

A New Diagnosis:

Building the Private Market to Improve Health Coverage for Texans

For two decades, Texas has consistently had the highest percentage in the nation of residents without health insurance. Nearly 25 percent of all Texans lack health coverage compared to the nationwide average of 16 percent. This amounts to 5.5 million Texans whose only guarantee of treatment is their local emergency room or a public health clinic. The high uninsured rate distorts and destabilizes the market even for those who have coverage, resulting in health care insecurity for all Texans.

Health insurance is too integral to the state's health care infrastructure to be treated as an optional commodity. In 21st century Texas, the health care delivery system upon which all of us depend can exist only if there is a reliable financing system. Absent a government-imposed universal system, that reliable financing comes primarily from a robust, effective private insurance market.

In Texas, as in other states, the Department of Insurance regulates the insurance industry and is charged with maintaining a healthy insurance market that assures Texans access to quality, affordable insurance products that are profitable for insurers. Texas currently has one of the least-regulated insurance markets in the nation, as well as the highest uninsured rate. By making much-needed statutory changes in the health insurance market and strengthening the Texas Department of Insurance's involvement and oversight, legislators could increase the availability and affordability of insurance to millions of working Texans, resulting in greater security for health consumers and greater stability for the state's health care system.

The Uninsured in Texas

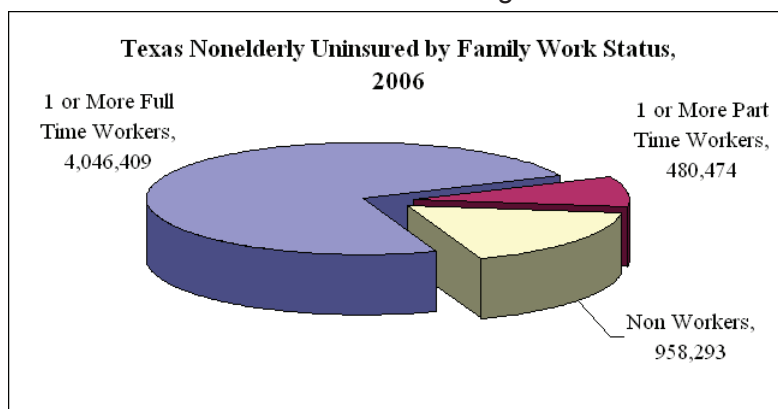
Texas has the highest percentage of uninsured people in the nation.

The Texas population in 2006 was about 23 million people. Of those, a little over half had private sector health insurance: slightly less than 11 million were covered by employer-sponsored insurance, and another million purchased insurance in the individual, or non-group, market. Another 5.5 million people had health coverage through public programs like Medicaid and Medicare. Finally, another 5.5 million people—about a quarter of the population—did not have health coverage at all.

Federal and state laws require hospitals, at a minimum, to give emergency health care to individuals who show up at the emergency room in need of such care. This is a very costly way of responding to the need for health care. Many studies have shown that providing health care to the uninsured is inefficient, ineffective, and expensive.

Most of the uninsured are in households with at least one full-time worker.

The vast majority of uninsured Texans are full- or part-time workers and their family members. Among uninsured Texans less than 65 years of age, 74 percent, or more than 4 million people, live in households with at least one full-time worker. Another nine percent—almost half a million people—live in households with at least one part-time worker.¹ That is to say, more than 80 percent of uninsured Texans are in working families.



Source: Kaiser Family Foundation, *State Health Facts*, 2006.



This is important because employer-sponsored health insurance is the largest source of health coverage, both nationally and in Texas. However, the gap between the national average and Texas percentages of the population covered by employer-sponsored health insurance (six points, from 54 percent to 48 percent) is the major share of the difference between the national and Texas levels of uninsured people (eight points, from 16 percent to 24 percent).

