities in 2006 and spent over two years reviewing and analyzing Texas uninsured data, commercial coverage options, employer and employee insurance preferences, benefit options and benefit designs, stakeholder input, and the explosion of state reform initiatives that rapidly rolled out within the course of several years.²⁶ Texas submitted its Medicaid 1115 waiver in April 2008 and began negotiations on funding, benefit development, and provision of subsidies for a benchmark benefit as well as for employer sponsored insurance. The waiver request is still pending federal approval.

Other Legislative direction from the 2007 and 2009 sessions include creation and facilitation of three-share coverage programs;²⁷ strengthening performance-based Medicaid and CHIP contracting and payments; an analysis and recommendation report for premium assistance options in Texas,²⁸ expansion of Texas's innovative use of health information technology²⁹ for improved health services and, in legislation passed June 1st, creation and reinsurance funding for

²³ <http://www.tdi.state.tx.us/reports/report7.html>.

²⁴ SB 10: <http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=80R&Bill=SB10>.

²⁵ Texas submitted an 1115 reform waiver April 16, 2008; negotiations stalled with the change in administration and Texas is now positioning itself for federal reform.

²⁶ See the Texas Medicaid reform website at: <http://www.hhs.state.tx.us/medicaid/reform.shtml>.

²⁷ 80th Legislature, SB 10. See link above.

²⁸ A Legislatively required study of premium assistance options for uninsured Texans. See: http://www.hhsc.state.tx.us/reports/1108_Uninsured_Subsidy.pdf.

²⁹ E.g., in the creation of a medical passport for foster children to ensure portable care coordination and continuity of care.

the “Healthy Texas” program.³⁰ This reinsurance program is based on New York’s successful Healthy New York reinsurance program and marks a significant state commitment and investment in increasing access to affordable insurance through Texas’ small employers market.

With the agency, provider and stakeholder relationships developed over time, data collected in part from TDI surveys and assessments funded by HRSA,³¹ and an improved understanding of the complicated dynamics of Texas’ uninsured challenges and how best to address them, Texas can, with HRSA funding, create a successful program to provide insurance coverage to small businesses and their uninsured employees.

National activities and other state approaches: Texas continually tracks national and state activities relating to health care at the Health and Human Services Commission and at the Department of Insurance. Medicaid and health care reform waiver activities in other states informed Texas’ approach to the 2008 waiver submission.³² Section 1115 Medicaid reform waivers from Massachusetts, Florida, California, Indiana and HIFA waiver in states like New Mexico provided concepts such as use of Safety Net providers, Insurance Exchanges, various approaches to provide subsidies, options to support insurance take-up, to address affordability and availability of insurance, insurance regulation changes, and enrollee incentives. For its Medicaid reform development, HHSC created a website in 2006 and posted whitepapers on key reform and insurance topics and initiatives.³³ In 2008, HHSC and TDI together provided a legislatively required Study of Premium Assistance Options for Uninsured Texans.³⁴ The report reviews national and state premium assistance programs and provided recommendations, including some which helped inform the development of Healthy Texas legislation. Texas’ HRSA SHAP grant application reflects how state and national approaches have informed its approach to providing affordable health coverage.

METHODOLOGY

HRSA funds will allow Texas to improve access to coverage by strategically targeting dollars to where they are most needed and can do the most good: low-income uninsured small business workers. By supporting Healthy Texas implementation and funding for CSAs, HRSA funding will significantly improve access to employer-sponsored coverage by making premiums more affordable and making first dollar coverage – what low-income individuals need – available. HRSA funding will enable Texas to help provide health insurance coverage to thousands of uninsured employees throughout the entire state, and will test unique approaches addressing insurance obstacles that apply nationwide.

The work plan, provided in Table 12, details how the state and contractors will implement the program and the budget detail and justification provide start up financing cost information.

³⁰ See text of SB 78, for Healthy Texas legislation:

<http://www.legis.state.tx.us/tlodocs/81R/billtext/doc/SB00078F.doc>.

³¹ See <http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=80R&Bill=SB10>

For detail on TDI’s State Planning Grant Reports from 2001 survey and coverage attitude reports through the culmination report on Healthy Texas in 2008.

³² See the Medicaid Reform Website, cited previously.

³³ <http://www.hhs.state.tx.us/medicaid/reform.shtml>.

³⁴ http://www.hhsc.state.tx.us/reports/1108_Uninsured_Subsidy.pdf.

Because authority to pursue Healthy Texas exists in SB 78 (81st Session), and three-share program authority exists both in SB 10 (80th Session) and SB 78, no local, regulatory or statutory changes will be needed to implement the Texas SHAP grant. The state is ready to implement the program. The Texas Health and Human Services Commission will work with its three partners, TDI, the TexHealth Coalition and Community First Health Plans, to implement the Texas SHAP program, and financing for the program will start with initial contractor and TDI grant allocations to support initial implementation and outreach costs. Additional detail on contractors, structure and use of funds is outlined below.

The Texas Department of Insurance (TDI): TDI is a key partner to HHSC for the SHAP grant. TDI is responsible for oversight and regulation of all insurance in Texas, and has also played an important role in analyzing issues related to health insurance coverage. TDI received two HRSA grants which have helped provide key data for policy analysis and development of insurance pilots and initiatives. TDI co-authored a Legislative Report submitted October 2008 on Premium Subsidy Options for Texas. Some of the recommendations and information helped inform development of the Healthy Texas Reinsurance program. TDI is responsible for implementation and ongoing oversight of the Healthy Texas program.

Development and design of the Healthy Texas Program as it was finally adopted by the Texas Legislature involved input from a statewide group of stakeholders, including: providers (such as the Texas Medical Association and the Texas Hospital Association), insurance carriers and health maintenance organizations, insurance agents (the Texas Association of Health Underwriters), employers, local chambers of commerce across the state, and various consumer organizations (the Center for Public Policy Priorities, Texas Impact, the Texas Health Institute, and the Texas Christian Life Coalition). The continued support and involvement of these and other local community organizations will greatly facilitate statewide implementation of Healthy Texas and ensure the Program is successful in reaching its maximum enrollment potential.

When the Texas legislature created Healthy Texas, it provided initial funding to create the program's reinsurance pool; however, limited implementation and outreach funds were provided for the program. Healthy Texas will use HRSA grant funds to implement and provide outreach and education and work with agents and small employers prior to providing access to insurance and to CSAs in June 2010.

TexHealth Coalition: Another key partner, the TexHealth Coalition, is a voluntary association of communities that have joined forces to identify statewide options to reduce the number of uninsured individuals in their communities while maintaining local and regional flexibility. The Coalition secured legislation to allow the creation of regional healthcare coverage programs outside the traditional health insurance structure. Six communities currently developing and implementing three-share programs include: Houston (Harris County), Central Texas (Travis (Austin), Hays, Williamson, Burnet, Caldwell and Bastrop Counties), Galveston (Galveston County), El Paso (El Paso County), North Texas (Dallas County), and Brazos Valley (Brazos, Burleson, Grimes, Leon, Madison, Albertson and Washington Counties).

Each of the Coalition partners leads a local collaboration that includes broad representation from stakeholder groups, including governmental entities, healthcare providers, small businesses,

small business employees, nonprofit organizations and the insurance broker community. These groups participate in the design, development, implementation and operation of their local initiatives.

The TexHealth Coalition will use program funds to offer uninsured workers a choice as to how CSAs will be applied to help finance his or her coverage program. Employees will be allowed to use the dollars towards point of service cost sharing (deductibles, co-payments or coinsurance) or payment of a portion of their share of the monthly premium. The coalition will be responsible for implementing, testing, monitoring and reporting on the CSAs established within their six program areas.

