



TEXAS NEEDS TOOLS TO INCREASE PRIVATE HEALTH COVERAGE

HOW IMPROVING PUBLIC OVERSIGHT CAN BRING HEALTH CARE TO MORE TEXANS

By insurance industry standards, Texas' commercial health insurance market is considered one of the healthiest in the United States because it has a relatively large number of insurance companies offering plans, is subject to less rate regulation than in most states, and brings in \$22 billion a year in premiums.¹ The effect of this market on Texas consumers, however, is anything but healthy. The private health insurance market in Texas leaves one in four uninsured, generates the third highest premium increases in the nation, and produces one of the lowest rates of coverage through employer-sponsored insurance in the nation.² Many small-business owners in Texas want to provide coverage to their workers but cannot afford to with premium quotes as high as \$23,000 a year per employee.³ Texans must think twice before switching jobs or starting businesses for fear that a preexisting condition will prevent them from getting health insurance. The notion that a hands-off approach to regulation promotes the best outcomes has not worked any better in the Texas health insurance market than it has in the mortgage industry. Texans deserve a truly healthy insurance market in which insurance companies vigorously compete for business and make reasonable profits while consumers are able to purchase the insurance they need at prices they can afford. This policy page focuses on sensible market reform options—many already enacted by other states—that can help make private health insurance more affordable and accessible in Texas.

- **Strengthen state oversight by updating TDI's mission, creating a division to expand health insurance coverage, and improving rate oversight and transparency.**
- **Expand access for small businesses and their employees through public reinsurance and reduced use of health status in setting premiums.**
- **Expand risk pool access by making coverage more affordable and adequate.**

Strengthen the Texas Department of Insurance

As the agency that oversees the insurance industry, TDI touches Texans lives daily. Texans rely on TDI to foster a healthy and competitive insurance marketplace. Today, plenty of health insurance companies are “competing” in the Texas marketplace. But they are competing mostly to avoid risks and cherry pick the healthiest consumers instead of competing to get the business of the large swath of uninsured Texans who want coverage. Competition is good for consumers when it results in the marketplace producing high-quality products that meet consumers' needs at prices that are fair and reasonable. Currently, TDI does not have the tools it needs to foster a healthy marketplace or help consumers access health insurance coverage. In order for TDI to meet the public's needs, the Legislature must give TDI both the legislative direction to actively help expand health insurance coverage and the authority to ensure that health insurance rates are fair.

Agency Direction

The function of all state agencies is to serve the public, but TDI's duties as laid out in state law and agency mission fail to direct the agency to protect consumers or help expand access to insurance coverage. TDI's duties in state

law are to: (1) regulate insurance in Texas, (2) administer the workers' compensation system, and (3) execute insurance laws.⁴ The agency's mission statement is:

The Texas Department of Insurance regulates the marketplace firmly and fairly by enforcing and implementing the law. TDI strives to enhance internal and external communication for efficient and effective regulation and to promote outreach to educate the public.⁵

As evidenced by TDI's mission statement and statutory duties, the agency lacks the clear legislative direction to protect consumers and expand coverage, two things Texans need. This lack of direction limits the agency's innovation and proactive work in the area of expanding private health insurance coverage. The agency itself has requested that the legislature give the agency clear direction to work on expanding private health insurance coverage.⁶ TDI has expertise in both the health insurance market and the barriers Texans face in obtaining coverage. If empowered to do so, TDI is uniquely positioned to generate options to expand private health insurance coverage in the state.

Recommendations

- **Update TDI's mission and duties.** Both TDI's mission and statutory duties should be updated to charge TDI with protecting consumers and helping consumers access high-quality, affordable insurance. Important concepts to include in the updated mission and statutory duties are:
 - A commitment to consumer protection, assistance, and education;
 - Vigilant and fair regulation of the insurance industry;
 - Fostering a healthy and competitive marketplace that provides consumers with access to high-quality insurance products; and
 - Ensuring that insurance companies offer products at prices that are fair and reasonable.
- **Create a division within TDI dedicated to expanding health insurance coverage.** To accomplish its updated mission as it applies to health insurance, TDI will need to organize a division dedicated to expanding health insurance coverage. This division should provide education and assistance to small-business owners and individuals seeking to get or keep insurance. This division should also develop strategies and policies to expand coverage by working with stakeholders, researching programs working in other states, analyzing the Texas market, and identifying barriers to coverage. TDI should include in its biennial report to the Legislature options for expanding health insurance coverage developed by this division.

Rate Transparency

With respect to health insurance companies, TDI regulates financial solvency, deceptive marketing, and the content of policy forms (to ensure standards are met in descriptions of coverage given to policyholders). All of these are critical consumer protections, but they fail to address consumers' primary barrier to accessing quality health insurance—cost. Regulation of health insurance premiums in Texas is less rigorous than most other states. Texas does not require group

Texas Health Insurance Markets Regulated by TDI

Group Market – The group market primarily consists of health insurance offered through employers. This market is further divided into the *large group* market (for businesses with more than 50 employees) and *small employer* market (for businesses with 2 to 50 employees). The large group and small employer markets are regulated differently in recognition of the additional challenges faced by small employers in obtaining insurance.

Individual Market – The individual market consists of policies sold directly to individuals or families.

insurers to submit rates and rate justifications to TDI and, unlike many states, lacks the authority to review rates charged by carriers to ensure that they are adequate and not excessive.⁷ Texas is one of just ten states that fails to actively review rates in the group or individual health insurance markets.⁸ With no rate oversight in Texas, how can consumers, much less the Commissioner of Insurance, know that health insurance rates are fair and justified? Most other states use oversight tools to make sure that health insurance rates charged in the small employer and individual markets are fair. Common tools used by other states are rate review and minimum medical loss ratios.

Rate Review

Thirty-two states use a rate review system called prior approval, in which the state reviews rate justifications submitted by insurance companies and verifies that proposed rates are not excessive before the rates are charged to policy holders.⁹ Not only would rate review allow TDI to ultimately reject an unfair rate, it would give TDI the opportunity to negotiate smaller increases with insurance companies based on expected medical claims and other costs. Regulators in many states with prior approval authority for health insurance rates report that they can often negotiate significant reductions in proposed increases to keep premiums reasonable in relation to the benefits offered.¹⁰

Minimum Medical Loss Ratios

In addition to or instead of rate review, many states set minimum medical loss ratios. Medical loss ratios are the percentage of health insurance premium dollars spent on medical care as opposed to administration, profits, and marketing. For example, a medical loss ratio of 75%, means that \$0.75 of every premium dollar taken in is spent on medical services while \$0.25 is spent on other non-medical costs. Setting minimum medical loss ratios prevents insurance companies from charging excessive rates and retaining large margins for profit and other non-medical expenses. Medical loss ratio standards provide incentives for insurance companies to prudently use premium dollars and pursue administrative efficiency. If an insurance company does not meet the minimum medical loss ratio standard, some states require the company's premiums be adjusted accordingly the next year. Other states require insurance companies that fail to meet the standard to refund excess premiums to enrollees.¹¹

Medical Loss Ratios in Other States

Fifteen states set a minimum medical loss ratio standard in the small employer or individual markets.¹² Following are some examples of states' experience and a table showing examples of state's medical loss ratio requirements.