As the costs of health care and insurance premiums continue to rise, the number of employers unable or unwilling to provide health insurance continues to rise as well. The share of Texans covered through employer-sponsored plans has dropped from 57 percent in 1999 to 48 percent in 2006.²

In this regard, Texas is no exception. More and more, the ranks of the uninsured are being swelled by working Americans. The National Coalition on Health Care has pointed out that:

- Nearly 1.3 million full-time workers lost their health insurance in 2006.
- The percentage of people (workers and dependents) with employment-based health insurance has dropped from 70 percent in 1987 to 59 percent in 2006. This is the lowest level of employment-based insurance coverage in more than a decade.
- In 2005, nearly 15 percent of employees had no employer-sponsored health coverage available to them, either through their own job or through a family member.
- In 2006, 37.7 million workers were uninsured because not all businesses offer health benefits, not all workers qualify for coverage and many

employees cannot afford their share of the health insurance premium even when coverage is at their fingertips.³

And according to the Kaiser Family Foundation, a one percent decline in employer-sponsored coverage between 2005 and 2006 was matched by a one percent increase in the percentage of Texans who were uninsured.⁴ These statistics indicate that providing access to affordable coverage for employees without insurance could significantly reduce the number of uninsured Texans.

Many studies agree that universal coverage is an important element in designing a more effective and equitable health care system. For instance, the Institute of Medicine embraces universality as the first guiding principle for evaluating health care reform initiatives.⁵ The Task Force on Access to Health Care in Texas adopted a set of ten principles to guide health care reform efforts, the first of which was “all individuals living in Texas should have access to adequate levels of health care.”⁶

There are three broad approaches to achieving affordable health coverage for every person.

In a **single-payer system**, the health care system is publicly regulated and funded. The population as a whole is covered, rather than individuals (as in the approaches described below). Many industrialized democracies, such as Canada, have such a system.

In a **mandatory private insurance system**, universal coverage is achieved by a statutory requirement that all residents must obtain health coverage, whether through employer-sponsored insurance, individual (non-group) insurance, or public programs like Medicare, Medicaid and CHIP. Because some percentage of businesses or individuals is not able to afford such coverage in spite of a legal mandate to do so, subsidies are offered. This approach was a cornerstone of health care reform efforts in the 1990s. It also has been implemented in Massachusetts, and legislation including an individual mandate, an employer mandate, or both has been proposed in California, New Mexico and Pennsylvania.⁷

In a **voluntary private insurance system**, the system neither covers the entire population nor contains a mandate for individual or employer

participation. Coverage is thus an aspirational goal and is not built into the design of the system. This is the current system in most of the United States, including Texas.

There are two basic strategies to reduce the percentage of uninsured in a voluntary private insurance system:

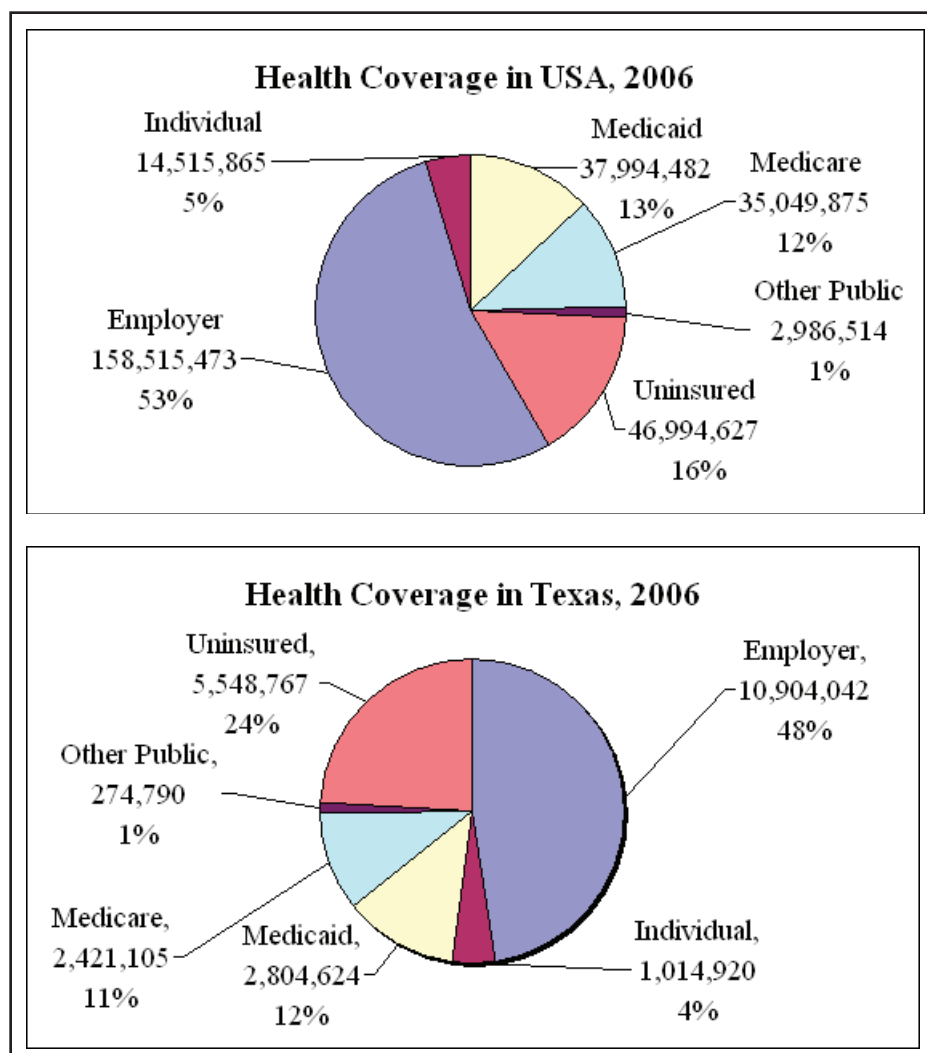
- expand participation in public programs like Medicare, Medicaid and CHIP; and
- institute reforms in the private health insurance market to increase access and affordability in that market, and thus the percentage of the population that is covered in that market.