Community First Health Plans (CFHP): University Health System (UHS) is the public hospital district for Bexar County and in partnership with The University of Texas Health Science Center at San Antonio, is a comprehensive and nationally recognized academic medical center.

Community First Health Plans, Bexar county's only locally-owned and operated, not-for-profit HMO, was established in 1995 by the [UHS](#), specifically to provide health care coverage to the citizens of Bexar and the surrounding seven counties. CFHP's commitment to its members is to provide exceptional health care benefits backed by outstanding service, delivered by people who live in South Texas. In its ten years of existence, CFHP has made great strides in becoming a fully mature health plan with a strong balance between its commercial and government-sponsored programs. Their 110,000+ members are divided almost equally among Commercial, Medicaid and CHIP coverage programs.

- The UHS is the third-largest public health system in the State of Texas and one of the largest employers in Bexar County, with more than 5,000 employees.
- University Hospital, one of 13 Level 1 Trauma Centers in Texas, operates and staffs 407 beds providing critical care, medical/surgical, obstetrics, pediatrics and rehabilitative care services. UH is the lead trauma center for 22 South Texas counties.
- The UHS has a long standing affiliation agreement with the University of Texas Health Science Center at San Antonio (UTHSCSA), and University Hospital is the primary teaching site for medical and surgical residents.
- CareLink is an innovative program for the poor and uninsured of Bexar County. Created in 1997, the program provides qualifying Bexar County residents with financial assistance, as well as access to primary care physicians and specialty services. While CareLink is not insurance, it has many similar advantages. Its schedule of benefits includes preventive health services and outpatient pharmaceuticals. Its structure encourages along-lasting relationship with a primary care provider, and a sense of shared responsibility between patients and clinicians for the patient's health. In 2008, CareLink had an average of 52,000 enrollees. Members pay a reduced rate for services based on family income and size. Through these monthly payments, CareLink members contributed over \$12 million to the Health System bottom line in 2008. CareLink members have medical homes and primary care providers responsible for assuring continuity of care.

CFHP will work collaboratively with its owner/sponsor, the UHS, with the state and with other designated partners to use HRSA funds to implement, test, monitor and report on CSAs used in conjunction with a commercial product tailored to the small businesses employing fewer than 20 workers.

HHSC will work together with its partners to implement and evaluate the Texas SHAP program. The partners, who comprise the HHSC operational work group, will each be responsible for completing project tasks, managing daily operations, meeting reporting criteria and addressing challenges as they arise within their existing operating structures. During pre-implementation, HHSC will host weekly status calls with its partners, and once the program is operational, HHSC will convene monthly status calls to report findings and share best practices. In addition to weekly and monthly conference calls with its partners, HHSC will also establish a SHAP executive oversight committee to address challenges that may arise, and discuss findings. Following is a summary of pre-implementation, implementation and post-implementation activities that all partners will be required to execute. For more detailed information, please refer to Table 11, Texas SHAP Grant Work Plan.

Table 8: Summary of Implementation Activities

Pre-Implementation Activities:
<ul style="list-style-type: none"> • Staffing and administrative activities, including development of policies and procedures • Outreach and education development, such as member materials, websites, etc. • Start up and enrollment, including setting schedule of benefits, establishing mechanisms for flow of funds, training/certification of brokers, etc.
Implementation Activities:
<ul style="list-style-type: none"> • Implement Healthy Texas • Select qualifying employers • Confirm selection of employers and enroll groups • Establish CSAs
Post-Implementation Activities:
<ul style="list-style-type: none"> • Ongoing program and grant management • Reporting and technical assistance activities

Outreach and maximizing enrollment: The Texas Department of Insurance (TDI), along with various members of the Coalition conducted focus groups that showed many small employers want to provide health benefits to their workers but are prevented from doing so mainly by the high cost of group coverage within the small employer environment. The grant contractors fully understand the impediments to small employer coverage and have designed their marketing efforts around consumer education, access and enrollment. Many businesses in the targeted market have difficulty choosing among benefit options, finding companies that are trustworthy and empathetic, and understanding how the different types of insured arrangements affect employees and their families.

All grant contractors have familiarity with and experience with designed effective outreach and enrollment campaigns to address several key imperatives across Texas’ different communities. Community First has existing commercial plans and has successfully reached out to small employers. It also services as a Medicaid and CHIP HMO and works closely with the UHS hospital district. The TexHealth Coalition has rolled out a three-share program in Galveston, and is preparing to roll out in Central Austin. It has done extensive marketing research and learned from Galveston’s experience in outreach and education. TDI has an understanding of the insurance system, the role of agents, and has worked extensively within the insurance industry to support increased access to health insurance. Key principles for all contractors include strategies that acknowledge:

- Small employers that do not offer health insurance will need to be reached through a variety of channels;
- Cost must be transparently communicated and affordability convincingly demonstrated;
- The materials must be straightforward and simple and supported by an easy sign-up process;
- Subsidies available to certain groups of lower-income employees, eligibility for them must have eligibility requirements explained in understandable terms.

Furthermore, because Hispanics make up the most significant group (36 percent) of uninsured Texans (both in absolute numbers and in relation to their proportional share of the overall population), outreach plans will include a requirement for demonstrated evidence of culturally competent Spanish-language materials for distribution to employees.

Community relations and marketing staff will be used to increase outreach efforts and promote the programs in community-based organizations and other public locations. Enrollment efforts will share some common thematic elements as indicated above, however, the customization of these materials for specific markets must reflect a sensitivity to, and understanding of, each community's small employer insurance markets. As such, each contractor and each TexHealth Coalition member has or will create an individual marketing and sales plan to maximize enrollment in their enrollment areas.

The outreach approach is broad-based to reach the obvious, as well as the not-so-obvious elements of the small employer market. For example, to effectively penetrate the market, the Coalition has also developed partnerships with groups and associations to promote enrollment into the three-share programs. The Coalition is working with the Texas Workforce Commission (TWC), a state agency that collects current employment data and regularly interacts with all employers. TWC is committed to helping target small businesses in the Coalition communities through outreach at the local level. They will also distribute brochures and posters through their regional workforce centers.

Chambers of commerce are among the many partners collaborating with the Coalition and an obvious distribution channel for small employers. There are a rich variety of them in the targeted communities including those that function on behalf of a particular city, and those whose membership is more focused. The Coalition has engaged various focused Chambers including several Hispanic and Inner City Chambers. The Texas Association of African-American Chambers of Commerce has more than 30 members that represent 10,000 businesses statewide. Also for the Coalition, in each entity's member media market, a "kick-off" press event is planned to announce the availability of this new health coverage opportunity for small businesses. The event is scheduled to feature prominent officials, local business partners, insurers, members of the medical community and hospital district and small businesses that have been identified as likely candidates for the new program.

Lastly, and likely the most effective way to maximize enrollment are outcome testimonials of how the coverage has affected individuals' healthcare outcomes. Our programs are designed to include pre and post surveys that will produce information that enables participants to provide face-to-face testimony of their experiences which will solidify the relevance and success of the programs.

Strategies to enhance utility of HRSA funding and to produce information: HHSC and the HRSA grant contractors will share information with other states primarily through web-based information that could include best practices, the schedule of benefits, training materials, evaluation and outcome data as well as overall lessons learned based on the program evaluations results through the course of the grant.

The TexHealth Coalition offers a great example of how Texas will share information, since this organization has capitalized on its ability to support its members by working together to combine development and implementation activities, and by supporting joint technical assistance purchases for actuarial, marketing and legal services. This approach has enabled communities to offer one-on-one advice and support among Coalition members, for developing resource materials and to transfer lessons learned across participating communities. Programs nearer to launch have been able to accelerate the learning and implementation tasks of those less near to launch.