Recent Oversight Changes in Other States

In 2008, Washington restored the authority of its insurance regulatory agency to review individual health insurance rates. Washington previously had rate review authority until rate oversight was revoked in 2000. In the years when the Washington Insurance Commissioner lacked rate review authority, rates increased 16% per year on average, and in 2007, one of the largest carriers in the state increased rates by as much as 40%. Washington Insurance Commissioner Mike Kreidler requested that rate transparency be restored so he can access the information necessary to know if rate increases are justified.

Also in 2008, Colorado started requiring insurers to file justification for rates and have rates approved before they can be charged to policy holders. In determining whether rate increases are justified, the Colorado Division of Insurance may consider the carrier's medical loss ratio, the percentage of premiums spent on medical care. Achieving an 80% medical loss ratio in the small employer market and 65% in the individual market helps qualify insurers for expedited rate review.

Sources: Chris McGann, "Senate approves bill giving state power to review insurance rate hikes." *Seattle Post-Intelligencer*, January 31, 2008; Washington State Office of the Insurance Commissioner, "Restoring authority in the individual health market: ESB 5261," updated December 21, 2007, www.insurance.wa.gov/oicfiles/rules/proposed/ESB5261FactSheet.pdf; and House Bill 08-1389, 66th Colorado General Assembly, 2008.

- New Jersey requires a minimum 75% medical loss ratio in the small employer and individual markets and requires insurers to issue refunds to policyholders when the standard is not met. The New Jersey Insurance Department reports that its minimum loss ratio standard is easy to administer, has helped control premiums in the individual market, and, due to the refund provision, allows both policyholders and insurance companies to benefit financially in good years when claim costs are less than expected.¹³
- Minnesota requires minimum medical loss ratios up to 72% in the individual market and 82% in the small employer market.¹⁴ The Minnesota Department of Commerce publishes medical loss ratio information by carrier in an annual report required by state law. The report serves the public interest by giving consumers medical loss ratio information to help them choose among available health insurance companies. In 2006, the overall market medical loss ratios exceeded the state's minimum standards with a 93% actual medical loss ratio in the individual market and 87% in the small employer market.¹⁵
- In 2008, Washington increased its minimum medical loss ratio standard in the individual market from 72 to 77%.¹⁶ The Washington State Office of the Insurance Commissioner maintains a website where consumers can access and compare insurers' medical loss ratios, profit margins, average premiums, premium increase in the last year, administrative costs, and surplus amounts.¹⁷

**Examples of Minimum Medical Loss Ratios in the
Small Employer and Individual Markets**

State	Individual Market	Small Employer Market
Delaware	-	75%
Kentucky	65%	70% - groups of 2-10 75% - groups of 11-50
Maine	65%	75% - 78%
Maryland	60%	75%
Minnesota	68% - 72%	71% - 82%
New Jersey	75%	75%
New York	80%	75%
North Dakota	55%	70%
Oklahoma	-	60%
South Dakota	65%	75%
Vermont	70%	-
Washington	77%	-
Wyoming	60%	73%

Sources: Families USA, *Medical Loss Ratios: Evidence from the States*, Health Policy Memo, June 2008, www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf; and Minnesota Department of Commerce, *Report of 2006 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations*, June 2007, www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf.

Loss Ratio Experience in Texas

Texas does not set minimum medical loss ratios or require insurance companies to report medical loss ratios to TDI. TDI does, however, collect data annually on the fully insured group health insurance market from which medical loss ratios can be calculated.¹⁸ TDI does not collect equivalent data on the individual health insurance market. For health insurance policies sold in Texas from 2003 through 2006, the overall market medical loss ratio averaged 72% for the small employer market and 84%

for the large employer market. However, the wide range in medical loss ratios between insurance companies shows that insurers vary considerably in the portion of premiums spent on medical care. The table *Medical Loss Ratios in Texas* shows the range of medical loss ratios per year reported to TDI by the ten companies with the largest market share in each year. In 2006, these large insurance companies charged over \$6 billion in premiums in the small and large group markets. Some of these insurance companies spent a surprisingly high percentage—some more than half—of Texans’ premium dollars on profits, administration, marketing, and other non-medical expenses.

Medical Loss Ratios in Texas

Market	Loss Ratio Category	2003	2004	2005	2006
Small Employer	Lowest loss ratio in top ten companies	61.7	52.4	43.7	58.1
	Highest loss ratio in top ten companies	97.4	80.4	90.0	84.7
Large Employer	Lowest loss ratio in top ten companies	67.4	69.7	68.6	37.5
	Highest loss ratio in top ten companies	124.2	130.5	87.5	134.4

Source: Texas Department of Insurance, Texas Group Accident and Health Insurance Survey, 2003-2006

Recommendations

Texas’ higher than average health insurance premiums and high uninsured rate results in part from the limited extent to which Texas engages in regulation of health insurance affordability. With health insurance premiums in Texas increasing at more than ten times the rate of personal income, insurance companies should be required to show that their rates and rate increases are reasonable and that they are not retaining an excessive margin for profits, administration, and marketing.¹⁹ Texas should explore the following rate oversight and transparency measures that are in place in many other states.

- **Prior approval of health insurance rates.** To bring TDI’s rate oversight authority in line with that of other states, TDI should be given statutory authority to review proposed rates in the small employer and individual health insurance markets and reject rates that are excessive, inadequate, or discriminatory. Without this authority, TDI cannot ensure that premium rates charged to consumers are fair and reasonable. To allow for efficient rate review, TDI should set the terms of reporting rates to ensure as minimal an impact as possible on both TDI staff resources and insurers. TDI can limit how often insurance companies can raise rates within a year to control the costs of regulation. To protect carriers from potential inaction on the part of TDI, rates could be deemed approved if not rejected within a reasonable timeframe such as 60 days.
- **Set minimum medical loss ratios.** Consumers deserve to know that a large percentage of their health insurance premiums will go to paying for medical services as opposed to profits, administration, and marketing. Texas should set minimum medical loss ratios at a level adequate to ensure prudent use of premiums in the small employer, large group, and individual markets, and require insurance companies to refund excess premiums to policy holders when the loss ratio standard is not met. In addition, insurance companies should report medical loss ratios to TDI annually for their Texas business. TDI should post this information on its website and insurance agents should share loss ratio data with individuals and employers shopping for insurance so consumers can choose to purchase policies from companies that direct the most premium dollars toward medical services.