While both a single-payer system and a mandatory private insurance system are more effective ways of achieving the goal of universal coverage, implementation of such reforms would require both

regulatory infrastructure and political consensus that are not currently available in Texas or at the national level. Therefore, this paper concerns itself with reforming the private health insurance market in order to expand the percentage of Texans participating in it, and the critical role that state regulation plays in advancing that goal.

The Private Health Insurance Market in Texas

A comparison of Texas data on the uninsured with the United States as a whole shows that the rate of employer-sponsored group health insurance coverage is significantly lower in Texas than nationally. About 54 percent of Americans had employer sponsored coverage in 2006, compared with only 48 percent of Texans, a six point gap.



Source: Kaiser Family Foundation, State Health Facts, 2006.

This 6 percent difference is a big deal: if the rate of employer-sponsored coverage were at the national average, one million more Texans would have health insurance.⁸ The Task Force on Access to Health Care's report characterized the employer-sponsored health insurance market in Texas as "weak."⁹

Certainly, several factors unique to Texas help explain lower participation in the private health insurance market. Overall, employer willingness to provide health insurance for employees is low, having declined from 57.1 percent in 1999 to 48 percent in 2006.¹⁰ Too, several industries that are prominent in the Texas economy typically have low coverage rates. These include the construction, tourism, recreation, agriculture, retail and wholesale, and personal services industries. Such industries are characterized by part-time or seasonal employment, cyclical work patterns with frequent layoffs, relatively low cash wages, and limited non-cash compensation (e.g., sick leave).¹¹

However, while these factors help explain Texas' low private health insurance market coverage rate, the statutory and regulatory structure of that market is part of the problem. In a 2005 paper, the Texas Department of Insurance said, "Despite the relatively high number of uninsured residents, Texas is widely recognized as having one of the healthiest commercial insurance markets in the country. ... Availability of private insurance—either group or individual—has not been a problem for most Texans, although affordability is a significant concern."¹²

In other words, insurers are able to make a profit in Texas while not providing affordable coverage to significant sectors of the market.

There are three sectors in the private health insurance market in Texas: large-employer group insurance, small employer group insurance, and individual (non-group) insurance. Most large employers' health coverage is self-insured and regulated by the federal Employee Retirement and Income Security Act of 1974, or ERISA. Of the 11 million Texans with some form of private coverage, 5 million are members of self-insured plans.¹³ Since ERISA pre-empts other insurance laws, state regulatory authority over self-insured plans is very limited.