The Coalition structure has facilitated the creation of a toolbox of work products and experience which other communities can access. The Coalition will be a ready partner to the State as well as others in developing guidance for small employer coverage initiatives. That partnership will help assure consistency with market-based principles in reducing in the number of uninsured working around the country. In addition, through the Coalition's efforts both the State and the Federal government can advance the development of three-share initiatives in coordination with existing healthcare reform efforts.

Matching requirement: Texas will meet the 20 percent matching requirement with general revenue funds allocated to the Healthy Texas reinsurance pool, and with funds appropriated to support development of the three-share programs and to assist them in providing subsidy assistance for eligible individuals. General revenue funding supporting these programs will be used as the 20 percent match of \$2 million for the Texas SHAP program.

Financing and sustaining the program at the end of the grant period: Funding for the employer sponsored reinsurance programs under Healthy Texas is included in the state base budget funding. The TexHealth Coalition three-share programs are also appropriated state revenue in the state's base budget. Additionally, three-share plans are designed to attract additional third share funding as part of their ongoing development work.

The CSA component that the HRSA grant may continue based on its perceived value. Because the program will gradually reduce the amount of the CSA subsidy provided to an employer group, it is intended that the group of employees will recognize the value of insurance, improve health status as a result of having access to health care services, and will continue to fund their health care coverage when the grant period ends. The CSAs will be set up to promote a culture of insurance, by gradually decreasing annual cost sharing assistance amount available to participants and increasing the individual's financial participation requirement over time. In addition to supporting development of a culture of insurance, the phase down approach of CSA accounts will help make CSA sustainability more feasible. The CSA funding "glide path" will taper subsidy amounts down over five years of the employers' enrollment. In years one and two,

CSA accounts will be funded with a maximum of \$900 in years one and two, \$750 in year three and; \$500 in years four and five.

The CareLink program will also continue to finance care for the qualifying uninsured at the end of the grant program. In addition, depending on the evaluation outcomes of the CSA model, CareLink, as well as the states other large hospital-based indigent care programs, may choose to divert some portion of tax funds to fund the cost share account under this fully insured product.

The Coalition plans to support the sustainability of the program and promote employee responsibility by replacing grant funds with local dollars and by reducing the amount of the individual subsidy over time. We intend to minimize the overall costs such that the burden for each payer group is as low as is feasible and that the cost of ongoing operations of the program is readily sustainable through program income. There are many strategies for integrating cost-savings mechanisms into health care delivery and financing. Our cost-sharing model spreads the financial burden rather than creating another entitlement program. Another option we will implement includes Disease Management. Disease management programs manage chronic conditions over the long-term to improve quality of care and prevent or minimize reoccurrences, thus reducing costs. Disease management programs partner with health plans and offer a series of tools and interventions and have demonstrated quality of care improvements along with lowering costs. All of our models include a substantial care/disease management component which will allow for the achievement of sustainability.

An example of a self-sustaining model is the oldest program of this kind- Project Access in Muskegon, Michigan. They developed and have operated a healthcare coverage program and have utilized program income as well as grant funding from local, state, and federal sources to sustain the program for 10 years. The Coalition has adopted many aspects of the Muskegon model and anticipates similar results. While other health coverage programs have proven successful throughout the country, no large-scale urban trial of such a product has been attempted to our knowledge. The Coalition also plans to support the sustainability of the program and promote employee responsibility by replacing grant funds with local dollars and by reducing the amount of the individual subsidy over time.

The five year grant period allows sufficient time for each community to demonstrate the value of investing in primary and preventive care as a way of reducing expensive uncompensated care for area healthcare providers and governments.

Using outcomes from the grant to contribute to national information and its relevance to Healthy People 2010: The grant design allows for a full evaluation of the reinsurance and CSA programs, including their ability to increase small employer insurance take-up and enrollment, increase the number of employed individuals receiving coverage, improve access to appropriate primary care, increase continuity of care, and support a sustainable culture of insurance. In addition, the goals of Texas' SHAP grant proposal are in alignment with Healthy People 2010's goals to: 1) increase quality and years of healthy life; and 2) eliminate health disparities. The Texas SHAP grant programs will provide for improved health outcomes by including care coordination and management of chronic conditions through a medical home and regular source of care.

Additionally, many of the health plans involved in the Texas SHAP grant program will be establishing partnerships with the public health infrastructure for indigent health care to help ensure ongoing coverage for those who have exhausted their health care coverage benefits.

Evaluation Plan

The overarching goal of the Texas SHAP demonstration grant is to allow currently uninsured, employed individuals access to affordable health coverage through employer-sponsored coverage.

The Texas SHAP program will focus on the use of two separate but complimentary approaches to insure more Texans: 1) implementation of the Healthy Texas statewide reinsurance program to reduce insurance premiums and encourage uninsured small business owners to offer insurance; and 2) Cost Sharing Accounts to assist employees in buying health care as a means of decreasing the number of uninsured. Cost Sharing Accounts will be delivered through three types of health care providers: a network of newly developed three-share community partnerships, CFHP, an established non-profit safety-net hospital-based health plan provider, and through Healthy Texas carriers. These partners will offer employees that meet the eligibility criteria the opportunity to supplement the costs using a CSA help with (a) employee health insurance premiums, or (b) point of service costs including co-pay, deductibles, or co-insurance. Enrollees in Healthy Texas will choose from approved private health plans selected through a competitive bidding process to participate in Healthy Texas.

Texas SHAP Objectives: The Texas SHAP program will:

- increase the number of previously uninsured individuals enrolled in health care coverage,
- increase small business participation in health care plans,
- increase utilization of primary and preventive care and decrease use of emergency room care,
- reduce the cost of health insurance,
- result in high employer and employee satisfaction with their health care plan,
- bring about an enhanced “culture of insurance” as evidenced by sustained participation in health care plans as funding assistance decreases and increased employee uptake rates during the grant period, and
- improve the continuity of care in medical homes through periods of benefit exhaustion by partnering with safety net providers.

Texas SHAP Program Evaluation: The Texas SHAP program evaluation will examine how the HRSA funding is used in the two types of health care plans as they relate to the program’s objectives.

- Programs receiving HRSA funding versus those similar programs not receiving HRSA funding;
- Premium assistance versus point of service cost-sharing, including co-payments, co-insurance premiums, and deductibles;

- Level of employee assistance based on a fixed amount versus a percentage of premium; and
- Levels of health care plan participation, health care utilization patterns, and employees' perceived importance in health insurance as the level of employee assistance decreases and ends over the grant period.

These tests will result in a better understanding of programs designed to provide coverage to the uninsured.

Evaluation Design:

Analysis Plan

An initial process evaluation of the Texas SHAP program implementation will be conducted six months after the implementation date to assess the aspects of the program contributing to or detracting from program success. The annual Healthy Texas assessment will apply to the statewide program and will address variances within geographic regions of the state. Since each implementation site will not initiate CSAs at the same time, annual reports will assess implementation of additional sites as they become fully operational. These assessments will guide program modifications throughout the remaining implementation years.

HHSC and TDI will administer an implementation survey which will inform the process evaluation and provide feedback to the implementation sites on their progress towards meeting program goals. The implementation outcomes are descriptive measures about Texas SHAP program implementation (see Table 9). A review of records and documentation along with survey methodology will be used for the process evaluation.

The Texas SHAP program will be evaluated using the performance measures of program outcomes presented in Table 10. They include outcome measures for employers, employees, and appropriate comparison groups. The evaluation will separately test HHSC's and TDI's hypotheses about CSA and Healthy Texas program outcomes by comparing outcomes for Texas SHAP program participants to those for the comparison group using chi-square and other appropriate analysis techniques. The evaluation will also compare outcomes between the two types of interventions looking specifically at the effect of differing program characteristics.