Expand Access for Small Businesses and Their Employees

Small businesses—those with 2 to 50 employees—traditionally face many challenges when trying to obtain health insurance coverage for their employees. Small employers in Texas report that they cannot afford to provide coverage, find shopping for coverage too complex and time consuming, and have difficulty finding an insurance agent willing to help find the best

coverage.²⁰ One of the largest hurdles to accessing affordable coverage results from the use of medical underwriting—the use of medical history or health status in setting premiums—in the small employer market. Unlike in the large group (51+ employees) market, small employer premiums are based in part on the health status of each employee.

These difficulties lead to small employers offering coverage to employees much less commonly than large employers. In Texas, only 34% of small businesses offer health insurance coverage compared with 93% of large employers.²¹ The weakness of the employer-sponsored insurance market in Texas, and in particular the small employer market, is a major driver of Texas' high uninsured rate.²²

Texas has implemented a number of programs and reforms with the goal of increasing small employer coverage, including purchasing cooperatives and coalitions that let small employers join together to buy insurance as a larger group; Consumer Choice plans that lack state-mandated benefits and have higher deductibles and co-payments; and the Texas Health Reinsurance System (discussed below). These programs have had only limited success in expanding coverage to uninsured small businesses. However, some programs and reforms in other states have had greater successes that Texas can learn from. Promising areas for Texas to explore include public reinsurance and decreasing variability in small employer premiums.

Public Reinsurance

What Is Reinsurance?

Reinsurance is essentially insurance for insurance companies. Insurance companies and other entities purchase reinsurance to protect against losses that may result from unusually high claims. When structured effectively, reinsurance spreads risks broadly among insurers and can lead to lower premiums by reducing potential risk for insurers and thus reducing their need to hold excess reserves and surpluses.²³ Reinsurance also promotes competition by helping insurers enter or remain in a state's insurance market by making the risks faced by insurers more predictable.

Reinsurance can take several forms, divided into three categories for the purposes of this paper: private, state-sponsored, and publicly funded. Insurance companies can purchase private reinsurance from a reinsurance carrier. States can also form reinsurance pools (Texas' is discussed below), where a state-sponsored entity collects reinsurance premiums from carriers and uses them to pay for the costs of risks ceded to the pool. At least 21 states have state-sponsored reinsurance pools, but many allow insurers to participate voluntarily, which results in such low enrollment that reinsured risks are not spread broadly across the market.²⁴ A third structure that more states are starting to look to is publicly funded reinsurance in which the state itself pays for some or all of the costs of the reinsured risk. Publicly funded reinsurance allows premiums to be reduced even further.

As with other types of insurance, reinsurance coverage takes effect once a deductible (called an attachment point) is met. Once the primary insurer has paid claims up to the attachment point, the reinsurer begins to cover claims up to the reinsurance ceiling, or upper limit. In some cases, the primary insurer must pay coinsurance towards the claims being covered by reinsurance.²⁵

The Texas Health Reinsurance System

The Texas Health Reinsurance System (THRS) is a voluntary, state-sponsored reinsurance pool for small employer health insurance carriers established by state law. THRS was established to guarantee that reinsurance was available to small employer carriers to guard against the possibility that a small employer carrier, whose policies are subject to guaranteed issue and renewability laws, may insure a disproportionate share of people with high-cost claims (called adverse selection). Insurer participation in THRS is optional for most carriers.²⁶ If a small employer carrier elects to participate in THRS, that carrier can reinsure small employer groups or individual members of groups. Carriers pay risk-adjusted premiums based on each person they choose to reinsure. THRS covers claims above \$10,000 in a year for all reinsured individuals. If THRS losses in a year

exceed the premiums collected, THRS covers the loss through an assessment on all participating carriers in an amount proportional to their market share.²⁷

The voluntary nature of THRS does not enable the system to accomplish its purpose of spreading risk for small employers over a large base. Only 7 of the approximately 60 small employer carriers participate in THRS, and participating carriers have reinsured only 30 lives.²⁸ The experience of many states has shown that to be effective in terms of enrollment and spreading risk, reinsurance pools must have mandatory participation of carriers in the market.²⁹

Reinsurance as Part of Insurance Reforms

State-sponsored reinsurance is used as a tool in many states to support broader health insurance market reform goals such as expanding access and addressing affordability. For example, state-sponsored reinsurance programs in Connecticut and Arizona help support the guaranteed issue of policies to sole proprietors. In New York, publicly funded reinsurance is used to expand coverage options for low-income, uninsured individuals and small groups.³⁰

Establishing a mandatory reinsurance program as part of a larger market reform initiative could help reduce uncertainty for insurers and stabilize market participation. If Texas used private market reforms to expand coverage in a way that introduces new risks for insurers—for example, by implementing community rating or requiring guaranteed issue of policies to sole proprietors—the state could diminish insurers’ risk by establishing a mandatory reinsurance program.³¹

Public Reinsurance

Interest is growing in public reinsurance programs due to the success of New York’s program, Healthy New York. Public reinsurance uses public funds to reduce risk for private health insurance companies, in turn lowering premiums for enrollees. Unlike premium assistance programs where subsidies directly reduce premiums paid by individuals, public reinsurance subsidizes insurers by paying part or all of the expense of high-cost claims. Consumers benefit from the subsidy indirectly through reduced premiums, which reflect insurers’ reduced risk. New York is the only state currently operating a public reinsurance program. Other states seriously considering public reinsurance as part of health coverage reform participated in a recent Reinsurance Institute sponsored by the Robert Wood Johnson Foundation’s State Coverage Initiatives and the Urban Institute. The Reinsurance Institute allowed states to model and analyze the potential impacts of introducing public reinsurance.³² New York’s program and lessons from the Reinsurance Institute are described below.

New York

New York uses state-funded reinsurance to make coverage more affordable for low-income, uninsured individuals and small businesses. Healthy New York has proven successful with approximately 150,000 people covered at reduced premiums. In 2006, premiums for Healthy New York *family coverage* were 45% less than commercial small employer coverage and 69% less than commercial HMO individual coverage. Reductions for *single adult coverage* were even greater.³³

Healthy New York contracts with private HMOs to offer coverage to qualified individuals and businesses. The insurance policies purchased through Healthy New York are reinsured with public funding, removing much of the risk to insurers of

Opportunities for Insurance Reform in Texas

The Texas Department of Insurance is currently under Sunset review. This process will entail a broad public and legislative review of the need for the agency as well as the effectiveness of its structure and functions. Through the Sunset review, the Sunset Advisory Commission can recommend some of the reforms highlighted in this Policy Page. Other reforms related to insurance regulation and the risk pool are the subject of interim charges currently being looked at by legislative committees. All reforms discussed in this Policy Page can be enacted by the Texas Legislature when it reconvenes in January of 2009.

high cost claims and resulting in much lower premiums. A small employer may purchase coverage through Healthy New York if 30% or more of its employees earn less than \$36,500 a year. Individuals and sole proprietors must earn less than 250% of the federal poverty level. In addition, to be eligible individuals must have been uninsured and small businesses must not have offered insurance for the previous year. These restrictions allow Healthy New York to target its resources to expanding coverage to the uninsured and deter substitution of existing private coverage.