State officials have more authority over the small-employer and individual health insurance markets, and they have been the subject of legislative and regulatory attention for almost two decades. This paper describes how each market functions currently in Texas and how it might be improved. In so doing, it focuses on four broad principles of state regulation affecting the operation of the small group and individual health insurance markets: access, affordability, coverage and pooling.

Access

Although insurance is the business of spreading risk, insurers are in business to limit their own risk in order to avoid losses. This allows them to offer a reasonably-priced product and still make a profit. One way to lower risk is to deny coverage to applicants who have specific health conditions or a history of health problems.

To identify and limit such risks in the small-employer and individual markets, insurers use *medical underwriting*; that is, they review the health status and medical history of each applicant for coverage, whether a single individual or all 50 employees of a small business. This creates a problem of **access**.

Public policymakers can address the access problem in a number of ways. The most important of these include:

- **Definition of the small-employer market:** Texas defines a "small employer" as having between 2 and 50 employees. On the other hand, fourteen states allow sole proprietors or self-employed people to participate in the small group insurance market. Colorado, for instance, calls self-employed individuals "Business Groups of One" and allows





them to purchase group insurance.¹⁴ New York also covers sole proprietors through Healthy New York, a health reinsurance program.¹⁵

- **Guaranteed issue:** “Guaranteed issue” laws prohibit insurers from denying coverage to applicants based on health status. Thus, if an insurer is selling coverage to one small group or individual, it must sell it to all regardless of health status. In the small group market today, all health insurance policies must be sold on a guaranteed-issue basis, as a result of the federal Health Insurance Portability and Accountability Act (HIPAA) passed in 1996.¹⁶

In the individual health insurance market, five states require insurers to sell coverage on a guaranteed issue basis. Several other states have other guaranteed access requirements. For instance, a handful of states require open enrollment periods during which insurers may not deny coverage due to a medical condition.¹⁷

- **Guaranteed renewability:** Guaranteed renewability laws prohibit insurers from canceling coverage on the basis of medical claims or diagnosis of an illness. HIPAA requires all group and individual health insurance policies to be guaranteed renewable. Although HIPAA does not prohibit insurers from canceling all their policies and leaving the market, there is a penalty on market reentry of 5 years.

- **Portability:** Because people change jobs more frequently in their careers than previously, the federal government passed the COBRA law, which basically allows continuation of health coverage with a previous employer. State policymakers have

also enacted coverage continuation laws similar to federal COBRA. These apply to policies purchased by small businesses not subject to federal COBRA. Thirty-eight states have such laws; some offer shorter periods of continuation coverage, while others are more generous than COBRA.¹⁸ Texas’ portability provisions are more generous than the federal COBRA, but not as generous as many other states.

- **Unfair marketing practices:** States also have developed fair marketing standards to prevent insurers from circumventing guaranteed issue and renewability requirements. For example, state marketing standards require insurers to actively market policies to all small businesses, not just the ones with a healthy workforce. Federal law does not provide for these kinds of fair marketing requirements.

- **Guaranteed access for special populations:** States have also passed laws to improve access to health coverage for “special populations.” For instance, most states prohibit insurers from canceling insurance for dependent adult handicapped children who were covered by their parents’ policies as minors. In all states, newborns are automatically covered under their parents’ policy for 30 days provided that the policy covers dependents.

Affordability

Medical underwriting also contributes to problems of affordability in the small group market. Since insurers have a strong incentive to compete for good risks and a low incentive to compete for poor risks, an insurer might offer insurance at a low rate for a health 25-year old male but charge a higher rate for another man twice his age. In a small group plan, every participant in the plan must be charged the same premium, so the presence of one or two individuals with higher-than-average health risks can skyrocket premiums for a whole group. Thus, a small business with 20 employees who are all under 30 may pay less in premiums than another business with only 12 employees, a few of whom are in their fifties. This has an adverse effect on the willingness of the second small employer to sponsor coverage.

In response, most states have enacted rating reforms in the small group market, prohibiting or restricting the ability of insurers to charge higher

premiums based on health status or the risk of having future medical claims. Some states have enacted similar laws for the individual market. Generally there are three types of restrictions on insurers—rate bands, pure community rating, and modified, or adjusted, community rating.