The objectives and performance measures will be used to identify demonstration successes, opportunities for program improvement, and guide whether the Texas SHAP strategies, goals, or anticipated contractor funding should be revised if necessary. The evaluation will also develop recommendations for improving the Texas SHAP program and similar programs in other states.

The annual performance measures will be based on the data available at the end of each year during the grant period. Should the Texas SHAP program experience delays in the goals and tasks, the related performance measures will be identified as incomplete and will be revised for the next annual report. Delays in progress will be managed on a case by case basis. If necessary, technical assistance will be offered, either by HHSC or by another implementation site that has already completed the delayed activity.

Data Sources

The study population includes the implementation site staff, and the employees and employers who are participating in SHAP. Informed consent will be obtained from all evaluation participants. Data sources will include:

- Health insurance claims data provided by health care plans;
- Health insurance survey data collected by TDI;
- Electronic medical records;
- Enrollment and implementation data provided by health care plans;
- Site visits with implementation site staff;
- Employer and employee surveys;
- Annual participant conference meeting notes;
- HHSC data on distributed funds;
- TDI data on the insurance rates of small business employers and utilization rates of non-enrolled, uninsured individuals employed in small businesses; and
- Implementation site surveys.

Performance Measures

The performance measures will capture, measure, and document both the implementation process and program outcomes (see Tables 9 and 10). These measures will provide information on key tasks, project milestones, and program objectives. This data will highlight whether the Texas SHAP program met program objectives.

Table 9: Texas SHAP Program Implementation Performance Measures

#	Objectives	Performance Measure	Data Source	Timeframe
1	Met process objectives	Number of three-share programs currently enrolling Texas SHAP participants	Data provided by TexHealth	Initial 6-month implementation report, annual report
		Employer uptake rates and assessment of outreach efforts by participating healthcare plans organizations	Data provided by health care plans	Initial 6-month implementation report, annual report
		Major implementation deadlines met	Data provided by health care plans and HHSC	Initial 6-month implementation report, annual report
		Employee enrollment targets met	Data provided by health care plans	Initial 6-month implementation report, annual report
		Progress of plan administration and fund distribution, including development of business rules, payment distribution protocols, and medical loss/benefits ratios	Site visits with implementation site staff, implementation site survey, HHSC data, and annual employee survey	Initial 6-month implementation report, annual report
		Results of pre/post enrollment surveys of employers and employees addressing employee participants understanding of the Texas SHAP program, whether or not	Pre/post-enrollment employer and employee surveys	Initial 6-month implementation report, annual report

#	Objectives	Performance Measure	Data Source	Timeframe
		the participation process was explained, if participants understood their program choices, and if the explanation influenced their choice		
		Documentation of lessons learned related to both administration and implementation processes	Data provided by health care plans	Annual report

Table 10: Texas SHAP Program Objectives and Annual Performance Measures.

#	Objective	Performance Measure	Data Source	Timeframe
1	Increase the number of previously uninsured enrolled in health care coverage	Number of people enrolled in Texas SHAP program, including CSAs and Healthy Texas	Data provided by health care plans	Annual report
		The employee participation rates of those enrolled compared to other like size companies with insurance plans and similar premiums/co-pays/deductibles*	Data provided by health care plans and the Texas Department of Insurance	Annual report
		Demographic and geographic distribution of program participants	Data provided by health care plans	Annual report
		Number/proportion of employees that chose premium assistance vs. point of service cost-sharing	Data provided by health care plans	Annual report
		Number/proportion of employees that switched from premium assistance to point of service cost-sharing and vice versa	Data provided by health care plans	Annual report
		PCP utilization rates over time (as employee costs increase) for those who chose point of service cost-sharing vs. premium assistance	Data provided by health care plans	Annual report
		Average subsidy per person and number of people enrolled for the fixed subsidy payment structure vs. the percent of premium payment structure	Data provided by health care plans	Annual report
2	Increase small business participation in health care plans	Number of employers offering a health care plan through the Texas SHAP program, including CSAs and Healthy Texas	Data provided by health care plans	Annual report
3	Increase utilization in primary and preventive care and decrease utilization in emergency room care	Percent of insured versus uninsured employees that visit their Primary Care Provider (PCP) and individual use over time*	Pre/post employee survey, claims data, review of available electronic medical records data, statewide utilization rates	Annual report
		Percent of insured versus uninsured employees that receive preventive care and individual use over time *	Pre/post employee survey, claims data, review of available electronic medical records data, statewide utilization rates	Annual report

#	Objective	Performance Measure	Data Source	Timeframe
		Emergency room utilization by insured versus uninsured employees and individual use over time*	Pre/post employee survey, claims data, review of available electronic medical records data, statewide utilization rates	Annual report
		Assessment of participants' experiences with the health care system including ease of finding a primary care physician, accessing services, and cost of medical services	Annual employee survey	Annual report
4	High employer and employee satisfaction with the Texas SHAP program	Employer and employee satisfaction with health coverage plans (e.g., Healthy Texas, three-shares, CFHP) and with CSAs, including employee perception of health status and control of chronic conditions	Annual employer and employee survey	Annual report
5	Enhance "culture of insurance" as evidenced by sustained participation in health care plans as assistance decreases and increased employee uptake rates	Relationship between increases in employee costs and employer and employee satisfaction, enrollment rates, and employee demographics	Data provided by health care plans, claims data, and the annual employer and employee survey	Annual report
		Percent of employees who plan to stay at current employer and/or pay for health insurance after funding ends	Annual employee survey	Annual report
		Percent of employers who plan to offer health insurance after funding ends	Annual employer survey	Annual report
		Level of employee enrollment as funding decreases over time	Data provided by health care plans	Annual report
		Level of employee rated importance in health insurance over time (from when the employee began the program to when they were no longer eligible for funding)	Pre/post employee survey	Annual report
		Relationship between Texas SHAP program and economic factors impacting participating employers such as health care costs, impact of coverage on staff productivity, number of missed days, and employee recruitment and retention	Pre/post employer survey	Annual report
6	Improve the continuity and portability of care in medical homes through periods of non-insurance by partnering with safety net providers.	Number of employees whose health care coverage is transferred to a safety net provider's program when employee has exhausted plan benefits.	Data provided by health care plans and employer and employee surveys.	Annual report
7	Create a reinsurance model to significantly	Cost of Healthy Texas premiums compared to market plans with similar benefits	Data provided by Healthy Texas health care plans participants and other	Annual report

#	Objective	Performance Measure	Data Source	Timeframe
	reduce premium costs for small businesses and low wage workers		insurers through TDI annual survey	
8	Use reduced participation requirements in Healthy Texas to increase enrollment	Number of groups with participation levels below commercial market requirement of 75%	Health plan data and employer surveys	Annual report
		Number of employers who indicate participation is possible due to reduced participation requirements	Employer and employee surveys	Annual report
9	Develop reinsurance benefit plans that are sufficient to meet the health care needs of the vast majority of enrollees	Number of enrollees who meet or exceed reinsurance risk corridor attachment point, or whose total annual claims exceed policy limits	Healthy Texas health plan data	Annual report

* Depending on data quality and availability, minor modifications may be needed.

WORK PLAN

HHSC’s high-level project timeline (Chart 3) and detailed work plan (Table 11), provided below, identifies key implementation dates, outlines steps HHSC and its partners will use to implement the Texas SHAP program, and lists responsible staff.