The state assumes 90% of the cost of claims between \$5,000 and \$75,000 per policy holder per year. This publicly funded reinsurance allows Healthy New York premiums to be much lower than premiums in the commercial market. Healthy New York is funded with tobacco settlement funds. In 2006, reinsurance payments through Healthy New York totaled \$92 million.³⁴

The Reinsurance Institute

Through the Reinsurance Institute, Rhode Island, Washington, and Wisconsin received technical assistance from the Urban Institute to model the potential cost, take-up rate, and overall effect of implementing a publicly funded reinsurance program. Modeling showed that publicly funded reinsurance could be used to cut premiums by one-third, expand coverage among the previously uninsured, increase the number of small employers offering coverage, and reduce the likelihood that employers with existing coverage would drop that coverage. The institute found that the most cost-effective way to use reinsurance to expand coverage is to make the reinsured coverage available only to the previously uninsured, as Healthy New York does.³⁵

Recommendation

When structured effectively, reinsurance can lower premiums, reduce the selection risk faced by carriers, and encourage carriers to remain in or enter the market. Drawing on lessons from other states, Texas should restructure THRS so that it achieves the following goals:

- Improves access to health coverage for small employers and possibly sole proprietors and individuals;
- Lowers premium costs by having the state assume some of the risk in exchange for expanding access;
- Spreads risk of high-cost claims broadly across the insurance market,
- Protects insurers from financial losses; and
- Fosters competition and participation in the health insurance market.

Decreasing Premium Variability

Spreading the Risk and Cost of Illness

As expected in a health insurance pool, a small percentage of the population accounts for the majority of health care spending. Experience in the Texas group health insurance market shows that 68% of people in 2005 had claims that totaled under \$1,000 while less than 1% had claims above \$50,000.³⁶ The purpose of insurance is to spread the risk and the costs of illness broadly. Spreading risk broadly through insurance helps to keep insurance available and affordable for people regardless of their health status. Because unregulated use of medical underwriting can result in many small employers being offered coverage only at the maximum rate, almost all states have adopted mechanisms to more broadly spread risk in the small employer market. The three mechanisms states use to limit variation in premiums in the small employer market are rate bands, modified community rating, and pure community rating. Of these, Texas now uses rate bands.

Texas' Small Employer Rate Bands

Texas limits the factors that can be used to set premiums for small employer groups and uses rate bands to limit the amount of rate variation caused by some of the rating factors. Rates in Texas are set in a two-step process. First, a base premium is calculated based on the following characteristics of the small group: age, geographic area, gender, group size, and industry classification. Within these rating factors, premium variation is limited in law only for group size and industry classification. For group size, the highest rating factor may not exceed the lowest by more than 20%. For industry classification, the highest rating factor may not exceed the lowest by more than 15%. Carriers may assign an unlimited range of rating factors associated with age, gender, and geography (i.e., premiums may vary based on these characteristics by any amount that can be actuarially justified). In the second step, carriers raise the base premium by as much as an additional 67% based on risk factors including health status, medical history, and duration of coverage of the small group or any of its members.³⁷

Significant Rate Variation between Groups Permitted

A common misinterpretation of Texas' rate band regulation is that premium rates for the same product can vary between employer groups only by 67% from the lowest premium to the highest premium, reflecting just the rate band on health status. That is incorrect because it fails to take into account the variation allowed in setting the base premium. Because Texas allows unlimited rate variation based on geographic area, age, and gender in setting the base premium (as long as variation is actuarially sound), there is in effect no limit on the extent to which rates can vary from the least to most expensive groups.

When examining whether coverage is affordable for small employers it is important to consider the wide range of premium variation. While the average rate in Texas for small employer coverage in 2005 was \$4,300 for single coverage and \$11,000 for family coverage, many groups do not qualify for the average rate and pay significantly more or are priced out of the market entirely.³⁸

To investigate premium variation faced by small employers in Texas and four other states in 2000, the U.S. Government Accountability Office (GAO) worked with licensed insurance agents to obtain actual rate quotes from carriers for three hypothetical small groups with differing risk characteristics. The lower-risk group was relatively young and had no health conditions. The medium-risk group was similar to the low-risk group except one member had juvenile-onset diabetes. The higher-risk group had the same member with juvenile-onset diabetes and also had older members, a smoker, and a higher-risk industry classification. Of the five states studied, Texas had the largest variation in rate quotes between groups. One carrier quoted a premium for the medium-risk group that was 62% higher than the lower-risk group, and a premium for the higher-risk group that was almost four times higher than the lower-risk group. These higher-risk group premiums cost \$5,000 a year more per person than the low-risk group.³⁹ This wide variation in premiums makes it very difficult for an employer who has older workers on staff or a few workers with health conditions to find affordable coverage, which explains in part why only 34% of Texas small businesses offer insurance. Furthermore, the 4:1 variation in this study was only a snapshot, and does not necessarily reflect the full range of premium variation that small employers may actually find in the market.

Data collected by TDI in 2003 show even wider premium variation in the small group market in Texas. TDI asked eight large insurers to report both average and maximum annual premiums per person in the small employer market and found striking variation. The average across all eight carriers showed that the maximum rates charged to small businesses were 5 times the average rate. With the current average premium at \$4,300 for single coverage, this range means some small business owners are being charged over \$21,000 a year per employee. Note that the range considered here is from the highest rate to the average rate, not down to the lowest rate. The carrier with the widest variation had a maximum rate seven times that of the average rate. Variation in the large group market (50+ employees) was much less pronounced with maximum rates on average "just" twice as high as average rates.⁴⁰

Options from Other States

Texas' rate bands are considered a less effective system of limiting premium variation and spreading risk than systems used in other states, which results in the significant premium variation discussed above.⁴¹ Including Texas, 37 states use rate bands for insurance sold in the small employer market.⁴² Several states' rate bands are "tighter" than those in Texas. The following are examples of limits in place in other states that produce tighter rate bands.