- **Rate bands:** Rate bands limit how much insurers can vary premiums for each policyholder based on health and claims of the policyholder. These limits force insurers to spread some risk more broadly across all policyholders. The extent to which premiums can vary under rate bands depends on the size of the rate band permitted and what factors are constrained by the band. Some states permit consideration of only a few factors (such as age and location) and limit the extent to which each factor can affect a rate. Others permit consideration of a larger array of factors or do not limit their impact in setting rates.

Texas has broad rate bands compared to other states. It allows consideration of location, age, gender, industry in which the group works, and group size, and assigns no limits whatsoever to the area, age or gender factors. After those five factors have been used to calculate a base rate, then health factors are also considered to calculate a final premium rate. This permits enormous variations in the amounts different groups pay for coverage.

At renewal, rate bands also limit how much insurers can surcharge a group or individual based on claims made in the prior year or other factors, such as the length of time (duration) since the policy was first purchased. The renewal surcharge permitted by the rate band, typically 15 percent, is applied in addition to any increase that would otherwise apply to all policyholders due to

the cost of medical care (called “trend”).

- **Pure community rating:** Community rating means that insurers must set prices for policies based on the collective claims experience of everyone with such a policy (and in theory, the price reflects the value of benefits and not the risk factors of people who purchase the policy). Insurers are not allowed to vary rates based on health or claims of a business or a person.

- **Adjusted or modified community rating:** Under adjusted or modified community rating, premiums may be adjusted based on geographic location and sometimes for a person’s age; adjustments for gender are generally not allowed. At renewal, premiums are based on the claims experience of all people with that policy. In other words, businesses and individuals who had claims are not charged higher rates than others with the same policy.

Rate regulation that spreads risk is, by nature, redistributive. To “even out” premiums for one person whose health condition could cause high medical costs, insurers must charge slightly more to many healthy individuals. Critics of rate regulation argue it raises premiums for healthy individuals and groups higher than they otherwise would pay in the absence of regulation. Advocates of tighter rate regulation note these rules protect consumers from dramatic premium increases when they are sick, or at renewal after they become sick.

Another approach to addressing affordability issues is to create **subsidies** for people who cannot afford coverage in the small-employer and individual health insurance market. Sixteen states provide some sort of premium subsidy in the small-employer market, and twelve also allow individuals to access the subsidy program to assist with purchasing individual coverage.¹⁹

Coverage

In an efficient, well-regulated private health insurance market, consumers get coverage for the health conditions for which they purchase insurance. States have a wide range of standards, called mandated benefits, which govern three things:

- the types of conditions (e.g., diabetes) and treatments (e.g., mammograms) a policy is required to cover;



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- the types of health care providers (e.g., nurse practitioners, chiropractors) that insurers must reimburse; and
- special populations (e.g., adult handicapped children) that must be covered.

The argument for mandated benefits is simple. It is the best way to spread the cost of a medical condition or treatment among a broad population, making it less expensive for the group of people who need such coverage. Such inclusions make good economic sense; sometimes they also promote a public policy, as in coverage for pregnancy and childbirth or HIV-AIDS. Mandated benefits also encourage people to seek certain care (e.g., preventive screenings) that they might otherwise forego.

Whether and how mandated benefits add to the cost of health insurance has been an issue of longstanding controversy. Insurers and some conservative policy groups²⁰ contend that mandates inflate premium costs by anywhere from 20 percent to more than 50 percent.²¹ According to the insurance industry-sponsored Council for Affordable Health Insurance, Texas requires 55 mandates in its health insurance policies, significantly raising premium costs.²²

These insurers believe that policies with exempted or reduced mandates, called limited-benefit policies, would increase access and improve affordability. Texas has experimented with limited-benefit policies since the mid-1990s, when the Legislature created the “basic” and “catastrophic” plans as small-employer market alternatives to full-benefit coverage. The plans were unpopular with both insurers, who did not want to market them, and small employers, who found they weren’t much less expensive.²³