Chart 3: Texas SHAP Grant Project Timeline

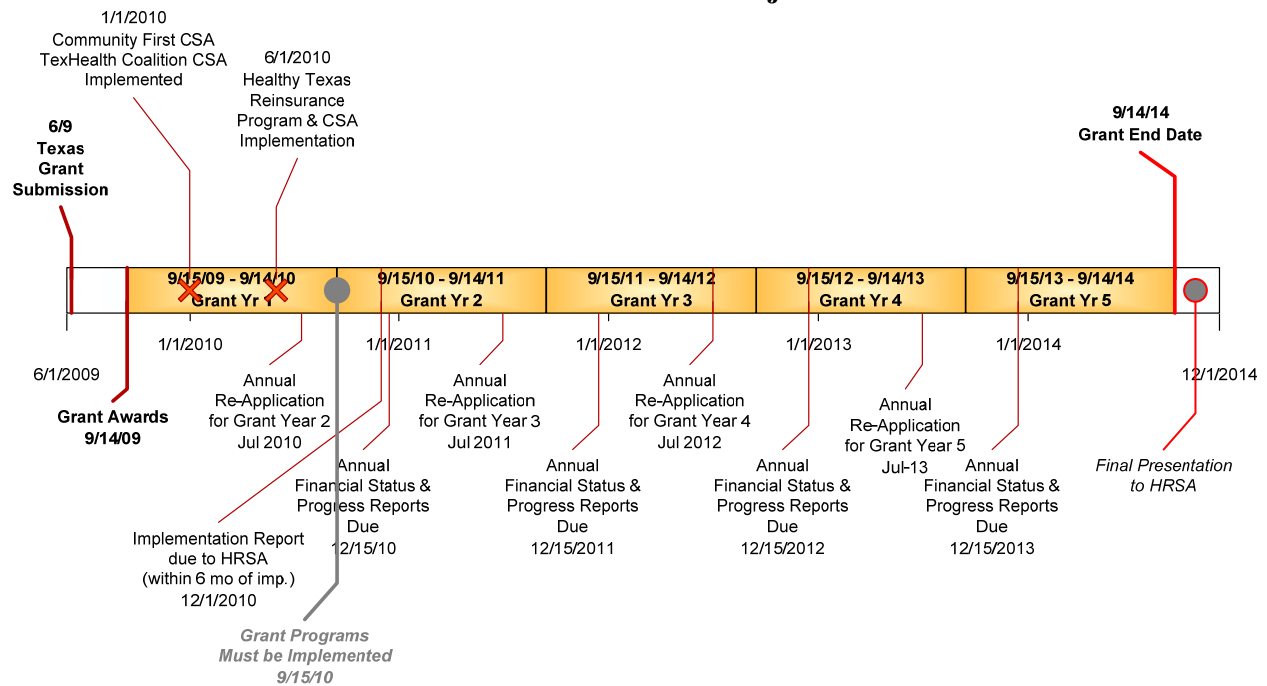


Table 11: Texas SHAP Grant Work Plan

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
	GRANTS AWARDED	9/14/09		
	Grant Year 1 Begins	9/15/09		
PRE-IMPLEMENTATION				
A	Texas Health & Human Services Commission (HHSC) Project Organization & Planning (Cost Sharing Account)			
1	Staffing and Administrative & Program Development Activities			
1.1	Establish SHAP grant account and payment procedures	Sept 2009	Budget Office	Account established, payment procedures in place
1.2	Hire SHAP Grant Project Manager	Sep – Oct 2009	Medicaid/CHIP Policy Director	Staff hired
1.3	Establish Memorandum of Understanding (MOU) between HHSC and Texas Department of Insurance (TDI) related to grant activities.	Sep 2009 – Oct 2009	Grant Project Manager, HHSC Legal, TDI Grant Manager, TDI Legal	MOU developed, negotiated and executed.
1.4	Project Manager works with HHSC's legal division to amend existing contracts for Community First and TexHealth Coalition, to include grant related activities	Sep 2009 – Oct 2009	Project Manager and HHSC Legal	Contracts developed, negotiated and executed.
1.5	Appoint project implementation workgroup members and oversight committee	Oct 2009	Project Manager	Workgroup established, team members and oversight committee appointed
1.6	Establish ongoing weekly/bi-weekly implementation meetings and issue resolution process with participating health plans	Oct 2009 – Imp.	Project Manager	Meetings scheduled to occur on a weekly or bi-weekly basis, as needed. Timely issues resolution process in place.
1.7	Develop detailed work plan and implementation timeline	Oct 2009 - Nov 2009	Project Manager	Work plan developed and approved by oversight committee
1.8	Workgroup develops program policies and procedures; including accounting, audit and evaluation	Oct 2009 – Nov 2009	Project Manager	Program P&Ps developed and approved by oversight committee
1.9	HHSC determines funding allocations for the participating entities	Sep 2009	Project Manager	Project Manager works with oversight committee

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
				to determine and finalize funding allocations.
1.10	Work with evaluation team to establish reporting requirements for participating health plans and refine details related to ongoing program evaluation	Sep 2009	Project Manager and Strategic Decision Support (SDS) Team	Reporting requirements established and communicated to health plans, evaluation methodology finalized and approved by oversight committee
1.10	Provide Quarterly Status Updates to Oversight Committee	Ongoing	Project Manager	Timely and informative quarterly status updates prepared and presented to oversight committee by Project Manager. Issues needing direction presented with options and recommendations.
1.11	Status updates and reporting to HRSA regarding implementation status.	Ongoing	Project Manager	Timely and informative implementation status updates provided to HRSA. Technical Assistance requested, when required.
B	Texas Department of Insurance (TDI) Project Organization & Planning (Healthy Texas Reinsurance Program)			
1	Task 1: Healthy Texas Staffing and Administrative Activities			
1.1	<u>Action Step 1:</u> Hire Project Staff and establish administrative functions	Sept 2009 – Oct 2009	TDI – Healthy Texas Program Director	Staff hired. Healthy Texas program implementation activities begin.
1.2	<u>Action Step 2:</u> Develop and publish actuarial and marketing RFPs	Oct 2009	TDI – Healthy Texas Program Director	Request for Proposals are published according to state requirements. Receipt of responses to RFP.
1.3	<u>Action Step 3</u> Review RFP responses; award contracts	Oct. 2009	TDI – Healthy Texas Program Director and staff	Contractors are selected from submitted RFPs and contracts awarded. Actuarial/Marketing services are provided as required by contract.
1.4	<u>Action Step 4</u> Develop and publish health plan participation RFP	Nov 2009 – Dec. 2009	TDI and actuarial consultants	Request for Proposals are published according to state requirements Receipt of responses to health plan RFP
1.5	<u>Action Step 5</u>	Feb 2009	TDI and	Eligible health plans are

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
	Review RFP responses; award contracts		actuarial consultants	selected from submitted RFPs Confirmation of Healthy Texas health plan participants
2	Task 2 - Healthy Texas Outreach and Information Development			
2.1	<u>Action Step 1:</u> Create official website for Healthy Texas	Sep 2009 – Oct 2009	TDI – Web Administrator	Website is developed Distribution of Healthy Texas information via web; number of website visits
2.2	<u>Action Step 2:</u> Develop and implement statewide outreach and information plan	Oct 2009 – Aug 2010	TDI, marketing contractor	TDI begins outreach and marketing campaign to inform public of Healthy Texas Receipt of inquiries re. program, visits to website, requests for information
3	Task 3 – Healthy Texas Start-up and Enrollment Activities			
3.1	<u>Action Step 1:</u> Initiate Healthy Texas Enrollment	June 2010	TDI, Health Plan contractors, Marketing contractor	Employers and employees will begin enrolling in Healthy Texas Number of enrollment applications received, number of businesses and individuals enrolled
3.2	<u>Action Step 4:</u> Initiate application process for Cost Sharing Accounts	June 2010	TDI	Employees will apply for Cost Sharing Assistance Number of CSA applications received and processed within a timely manner; number of CSA awards approved
3.3	<u>Action Step 2:</u> Conduct Healthy Texas enrollment fairs across state	June 2010 – August 2010	TDI, Marketing contractor	Employers, agents and employees will attend Healthy Texas insurance enrollment fairs Number of people attending fairs, number of applications received
3.4	<u>Action Step 3:</u> Monitor enrollment and address inquiries or problems in a timely manner	June 2010- August 2010	TDI	Staff will evaluate enrollment progress, identify need for targeted outreach, respond to inquiries Distribution of enrollment across the state by demographic and geographic variations; timely resolution of