- 12 states prohibit or limit the use of gender in setting premiums. Texas does not limit the use of gender.
- 8 states limit the use of health status in setting premiums more than Texas does. Texas applies a plus or minus 25% rate band on health status.
- 8 states limit the use of age in setting premiums. Texas does not limit the use of age.
- 4 states prohibit the use of group size entirely in setting premiums, and 2 other states limit its use more than Texas does. Texas limits the difference between the lowest and highest rating factor associated with group size to 20%.
- 4 states prohibit the use of industry type entirely in setting premiums, and 1 other state limits its use more than Texas does. Texas limits the difference between the lowest and highest rating factor associated with industry type to 15%.⁴³

Some states limit variation in premiums in the small employer market through *adjusted community rating* and *pure community rating*. Both systems prohibit the use of health status in setting premiums. Pure community rating limits rating factors to geographic area and family size only and is used in New York and Vermont. Adjusted community rating, used in ten other states, allows additional premium variation within specific limits for other factors such as age and geography. The National Association of Insurance Commissioners' (NAIC) model law on small employer and individual health insurance rate setting prescribes adjusted community rating with premium variation based on geographic area, family composition, and age. After a transition period, the model law allows for an overall premium variation range of no more than 2:1.⁴⁴

Lessons from New Hampshire

New Hampshire has experimented with both adjusted community rating and rate bands in its small employer market, and thus can provide valuable lessons to other states. In 2003, state lawmakers replaced adjusted community rating with rate bands, allowing rates to vary substantially by health status, age, geography, group size, and industry classification. Just one year after the law took effect, lawmakers repealed it in reaction to skyrocketing health insurance rates, and returned to adjusted community rating.

As with any change in how risk is spread, New Hampshire's move from adjusted community rating to rate bands resulted in both winners and losers. Some firms with more employees or relatively young and healthy workers saw premiums decrease with rate bands. Most firms, however, especially those with just a few employees or relatively older or less healthy workers, saw significant premium increases. Overall, about 77% of firms with fewer than 25 employees saw rate increases, while 23% of firms were charged the same or lower premiums. The smallest firms (those with 2 to 9 employees) saw the most drastic increases. Of the smallest firms, 41% faced an increase of 30% or more, while only 2% saw a reduction of 30% or more. Nearly 17% of the smallest firms saw at least a 50% increase and 7% of firms faced an increase of 70% or more.

Source: Edwin Park, *Lessons from New Hampshire: Senate Health Bill Could Drive up Health Insurance Premiums for Many Small Businesses*, Center on Budget and Policy Priorities, April 26, 2006, www.cbpp.org/4-26-06health.pdf.

Recommendations

Texas should improve its premium variation regulations; however, making these changes will not make health insurance more affordable on average. Limiting variation spreads risk by raising rates for the lower-risk and younger groups while lowering rates for the higher-risk and older groups. Changes to the current systems can increase affordability and accessibility for higher-risk groups, who arguably need insurance the most and are priced out of the market currently. Changes can also decrease the ability of carriers to “cherry pick” the lowest risk groups by offering them much lower rates while assigning maximum rates to groups with even moderate risk characteristics. To reduce premium variation *and* lower premiums overall, **the options listed below could be combined with publicly funded reinsurance discussed above.**

- **Tighten rate bands.** One way to decrease premium variation and increase access for higher-risk groups would be to tighten the current rates bands. The rate band for health status could be decreased from plus or minus 25% to plus or minus 10%. Another option is to introduce a rating factor limitation for age.

The complicated structure of the current rate bands could also be replaced with a more simple structure. After allowing for a base rate set using family size and geography, Texas could allow insurers to rate according to the current factors (age, gender, industry, group size, and health status) but with an overall limit on total premium variation caused by these factors of 2:1.

- **Implement adjusted community rating.** Texas could implement the NAIC model law on rating in the small employer and individual markets, which calls for adjusted community rating and with a maximum allowable overall premium variation of 2:1. Under adjusted community rating, Texas would no longer allow insurance companies to use health status and medical history for setting premiums.

Expand Access for Individuals: Fix the Risk Pool

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 also serves as the Texas alternative mechanism for individual health insurance coverage, guaranteeing portability of coverage to qualified individuals as mandated by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).⁴⁵ The pool began offering coverage in 1998, and as of May 2008 had 27,528 people enrolled.⁴⁶

Who Qualifies for Pool Coverage?

Access to coverage from the risk pool is not guaranteed. To qualify, individuals must generally be under age 65, be a Texas resident, be a U.S. citizen or legal permanent resident, have no access to employer-sponsored coverage, and meet any one of the following criteria below:

- Be unable to get individual health insurance due to health reasons;
- Be able to get only an individual health insurance policy that excludes coverage for existing conditions;
- Have a diagnosis for certain health conditions that would result in rejection of individual health insurance such as cancer, heart disease, or diabetes; or
- Be HIPAA-eligible.⁴⁷

Most individuals with access to employer-sponsored coverage, even if not enrolled in that coverage, are ineligible for the pool; however, in 2007, the Texas Legislature passed two narrow exceptions to expand pool access.⁴⁸ Individuals transitioning from employer-sponsored coverage who have not exhausted COBRA continuation coverage may now access pool coverage with a

minimum 6-month preexisting condition exclusion period if otherwise eligible for the pool.⁴⁹ Previously, individuals were ineligible for the pool during their entire COBRA continuation coverage eligibility period (usually 18 months) even though individuals have only 60 days in which to elect COBRA coverage after leaving employment. This limitation caused individuals who were unable to afford COBRA coverage during the 60-day election window, due to job loss for example, to be locked out of both COBRA and pool coverage for at least 18 months, even if they later became able to afford premiums.

The other exception allows individuals who meet all of the following three conditions to elect pool coverage: (1) they are employed part-time, (2) their employer makes no contribution toward their employer-sponsored coverage, and (3) the employer-sponsored coverage is more limited than the pool coverage. All other individuals with access to limited coverage through their employer remain ineligible for the pool. TDI reports an increase in the prevalence of employer plans with very limited coverage—for example, some plans have an annual maximum benefit of just \$1,500. When offered jobs with limited health insurance plans, current pool enrollees and potential enrollees must choose between the relatively comprehensive pool coverage and accepting a new job.

Texas Health Insurance Risk Pool at a Glance

- Enrollment, May 2008: 27,528 individuals
- Average enrollee age: 51
- Percent of enrollees age 50-64: 65%
- Percent of enrollees age 18 or under: 5%
- Average monthly premium, March 2008: \$595
- Claims paid, 2007: \$242 million
- Enrollee premiums collected, 2007: \$185 million
- Assessments collected, 2007: \$82 million
- Top three diagnoses by claims costs: heart disease, breast cancer, and arthritis and spine disorders

What Coverage is Available?

The pool's nine-member Board of Directors determines the pool's covered services, exclusions, annual deductibles, coinsurance requirements, and co-payment amounts. The board designs pool coverage to be consistent with policies available in the commercial individual health insurance market.⁵⁰ Covered services include hospitalization, emergency care, surgery, physician office visits, home health care, hospice care, serious mental illness services, physical therapy, and prescription drugs. The pool utilizes a statewide Preferred Provider Organization (PPO). Enrollees pay 20% coinsurance for services delivered by PPO providers and 40% coinsurance for out-of-network providers. The pool offers four different deductible levels: \$1,000, \$2,500, \$5,000, and \$7,500. In 2007, 83% of pool members were enrolled in plans with a deductible of \$2,500 or higher.⁵¹ The pool contracts with two third-party administrators—Blue Cross Blue Shield of Texas and Medco Health Solutions—to provide administrative functions such as member enrollment, premium billing, and claims processing and cost containment services such as use of provider networks and utilization review programs.