In 2003, the Legislature abolished those plans and allowed insurers to create Consumer Choice Benefit Plans (CCBPs) that exclude or reduce coverage for some mandated benefits. The list of mandates which are subject to reduction or elimination was determined by the Legislature after considerable debate. In addition, carriers may also charge higher deductible and coinsurance requirements than are allowed under traditional plans. Insurers/HMOs are required to continue offering full coverage plans with all the mandated benefits, and they must obtain

written notice from a purchaser that verifies he/she is aware that they are buying a CCBP that excludes some benefits.²⁴

The CCBP approach has slightly increased coverage rates; in 2005, the plans covered 87,675 people, 7,325 of whom were previously uninsured. However, savings were modest and mostly resulted from the higher levels of deductibles and co-payments. Carriers reported less than three percent savings due to mandated benefit exclusions and reductions.²⁵ This is consistent with other studies that have shown that exempting or reducing mandates reduces premiums by only five percent,²⁶ and is an example of “actuarial schizophrenia:” insurers claim mandates raise costs by 20-50 percent, but only reduce premiums by 3-5 percent when eliminated.

Pooling

Since insurance involves spreading the risk, it makes sense that pooling businesses in the small group market or individuals in the non-group market would improve both access and affordability for everyone. Pooling efforts in Texas have not been successful for the most part, although some credit should be given for regulatory and business community successes. The insurance industry in Texas has historically resisted attempts to expand health insurance through pooling strategies.²⁷

In the small group market, pooling strategies include **health purchasing cooperatives** (HPCs), which are groups of large or small employers or in some cases, a combination of both, that join together to obtain health coverage for the cooperative as a single entity.²⁸ The larger the cooperative, the more clout it has to negotiate favorable prices and coverage. According to TDI, there are approximately 50 purchasing cooperatives doing business in Texas now.²⁹

Texas law permits four kinds of pooling in the group health insurance market: private purchasing cooperatives, small employer health coalitions, and two kinds of health group cooperatives, distinguishable by the size of employer groups that can participate in them.³⁰

In the individual health insurance market, the **Texas**

Increasing Access and Affordability Through Reinsurance

According to a 2004 study, at least 21 states had reinsurance programs through which insurers could indemnify themselves against losses in the small-group and private health insurance market.¹ State reinsurance programs can be funded in various ways, but most rely on either assessments of participating insurers or state revenues as a financial back-stop.

Two states rely upon state revenues to expand access and affordability in their small-employer and individual health markets.

Healthy New York

Established in 2001, Healthy New York targets the employers of middle- to low-wage workers, sole proprietors, and individuals who have not been previously covered. It is thus aimed explicitly at the uninsured, with a focus on low-income and working-class participants. For instance, small employers may participate only if at least 30 percent of their employees earn less than an inflation-adjusted \$32,000 per year and the employer did not offer or contribute substantially (more than \$50 per month) to comprehensive group coverage in the prior year. HNY offers excess-of-loss reinsurance, paying 90 percent of claims between \$5,000 and \$75,000. The state subsidized the program to the tune of about \$12 million in 2004, although that amount has been declining.

Health Care Group

In Arizona, the Health Care Group uses state funds to subsidize aggregate losses incurred by participating insurance plans. At first, there was a direct cash subsidy, starting at \$8 million in 2000 and working down to \$4 million by 2004. Now the state support is triggered by an insurer's medical loss ratio, or the percentage of earned premiums actually paid in claims, and only kicks in when that ration exceeds 86 percent.²

There has been little political support in Texas for using state revenues to back-stop reinsurance arrangements. Several other states, including Connecticut, Idaho, and New Mexico, have developed reinsurance pools that rely upon insurer assessments to cover shortfalls in their programs. This is the model used in the Texas Health Reinsurance System, and has not proven successful so far. There are ways to make assessment-based reinsurance pools more attractive, but they are problematic, as Swartz notes:

There are several significant drawbacks, however, to going this route. One is that it would work against a prime purpose of the reinsurance, which is to reduce insurers' concerns about adverse selection in these markets. If the insurers have to pay for the reinsurance, they no longer have an incentive to reduce their use of selection mechanisms to avoid people who might have high expenses. A second concern is that insurers would not reduce their premiums as much if they have to pay an assessment to fund the reinsurance. This would hurt another of the prime objectives of the reinsurance program: to make small-group and individual coverage significantly less expensive so more workers will buy it.