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
				inquiries or any problems
3.5	<u>Action Step 4</u> Develop report on implementation of Healthy Texas	August – September 2010	TDI	Staff will complete comprehensive report on activities in Healthy Texas P Submission of report to HHSC, HRSA and state legislative leadership
C	Health Plan Pre-Implementation Activities			
1.1	Community First submits proposed health benefit plan for Texas Dept of Ins (TDI) approval	Jun 2009 - Nov 2009	Charles Kight, Community First Health Plans	TDI approves Community First's proposed benefit plan; Community First prepares to market.
1.2	Community First develops P&Ps, marketing plan, funding distribution procedures, refined budget and participation estimates for submission to HHSC	Sept 2009 - Nov 2009	Charles Kight, Community First Health Plans	Required documents and information submitted to and approved by HHSC.
1.3	Community First participates in weekly/bi-weekly implementation meetings/conf. calls with HHSC and provides regular implementation status updates	Oct 2009 – Imp.	Charles Kight, Community First Health Plans	Community First participates in implementation meetings/calls, and provides timely and accurate updates.
1.4	Community First completes pre-implementation preparations, as appropriate: hire staff, create financial accounts, training, market to employers	Sep 2009 – Imp	Charles Kight, Community First Health Plans, and other representatives	Pre-implementation activities successfully completed, issues/risks identified and mitigated or resolved. Timely implementation achieved.
2.1	TexHealth Coalition provides HHSC with ongoing information and updates concerning the imp. status for any three-share plans that are not yet operational	Aug 2009 – Imp.	Ann Kitchen, TexHealth Coalition	Timely and accurate information and updates provided to HHSC, as established
2.2	TexHealth Coalition develops P&Ps, marketing plan, funding distribution procedures, refined budget and participation estimates for submission to HHSC	Sep 2009 – Nov 2009	Ann Kitchen, TexHealth Coalition	Required documents and information submitted to and approved by HHSC
2.3	TexHealth Coalition participates in weekly/bi-weekly implementation meetings/conf. calls with HHSC and provides regular implementation status updates	Oct 2009 – Imp	TexHealth Coalition, and other representatives	TexHealth Coalition representatives participate in implementation meetings/calls, and provide timely and accurate updates.

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
2.4	TexHealth Coalition entities (6 three-shares) complete pre-implementation preparations, as appropriate: hire staff, create financial accounts, training, market to employers	Sep 2009 – Imp	Six TexHealth Coalition Member three-shares	Pre-implementation activities successfully completed, issues/risks identified and mitigated or resolved. Timely implementation achieved.
POST IMPLEMENTATION ACTIVITIES				
Ongoing Program and Grant Management				
1 Texas Financing and Reporting Activities				
1.1	Initial grant funding distribution to TDI's Healthy Texas Program; and at quarterly intervals thereafter.	Oct 2009	Project Manager, HHSC Grant Accounting	Initial grant funding distributed to TDI; and quarterly thereafter. Funding need periodically reassessed.
1.2	Initial grant funding distribution to CSA Entities; and at quarterly intervals thereafter.	Dec 2009	Project Manager, HHSC Grant Accounting	Initial grant funding distributed to Community First and TexHealth Coalition. Future funding distributions dependant on meeting reporting requirements and needs assessment.
1.3	Sub-contractors submit quarterly electronic expenditure reports to HHSC.	Quarterly	HHSC Grant Accounting & Project Manager	Quarterly expenditure reports assessed for compliance with grant requirements and future funding needs.
1.4	Sub-contractors submit an implementation report to HHSC within 4.5 months of implementation.	4.5 months post imp.	TexHealth Coalition, Community First Health Plans	Implementation report provided to HHSC timely, to be incorporated into the 6-month implementation report to HRSA, as required in the grant.
1.5	Sub-contractors and TDI's Healthy Texas submit Annual Reports to HHSC's Grant Project Manager	1.5 months prior to HRSA Annual Grant Report due date	TDI's Healthy Texas Project Manager	Annual Reports submitted to HHSC timely, to be incorporated into annual report to HRSA, as required in the grant.
2 HRSA Grant Related Reporting and Technical Assistance Activities				
2.1	Implementation Report Due to HRSA	Due within 6 months of	Project Manager	Required report completed and submitted

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
		imp.		within required timeframe.
2.2	Electronic Quarterly (Form PSC-272) Report which identifies cash expenditures against the authorized funds for the grant.	Due quarterly throughout the 5-year grant period	Project Manager??	Required report completed and submitted within required timeframe.
2.3	Annual Grant Re-application Process	Due annually prior to beginning of next grant year	Project Manager	Required re-application documentation submitted timely; grant renewal approved by HRSA for next grant year.
2.4	Annual Financial Status Report	Due within 90 days of the end of each budget period	Project Manager	Required reports completed and submitted within required timeframe.
2.5	Annual Progress Report	Due within 90 days of the end of each grant year	Project Manager	Required reports completed and submitted within required timeframe.
2.6	Grantee Technical Assistance Workshops (2-days)	2 during the grant period	Project Manager	Project Manager (+1) travels to Washington DC to participate in 2 TA workshops
2.7	Technical Assistance Conference Calls	2 calls during each grant year	Project Manager, and team	Grant team participates in TA calls.
2.9	Possible On-site Performance Review, as appropriate (determined by HRSA)	Possible at some point during 5-year grant period	Project Manager	Project Manager and team prepare and accommodate for on-site performance review, ensuring that the necessary information is available to HRSA's review team.
2.10	If Performance Review occurs, grantee must prepare an Action Plan to identify key actions to improve program performance and address any identified issues.	Follow-up, if Performance Rev is done.	Project Manager	If review occurs, required Action Plan is prepared, as specified by HRSA's review team and submitted within required timeframe.
2.11	Final Status Report (format and	Due at the	Project Manager	Required report

Task #	TASK	Timeframe	Responsible Party	Anticipated Results / Evaluation Measurement
	electronic submission requirements to be provided by HRSA)	end of the 5-year grant period		completed and submitted within required timeframe.
2.12	Final Presentation. May be requested of grantees.	At the end of the grant period	Project Manager	2 representatives would travel to Washington DC to present information on the grant.