Lifetime Limit

Texans enrolled in the pool face a lifetime maximum benefit of \$1.5 million. After the pool has paid claims for a member totaling \$1.5 million over that member's lifetime, the member is ineligible for further pool coverage. The pool board sets the lifetime maximum benefit, as with all pool benefits and limitations, to be consistent with commercial individual health insurance policies. The lifetime maximum was raised from \$1 million to \$1.5 in 2004. Nine state risk pools have lifetime maximums higher than Texas' ranging from \$2 million to \$5 million, and three state risk pools impose no lifetime maximum.⁵²

Since 2005, three pool members have reached their \$1.5 million lifetime maximum, and currently, three members are nearing their lifetime maximum with over \$1.25 million in paid claims. Of the 38 current pool members with over \$500,000 in paid claims, 11 are under age 30 and are at greater risk of hitting their pool lifetime limit prior to qualifying for Medicare.⁵³

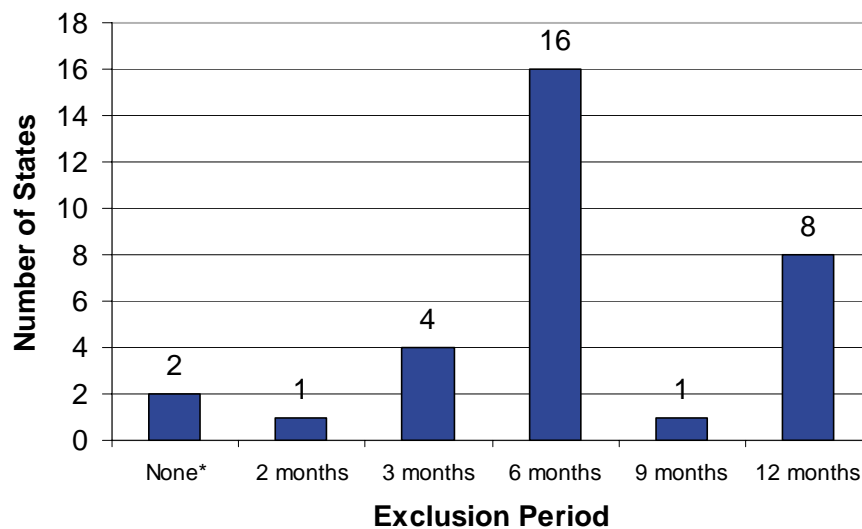
Pool members who hit their lifetime maximum have no other coverage options. They are uninsurable through the private individual health insurance market and do not have access to employer-sponsored coverage. Families who can pay the pool's high premiums are unlikely to qualify for public programs like Medicaid or CHIP.

Preexisting Conditions Exclusion

Care related to preexisting conditions is excluded from coverage for the first 12 months.⁵⁴ This exclusion does not apply to pool members who are HIPAA-eligible. If a pool member is not HIPAA-eligible—for example, an applicant that had prior coverage through individual health insurance as opposed to an employer-sponsored plan—the pool will “credit” prior coverage to reduce the exclusion period. Thus, a pool applicant with 3 months of prior creditable coverage will be subject to a 9-month exclusion period, while a pool applicant with 12 or more months of prior creditable coverage will not be subject to an exclusion period at all.⁵⁵ Pool members who are still within their 18-month COBRA continuation eligibility period, but are pool-eligible due to changes made during the 2007 legislative session, are subject to a minimum 6-month preexisting condition exclusion period.⁵⁶ On average, Texas pool members who are subject to an exclusion period face a 10-month wait before the pool will pay for care related to their preexisting conditions.⁵⁷

Most other states with risk pools have a shorter preexisting condition exclusion period than Texas. Nationally, the most common preexisting condition exclusion period in risk pools is 6 months. Texas and seven other states set their exclusion period at 12 months.⁵⁸ The distribution of state pool exclusion periods is shown in the chart below. Of course, by definition all pool members have preexisting conditions—ones that are serious enough to make them uninsurable in the private market. Texas' lengthy exclusion period is inappropriate for the pool population because it requires members to pay almost \$600 a month in premiums for up to a full year while not covering the care needed to address their serious illnesses.

State High Risk Pool Preexisting Condition Exclusion Periods



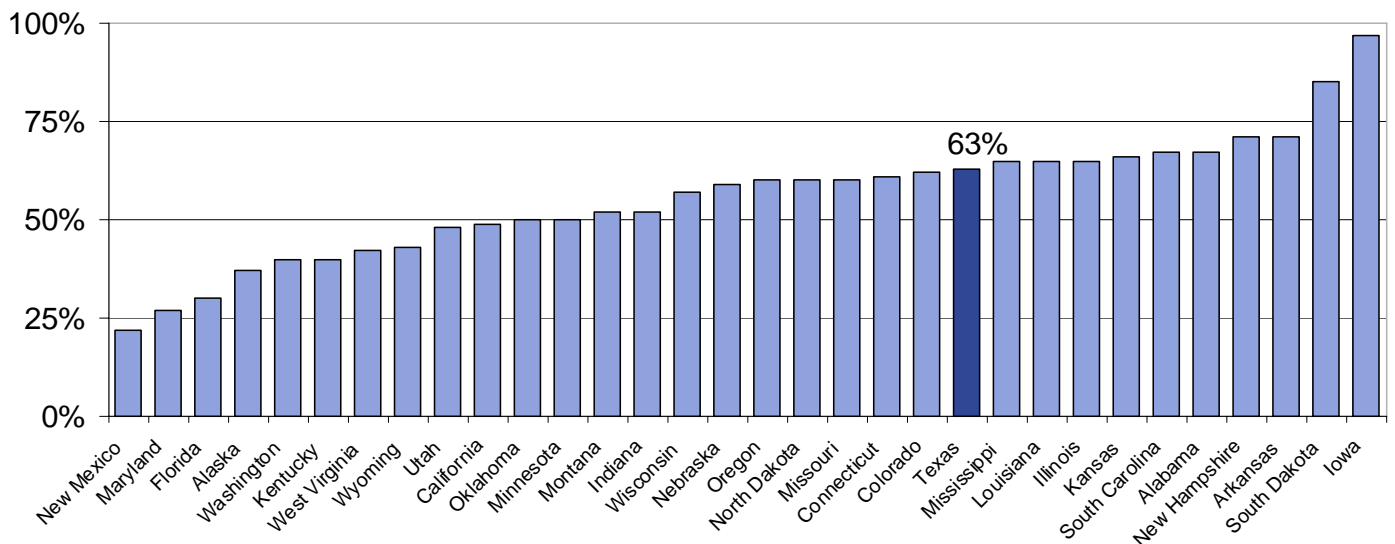
Source: Kaiser Family Foundation, statehealthfacts.org, “State High Risk Pool Pre-Existing Condition Exclusion and Look Back Periods, 2007.”
 *Risk pools in Alabama and South Dakota only accept HIPAA-eligible individuals so do not impose a preexisting condition exclusion.