A third drawback to assessing insurers to pay for a reinsurance program is that doing so reduces the size of the funding base for the program. Because self-funded health plans do not pay state taxes on insurance premiums, the funding base for an assessment-funded program is much smaller than the general population and corporate bases that are tapped for general state revenues.³

¹ Chollet, Deborah, "The Role of Reinsurance in State Efforts to Expand Coverage," State Coverage Initiatives Issue Brief, 2004, pg. 2. Retrieved May 28, 2008 from <http://www.statecoverage.net/pdf/issuebrief1004.pdf>.

² Swartz, Katherine. "Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers," Commonwealth Fund, July 2005, pg. 8. Retrieved May 27, 2008 from http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=286904.

³ Swartz, op. cit., pg. 16-17.

Health Insurance Risk Pool is the only available pooling mechanism. The Texas Health Insurance Risk Pool was created by the Texas Legislature to provide health insurance to eligible Texas residents who, due to medical conditions are unable to obtain coverage from commercial insurers. The Pool is a “safety net” for individuals who have been denied health insurance coverage because of pre-existing conditions, can afford the Pool’s premiums, and do not have other coverage options.³¹ The Pool currently insures 27,528 Texans.³²

The Pool is designed to offer affordable insurance to Texans who could not otherwise get coverage in the individual market. To do this, premiums were originally capped at 137 percent of the individual market rate, but allowed to increase up to double the cost if circumstances dictated. Circumstances quickly dictated, and premiums now are at the 200 percent level. Losses in the Pool are subsidized by an assessment on insurers and HMOs. As enrollment has grown, assessments paid by insurers approached the \$100 million mark in 2005.³³

The Pool has succeeded in insuring some otherwise-uninsurable people, but high cost is still a barrier. In 2006, the average monthly premium paid was \$510, up from \$490 in 2005.³⁴ A 2005 TDI found that “cost of the pool is the most frequent reason why eligible, uninsured Texans do not enroll, or cancel existing THIRP coverage.”³⁵ So the challenge still remains to provide affordable coverage for the medically uninsurable.

Another way of pooling risk is through **reinsurance**, in which an insurance company purchases insurance against the risk of unusually high claims. This helps spread the risk more broadly among insurers, reducing each insurer’s need to hold excess reserves and surpluses, and therefore reducing its premiums.³⁶ Reinsurance also promotes competition by helping insurers enter or remain in a state’s insurance market.³⁷

Insurers typically worry about two types of very large losses—aggregate losses for a group being above some overall level, and loss per insured person exceeding some threshold. Aggregate losses could exceed expectations if more group members had expenses above the average than was expected for the group. To place a limit on their

exposure to such expenses, insurers often purchase *aggregate stop-loss* reinsurance, since it puts a stop to overall losses above some level.

Annual losses per insured person also could become excessive—perhaps passing the threshold above which people are in the top, say, 5 or 1 percent of the country’s health care expenditure distribution. Insurers purchase *excess-of-loss* reinsurance in order to avoid bearing full risk for any individual’s expenses that exceed some level.³⁸

As discussed in the sidebar, there are two basic ways to fund a state reinsurance program: through assessments on insurers (either only those participating in the reinsurance pool or on all insurers in that market) or through state revenues. The Texas Health Reinsurance System is this state’s reinsurance mechanism for the small group market. Because carrier participation is voluntary, and because few insurers elect to participate, the system has not been very effective and, in fact, the Texas Department of Insurance has recommended phasing it out.

Recommendations

In comparison with other states, Texas has not been very aggressive in promoting small group and individual market reforms. However, the problems of the uninsured worsen daily and addressing those problems must involve reform of the private health insurance market. Texas’ efforts to reform its small group and individual health insurance markets should be guided by the four principles of an efficient, well-regulated private health insurance market – access, affordability, coverage and pooling.