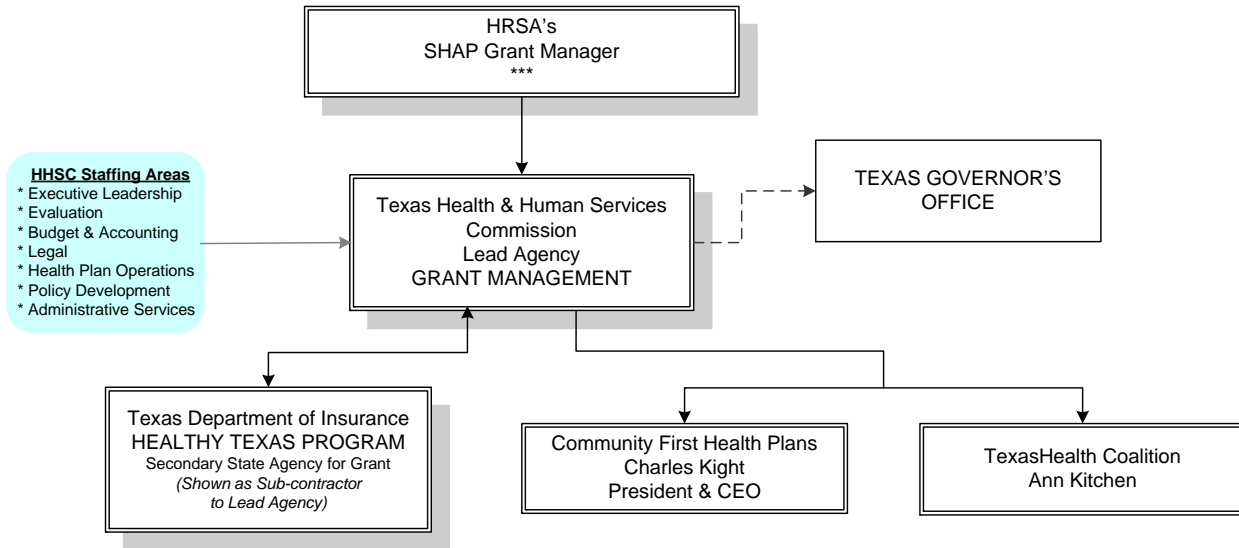
Management, accounting and governance structure: As the lead agency for the grant, HHSC will manage the project using the agency's accounting, evaluation and other existing infrastructure. HHSC will also create a SHAP executive oversight committee, an implementation management team, and an ongoing operational workgroup, which will include the HHSC grant director, the HHSC project manager, the TDI Director, the President and CEO of CFHP, the appointed representative for the TexHealth Coalition, and the lead program evaluator. Regularly scheduled quarterly meetings will be set to review program performance, grant expenditures, and discuss any issues or consideration for the program. In addition, the grant manager will host monthly (as needed) technical assistance calls with the partners. Program challenges and issues ultimately will be addressed within the SHAP executive project management team, with final determination by HHSC and coordination with the HRSA grant manager.

Organizations Conducting the Evaluation

The Evaluation Unit of the HHSC Center for Strategic Decision Support (SDS) will evaluate the Texas SHAP program. The SDS division operates as an enterprise function for the Texas Health and Human Services Commission (HHSC)³⁵ and four other Texas health and human services agencies, and is independent of program operations. This evaluation unit has many years of experience evaluating statewide health and human services programs and it includes professional evaluators with expert knowledge of data systems that will be used for this evaluation, and with ongoing, unlimited access to the data. In addition to the Evaluation Unit, SDS includes the demographers and epidemiologists that will be providing population data for the evaluation and twenty-five analysts that work with HHSC data and policies every day. SDS is located within the HHSC Financial Services Division. Financial Services also includes the budget and accounting staff who will be contributing to the evaluation. The SDS Evaluation Unit is uniquely positioned to evaluate the Texas SHAP program and coordinate with HRSA. State statute designates HHSC as an oversight agency and consolidates the evaluation function for all state health and human services agencies under SDS.

The Texas Department of Insurance (TDI) will evaluate the operation of the Healthy Texas program and will provide program information to HHSC per the terms of the SHAP contract.

³⁵ Texas' health and human services oversight umbrella agency.

Chart 4: Texas SHAP Grant Organizational Structure

Evaluation Reports to be Provided to HRSA: HHSC will provide ongoing annual progress reports, and the final report to HRSA in accordance with the schedule presented in Table 3.

- Annual progress reports will include the results of the annual performance measures analysis and the tests of the Texas SHAP objectives. The report will discuss the demonstration successes and opportunities for improvement, and will include recommendations for improving the Texas SHAP program. Annual progress reports will be submitted to HRSA ninety days after the end of each demonstration year. The last annual report will be the final demonstration report.
- Results from internal monitoring are designed to examine issues such as program administration and fund distribution. For example, the Texas SHAP program will monitor whether there is a seamless transfer of HRSA funds from HHSC to the health care entities and whether the health care entities provide timely documentation of distributed HRSA funds to HHSC. This information will be used to make necessary modifications to program goals, objectives, and interventions in accordance with HRSA guidelines.
- The final demonstration report will include the information that would have been in the last annual report and a discussion of the principal conclusions of the evaluation. The final report will be submitted to HRSA ninety days after the end of the demonstration.
- The final demonstration report will include a review of program outcomes, strategies, and lessons learned by the Texas SHAP program. This information will contribute to discussions on providing health care coverage to the uninsured. It will also include a discussion on how the program results are relevant to the goals of Healthy People 2010.

Timeline of the Evaluation and Reporting Deliverables

Data collection for the Texas SHAP evaluation will begin when funds are distributed to HHSC, and data will be collected throughout the five-year demonstration period. The evaluation reporting timeline is presented in Table 12.

Table 12. Texas SHAP Evaluation Reporting Timeline

Report	Report Type
Year 1 Quarter 1	Quarterly expenditure and enrollment report
Year 1 Quarter 2	Quarterly expenditure and enrollment report and 6-month implementation report
Year 1 Quarter 3	Quarterly expenditure and enrollment report
Year 1 Annual	Annual report including performance measures, and quarterly and annual expenditure and enrollments
Year 2 Quarter 1	Quarterly expenditure and enrollment report
Year 2 Quarter 2	Quarterly expenditure and enrollment report
Year 2 Quarter 3	Quarterly expenditure and enrollment report
Year 2 Annual	Report including annual performance measures, longitudinal assessment, and quarterly and annual expenditure and enrollments
Year 3 Quarter 1	Quarterly expenditure and enrollment report
Year 3 Quarter 2	Quarterly expenditure and enrollment report
Year 3 Quarter 3	Quarterly expenditure and enrollment report
Year 3 Annual	Report including annual performance measures, longitudinal assessment, and quarterly and annual expenditure and enrollments
Year 4 Quarter 1	Quarterly expenditure and enrollment report
Year 4 Quarter 2	Quarterly expenditure and enrollment report
Year 4 Quarter 3	Quarterly expenditure and enrollment report
Year 4 Annual	Report including annual performance measures, longitudinal assessment, and quarterly and annual expenditure and enrollments
Year 5 Quarter 1	Quarterly expenditure and enrollment report
Year 5 Quarter 2	Quarterly expenditure and enrollment report
Year 5 Quarter 3	Quarterly expenditure and enrollment report
Final Report	Final report including annual performance measures; longitudinal assessment; and quarterly, annual and, final expenditure and enrollments ³⁶

RESOLUTION OF CHALLENGES

HHSC and its partners have identified the following challenges and solutions that may be encountered and addressed as the Texas SHAP program rolls out:

- Distribution network for commercial products: Currently, commercial business is marketed through brokers who receive a percentage of the employee's portion of the monthly premium. Participating health plans may wish to sell this product directly to employers; or, if brokers are used, select and certify a limited number, and modify the payment structure.
- Preventing adverse selection: Participating health plans, including three-share programs, plan to target employers who have not offered a health benefit in the last 12 months. Some

³⁶ The final report will include a detailed description of the Texas SHAP program's efficacy in accomplishing project goals, a plan for ongoing evaluation of the program's efficacy in reaching uninsured Texans. The final report will assess the Texas SHAP program, including strategies and lessons learned, for potential replication in other states. The final report will also include a plan for future public education about the health care coverage program.

health plans have expressed concern about openly advertising the grant funded program for fear that only employers with sick employees will sign up. CFHP, for example, intends to continue to educate all small employers about the value of health coverage and appropriately underwrite new business so that the pool of covered lives remains balanced.

- **Medical Loss Ratio:** As with any product, the health plans will closely monitor the medical loss/benefit ratio. CFHP the three-share programs have developed comprehensive health promotion programs, disease and case management services, and fraud prevention and detection to ensure members receive the right care at the right time, and it is anticipated that such services will be incorporated into Healthy Texas plans, too.