How Is the Pool Funded?

Because state risk pools serve high-risk individuals, the average claims cost per enrollee is typically quite high, and no state's risk pool relies solely on enrollee premiums to cover claims costs. The Texas pool is financed by premiums paid by enrollees

and assessments on insurers and HMOs. The pool does not receive any state General Revenue funding. Over the 10-year history of the pool, enrollee premiums have accounted for 63% of pool revenue and insurer assessments have accounted for 36% of revenue.⁵⁹ Texas relies more heavily on member premiums to finance its pool than most other states with pools as shown in the graph below. In addition to assessments on commercial health insurers, HMOs, and reinsurers, other states partially subsidize pool losses through state general revenue, appropriations from special funds such as tobacco settlements, assessments on Medicaid carriers, assessments on third-party administrators, and assessments on hospitals.⁶⁰

Percent of Total Pool Costs Paid by Member Premiums, 2006



Source: Kaiser Family Foundation, statehealthfacts.org, "State High Risk Pool Costs, 2006."
 Note: Only 32 states had high risk pools in 2006

In 2007, 180 insurers and HMOs were assessed by the Texas pool with amounts due ranging from just \$7 to \$21,000,000, for a total assessment of \$82 million.⁶¹ Insurer assessments are established by a complicated methodology in state law. To spread pool risk across the fully insured market, the pool assesses health insurance companies and HMOs based on their premium volume.⁶² The pool also assesses reinsurance carriers based on the number of lives covered under their policies. Assessing reinsurance carriers indirectly pulls in support from the part of the insurance market that is self-funded, because many self-funded plans purchase reinsurance to protect against higher-than-expected losses.

The pool's assessment is not as broad-based as it could be. Reinsurance carriers pay an assessment using a methodology that only counts one of ten lives covered. Also, not all self-funded plans reinsure. Those that do not reinsure do not support the pool financially, though their enrollees may end up in the pool if they lose access to employer-sponsored coverage. Finally, premiums for a few different types of accident and health insurance coverages are exempted from pool assessments all together. Texas has never assessed carriers on their premiums earned in the small employer market, and in 2005, legislation also exempted accident-only, fixed indemnity, and specified disease coverages from the assessment.

The High Cost of Pool Coverage

The high cost of risk pool coverage places it out of reach for most Texans. The only current provision for affordability in the pool is the statutory premium cap set at 200% of the average rate for commercial individual health insurance, and individual health insurance rates in Texas are not regulated or even subject to the rate bands used in the small employer market.⁶³ Despite this cap, the average monthly premium in the pool is \$595 per month, which is reflective of a plan with a deductible at \$2,500

a year.⁶⁴ Based on rating factors like age, gender, geographic area, deductible selected, and smoking status, some pool enrollees are charged premiums as much as \$1,700 a month. Since the pool began offering coverage in 1998, premiums have increased 13% per year on average.⁶⁵

Annual average pool costs per enrollee—before co-payments and co-insurance—are nearly \$10,000 a year (\$595 premium x 12 months + \$2,500 deductible = \$9,640 per year). This cost is a prohibitive barrier for low- and moderate-income Texans for whom average pool costs for just one family member can represent a significant portion of family income as shown in the table below.

Pool Costs per Enrollee as% of Income

Annual income		Annual pool costs (average premium + deductible) per enrollee	Pool costs as percentage of income
Median family income in Texas (family of 3, 2006)	\$52,313	\$9,640	18%
200% of the federal poverty level (family of 3, 2008)	\$35,200	\$9,640	27%
At the poverty level (family of 3, 2008)	\$17,600	\$9,640	55%
Individual working full-time at minimum wage (\$6.55 per hour effective July 24, 2008)	\$13,624	\$9,640	71%

How Do Other States Help Pool Members Afford Coverage?

Affordability of coverage is an issue in all state risk pools, but some states have found meaningful ways to make coverage affordable for more people. At least 10 of the 34 state risk pools operate low-income subsidy or premium assistance programs.⁶⁶

- New Mexico’s risk pool reduces premiums by 75% for individuals with incomes below 200% of the federal poverty level (under \$35,200 a year for a family of three) and 50% for individuals between 200 and 400% of the federal poverty level (up to \$70,400 for a family of three).⁶⁷
- Colorado’s risk pool grants a 34% premium discount to people with incomes under \$40,000 a year and a 20% discount to those with incomes between \$40,000 and \$50,000.⁶⁸
- Maryland’s risk pool offers a sliding scale subsidy for enrollees with incomes up to 300% of the federal poverty level (\$52,300 for a family of 3) and reduces premiums in addition to deductibles, out-of-pocket maximums, and drug co-payments.⁶⁹
- Montana’s risk pool reduces the length of the preexisting condition exclusion for low-income enrollees from 12 to 4 months and also reduces premiums by 45%.⁷⁰

Many states make risk pool coverage more affordable by setting premiums lower relative to the cost of insurance in the private market. Texas charges pool premiums at its cap of 200% of the average cost of commercial individual health insurance policies and is one of just four states that charges premiums at least twice as high as private individual insurance. More than half of state risk pools cap pool premiums at 125 to 150% of private individual market premiums, and many of these states actually charge premiums below the cap.⁷¹

In many states, coverage is also more affordable because the preexisting condition exclusion period is shorter. A shorter exclusion period makes insurance more affordable by limiting the time pool enrollees must pay premiums while also having to pay completely out-of-pocket for treatment of their existing medical conditions.

Recommendations

As the insurer of last resort, the pool plays a vital role in providing access to health insurance; however, the high cost of the pool prevents average Texans from affording coverage. In addition, other Texans with complex medical needs who want to enroll in the pool are excluded due to restrictive eligibility criteria.

- **Increase pool affordability.** Several states offer subsidies to low-income individuals in their state risk pools. Texas should develop a pool subsidy program that reduces premiums and deductibles on a sliding scale for individuals. Because even moderate-income families are unable to afford the high cost of pool coverage, Texas should look to other states that have extended sliding scale subsidies in risk pools up to 300 to 400% of the federal poverty level. Alternately, Texas could reduce the pool's premium cap from 200% of commercial rates to 150% to bring it line with other state's pools. A subsidy program for low-income enrollees would have a targeted benefit to those who are least able to afford pool coverage, while a lower premium cap would benefit all pool enrollees.