1. Expand access to health insurance for sole proprietorships. Texas law currently defines small employers as those having between two and fifty employees. This means that sole proprietorships are not eligible for the benefits of small group coverage, and must purchase insurance in the individual market, if at all. The Census Bureau estimates that there are over 1.6 million sole proprietors and self-employed individuals doing business in Texas.³⁹ Sole proprietors are a critical part of the Texas economy and a significant share of the Texas workforce. There are two ways to expand access to coverage for sole proprietors:

a. Amend Texas law to include sole proprietorships in the definition of small employers, giving them guaranteed access to health coverage, the ability to participate in health purchasing cooperatives, and other benefits. Thirteen other states already do this.

b. Amend Texas law to allow sole proprietors to participate in the group health insurance programs of the Employee Retirement System or other public employee benefit systems on a guaranteed-issue basis.

2. Improve affordability in the small group health insurance market by narrowing rate bands and reducing wide disparities in coverage rates. Texas uses rate bands to regulate fluctuations in the cost of health coverage based on such factors as industry and group size. This produces extreme differences in premium costs, sufficient in many instances to deter employers from seeking coverage for their employees. Ratcheting down excessive variations in manual rating factors would smooth out rate variations between similar small employer groups. The majority of states that use rate bands have narrower limits than Texas.⁴⁰

3. Improve affordability in the small group and individual health insurance market by giving TDI authority to review and approve rates. Although current law includes statutory guidelines for rate bands, the Department of Insurance does not approve the rates that are being charged by insurers.

4. Improve affordability in the small group market by making the temporary margins tax deduction given to small employers who purchase health insurance for their employees permanent. The revised state franchise tax (also known as the “margins tax”) includes a provision giving a deduction for small businesses that offer employee health benefits for the first time. The deduction is 50% of health plan costs in the first year and 25% in the second year.⁴¹ In the event that the margins tax is revised or replaced in the future, Texas should ensure that whatever business tax replaces it includes an incentive for small employers to cover employees.

5. Monitor the effect of Consumer Choice Benefit Plans (CCBPs) in the small group health insurance market on selection and pricing of

standard-benefit policies that provide coverage of exempted or reduced mandates to promote adequate coverage in the market. As discussed earlier, high participation in CCBPs that exclude important benefits could cause adverse selection of standard-benefit policies as they become the only source for coverage of necessary but expensive conditions, leading to a “death spiral” in that market. TDI should monitor the evolution of CCPBs and report specifically on any adverse effects occurring in the standard-benefit market.

6. Promote pooling in the small group and individual health insurance markets by reanimating and restructuring the Texas Health Reinsurance System so that it achieves the following goals:

- Improve access to health coverage for small employers and possibly sole proprietors and individuals,
- Lower premium costs by having the state assume some of the risk,
- Spread risk of high-cost claims broadly across the insurance market,
- Protect insurers from financial losses, and
- Foster competition and participation in the health insurance market.⁴²

7. Promote pooling in the small group health insurance market by giving a discount on the premium tax paid for policies purchased from that insurer through a health purchasing cooperative or the Texas Health Insurance Risk Pool. The biggest obstacle to pooling strategies in Texas has been the unwillingness of health insurers to negotiate with them. All insurers have to pay a premium tax, currently set at 1.75 percent of gross premium receipts. Texas should offer a 50% discount on the premium tax due on all policies sold through a health purchasing cooperative or the Texas Health Insurance Risk Pool. This will give insurers a marginal incentive to participate in these pooling arrangements.

8. Clarify the Texas Department of Insurance’s mission to serve Texas taxpayers. TDI’s statutory mission should be clear: the agency should ensure a healthy insurance market that protects and serves consumers and is profitable for insurers. Currently, the agency’s mission makes no mention of consumers, unlike the mission statements of the insurance regulatory agencies in many other states.

TDI's mission statement should be rewritten, and the agency should be specifically tasked with:

- Ensuring the availability of quality, affordable insurance products,
- Vigilant oversight of the industry,
- Direct consumer assistance in resolving disputes with insurers, and
- Assistance in navigating the market.

9. Establish a Market Innovations Center in the Texas Department of Insurance to work with stakeholders to increase Texans' access to quality, affordable health insurance products.

TDI staff understand the insurance market and are in a good position to work with groups of stakeholders to develop products, programs and practices to meet Texans' array of health insurance needs.

Such a center would be distinct from TDI's existing assistance programs for individual consumers, since it would be charged with spurring market innovation rather than simply responding to conflicts.

Endnotes

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