As anticipated or new challenges arise, HHSC and its SHAP partners will use the outlined program structure using conference calls, work groups and committees to raise issues, identify solutions and find results.

EVALUATION AND TECHNICAL SUPPORT

Key project staff: Highly knowledgeable and skilled staff with years of experience make up the key Texas SHAP grant staff, as listed below, and as detailed in the biographical information in Attachments 5.

- Maureen Milligan is the Deputy Chief of Staff at HHSC and will serve as the SHAP Program Director for HHSC, and overall for the SHAP grant.
- Dianne Longley is the Director of Research and Analysis for the Life, Health and Licensing Program at the Texas Department of Insurance (TDI) and will serve as the Program Director for the Healthy Texas Program and related grant activities.
- Charles L. Kight is the President/CEO of CFHP and will serve as the SHAP Program Director for CFHP.
- A director of a local three-share program will be designated as lead for SHAP Grant for the TexHealth Coalition, and will act as primary liaison to the lead Texas agency for the SHAP grant.

Information technology capabilities: HHSC and its partners will work within existing system and information technology parameters to implement the Texas SHAP program. Funding for systems changes is not needed or required.

ORGANIZATIONAL INFORMATION

As outlined in the Methodology, Evaluation and Work Plan sections of this proposal, HHSC, and its Texas SHAP grant partners bring to this program extensive resources, history, knowledge and experience.

Texas Health and Human Services Commission: Texas HHSC provides leadership and direction, and fosters the spirit of innovation needed to achieve an efficient and effective health and human services system for Texans, which is composed of five agencies: Health and Human Services Commission (HHSC); Department of Aging and Disability Services (DADS); Department of State Health Services (DSHS); Department of Assistive and Rehabilitative Services (DARS); and Department of Family and Protective Services (DFPS).

HHSC oversees the operations of the health and human services system, provides administrative oversight of Texas health and human services programs, and provides direct administration of some programs. Programs administered by HHSC include: Medicaid, CHIP, Temporary Assistance for Needy Families Food Stamps and Nutritional Programs Family Violence Services Refugee Services Disaster Assistance

Texas Department of Insurance: The Texas Department of Insurance works to provide a financially stable and fair marketplace and an effective and efficient workers' compensation system. TDI's mission is to protect insurance consumers by:

- regulating the insurance industry fairly and diligently;
- promoting a stable and competitive market;
- providing information that makes a difference;
- providing the best value in services to the people of Texas;
- applying the law and the agency policy fairly and consistently throughout the state;
- communicating openly and providing timely and accurate information to the public we serve, and to all our fellow employees; and
- communicating internally and externally, we evaluate and adjust the course of the agency in response to changes in conditions.

Community First Health Plans: Community First Health Plans' mission is to engage in public and private partnerships to increase the number of Bexar County residents enrolled in funded health benefit programs, which provide access to affordable, quality health care. CFHP has 15 years experience, and currently manages 115,000 members in a variety of products: It offers commercial full risk coverage (HMO, PPO), functions as third party administrator for employers who wish to self-fund health coverage, and it provides Medicaid, CHIP, and CHIP Perinate benefits through its contract with the Health and Human Services Commission.

CFHP has recently revamped its commercial plan offerings, streamlined business process for greater efficiency, conducted broker interviews, and is seeing growth in its small group business. It is currently in the marketplace offering group health coverage to local businesses. The addition of grant funds will make our products more appealing to the business owner and employees. The CFHP Board of Directors is accountable to the UHS Board of Managers.

TexHealth Coalition: The TexHealth Coalition is a voluntary association of communities that have joined forces to identify statewide options to reduce the number of uninsured individuals in their communities while maintaining local and regional flexibility. Six communities currently developing and implementing three-share programs include: Houston (Harris County), Central Texas (Travis (Austin), Hays, Williamson, Burnet, Caldwell and Bastrop Counties), Galveston (Galveston County), El Paso (El Paso County), North Texas (Dallas County), and Brazos Valley (Brazos, Burleson, Grimes, Leon, Madison, Albertson and Washington Counties).

Harris County Healthcare Alliance (Houston/Harris County): The Alliance serves as a catalyst for improving the healthcare system of Houston/Harris County. It is governed by a 13-member community board and is funded by dues from member organizations, self-supporting projects

and grants. The Alliance expanded community-wide Nurse Triage system to incorporate low level 9-1-1 and steer callers to appropriate care. It has completed an analysis of the gap between supply and demand for primary care and has assessed the ability of existing providers to improve their capacity to meet the excess demand. It is the recognized entity to create a community health information exchange.

University of Texas Medical Branch at Galveston (Galveston/Galveston County): The mission of UTMB is to provide scholarly teaching, innovative scientific investigation, and state-of-the-art patient care in a learning environment to better the health of society. UTMB is the lead entity representing Galveston County in the Coalition and in the development of a health coverage options for small businesses. UTMB provides comprehensive primary, specialty, and sub-specialty care clinical programs and since opening in 1891, has addressed the health needs of medically underserved populations and has developed a strong record of creating innovative programs to meet those needs.

El Paso (El Paso/El Paso County): The mission of the El Paso County Hospital District is to enhance the health and wellness of the El Paso community by making high quality, affordable healthcare services accessible to all. The District is a public not-for-profit health care system serving the needs of the community through a variety of care settings and programs, including an acute care hospital, out patient clinics, a Medicaid HMO and HealthCARE Options, a targeted benefit plan designed primarily for the indigent adult population. The District is governed by a seven-member Board of Managers appointed by the El Paso County Commissioners Court.

TexHealth Central Texas (Travis, Hays, Williamson, Burnet, Caldwell and Bastrop Counties in Central Texas): TexHealth Central Texas is the nonprofit corporation created to manage start-up, implementation, and ongoing operations of the three-share program in Central Texas. The Board of Directors is composed of physician, business, and chamber, healthcare, agent, and community leaders from participating regional communities who have been working on program design over that past one to three years. The TexHealth Central Texas Board is supported by an Advisory Council of over 60 physician, hospital, government, business, and other community leaders who are responsible for ongoing publicity, philanthropic, marketing and other support and promotion of the program in their respective communities.

North Texas 3-Share (Dallas/Dallas County): The mission of North Texas 3-Share is to develop and implement a multi[share program, initially in Dallas County and subsequently in surrounding counties of North Texas based on community interest. North Texas's efforts have been endorsed by the Parkland Health and Hospital System and the Dallas County Commissioners Court. Currently governed by a Board with broad community representation, the intent is to expand the Board to include representatives from each of the five major hospital systems in North Texas and an appointee from the Dallas County Medical Society.

Brazos Valley Council of Governments (Brazos, Burleson, Robertson, Grimes, Leon, Madison, and Washington Counties): The mission of the Brazos Valley Council of Governments (BVCOG) is to benefit the citizens of the Brazos Valley region by serving as the vehicle for their local governments to cooperatively identify needs, develop responses, implement solutions, eliminate duplication, promote the efficient and accountable use of public resources, and improve the quality of life. The Board of Directors includes all seven county judges, as well as representation from city councils and other key community leadership groups. BVCOG manages

14 programs that have been awarded more than 80 grants, for a combined budget of approximately \$30 million, including pass-through funding to grant recipients and subcontractors.

Community First Health Plans: Community First Health Plans' mission is to engage in public and private partnerships to increase the number of Bexar County residents enrolled in funded health benefit programs, which provide access to affordable, quality health care. CFHP has 15 years experience, and currently manages 115,000 members in a variety of products: It offers commercial full risk coverage (HMO, PPO), functions as third party administrator for employers who wish to self-fund health coverage, and it provides Medicaid, CHIP, and CHIP Perinate benefits through its contract with the Health and Human Services Commission.

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