To fund a portion of the subsidy program or premium reduction, Texas could restructure its assessments on insurers to generate new revenue. To further broaden the base for the assessments across self-funded plans, Texas could expand the assessment to third-party administrators and adjust the methodology for assessing stop loss, excess loss, and reinsurance carriers so they are assessed for more of the lives they cover. Texas could also reinstate the assessments on limited benefit coverage that were exempted in 2005. Finally, Texas could use available federal grant money to fund premium reductions.⁷²

- **Improve the adequacy of pool coverage.** Texas should reduce the preexisting condition exclusion period in the pool from 12 months to 6 months to bring it in line with other states. Unlike some individuals in commercial insurance pools, all pool members have preexisting conditions, which leaves them with no coverage option other than the pool. Not only would this change make the pool coverage more appropriate for the uninsured population that must rely on its coverage, it will also make pool coverage more affordable as members are made to pay for fewer months of premiums with no benefits.

Texas should also increase the lifetime maximum limit on pool coverage. A lifetime limit as low as \$1.5 million is not appropriate for the risk pool population, and the low limit ends up forcing individuals with no other coverage options out of the pool. Individuals left most vulnerable because of the low lifetime limit are the seriously ill and children and young adults who may spend a greater proportion of their lives covered in the pool. The pool's lifetime limit should be increased to between \$3 million and \$5 million.

- **Expand pool access.** Pool members should not be forced to choose between staying in the pool or taking new employment with benefits less generous than the pool's. If a person otherwise eligible for pool coverage has access to employer-sponsored insurance that is not as comprehensive as the pool's and will not meet their medical needs, they should be able to choose pool coverage. The exception passed last session for some part-time employees could be broadened to include all full-time and part-time employees who are offered coverage more limited than the pool's through work regardless of the employer contribution.

Conclusion

Private health insurance is a vital component in providing health coverage to Texans, along with Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The private health insurance market in Texas, however, is not currently functioning well or meeting Texans' needs. Too many Texans who could afford health coverage right now are still denied access to the coverage they need, while others could join the ranks of the insured if Texas exercised oversight that is routine in other states to make modest but meaningful improvements in affordability. Texans deserve a health insurance market that provides consumers with access to high quality coverage at prices that are fair. Texas can achieve this goal by giving TDI appropriate tools to ensure that prices are reasonable, enacting sensible market reforms, and improving the risk pool.

¹ Texas Department of Insurance, *State Planning Grant Interim Report*, 2005, pg. 18, www.tdi.state.tx.us/reports/life/documents/spgint05.pdf; Texas Department of Insurance, *State Planning Grant Interim Report*, 2006, pg. 22, www.tdi.state.tx.us/reports/life/documents/spgint061.pdf; and Texas Department of Insurance, *Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature*, December 2006, www.tdi.state.tx.us/reports/documents/finalbie07.pdf.

² Between 2001 and 2005 (2005 is the most recent data available), Texas health insurance premiums for family coverage increased 39.7%. This is the third highest premium increase seen in the nation. Nationally, the average increase over this timeframe was 29.5%. State Health Access Data Assistance Center, University of Minnesota, *Squeezed: How Cost for Insuring Families are Outpacing Income*, April 2008, www.rwif.org/files/research/042508ctuwfinalembargoed.pdf. In Texas, only 52.2% of people have health insurance coverage through employment, compared to 59.7% nationally. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

³ Texas Department of Insurance, Texas Group Accident and Health Insurance Survey, 2005.

⁴ Texas Insurance Code, § 31.002.

⁵ Texas Department of Insurance, *Self-Evaluation Report*, 2007, p. 1, www.sunset.state.tx.us/81streports/tdi/ser.pdf; and Texas Department of Insurance, *2007-2001 Agency Strategic Plan*, July 2006, p. 4, www.tdi.state.tx.us/reports/documents/splan1-0706.pdf.

⁶ Texas Department of Insurance, *Self-Evaluation Report*, 2007, p. 340, www.sunset.state.tx.us/81streports/tdi/ser.pdf.

⁷ State-by-state listing of health insurance rate filing and review authority in the National Association of Insurance Commissioners, Compendium of State Laws on Insurance Topics, Filing Requirements for Health Insurance Forms and Rates, updated as of November 2007.

⁸ Adele M. Kirk and Deborah Chollet, "State Review of Major Medical Health Insurance Rates," *Journal of Insurance Regulation*, Summer 2002, pp. 3-18.

⁹ Families USA, *The Facts about Prior Approval of Health Insurance Premium Rates*, Health Policy Memo, June 2008, www.familiesusa.org/assets/pdfs/prior-approval.pdf. Thirty-two states engage in prior approval in the individual or small employer markets. In five of these states, prior approval authority only applies to certain products in the market like Blue Cross Blue Shield plans or managed care products.

¹⁰ Families USA, *The Facts about Prior Approval of Health Insurance Premium Rates*, Health Policy Memo, June 2008, www.familiesusa.org/assets/pdfs/prior-approval.pdf.

¹¹ Families USA, *Medical Loss Ratios: Evidence from the States*, Health Policy Memo, June 2008, www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf.

¹² Families USA, *Medical Loss Ratios: Evidence from the States*, Health Policy Memo, June 2008, www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf.

¹³ Families USA, *Understanding How Health Insurance Premiums are Regulated*, September 2006, www.familiesusa.org/assets/pdfs/rate-regulation.pdf.

¹⁴ Minnesota varies minimum loss ratio standards by the insurer's market share. Companies with a larger market share must meet a higher loss ratio standard. In the small employer market, Minnesota also varies loss ratio standards for companies with a small market share by group size. Carriers must meet a lower standard on their policies sold to groups with fewer than 10 employees and a higher standard on policies sold to groups with 10 or more employees. Loss ratio standards range from 68 to 72% in the individual market and 71 to 82% in the small employer market.

¹⁵ Minnesota Department of Commerce, *Report of 2006 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations*, June 2007, www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf.

¹⁶ Families USA, *Medical Loss Ratios: Evidence from the States*, Health Policy Memo, June 2008, www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf.

¹⁷ Washington State Office of the Insurance Commissioner, Health Carrier Information Comparison – Home, <https://fortress.wa.gov/oic/hcis/public/comparisonhome.aspx>.

¹⁸ Data collected in TDI's annual Texas Group Accident and Health Insurance Survey. Data are collected only for Texas' fully insured business, so unlike medical loss ratios reported by companies in their Annual Statement filings with state regulators and NAIC, data from the TDI survey reflects just insurers' experience in Texas. TDI collects data for both the small employer and large group market, but does not collect similar data for the individual health insurance market. Insurers are not identified in the survey data released to the public.

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- ¹⁹ Premium and income data from State Health Access Data Assistance Center, University of Minnesota, *Squeezed: How Cost for Insuring Families are Outpacing Income*, April 2008, www.rwjf.org/files/research/042508ctuwfinalembargoed.pdf.
- ²⁰ Texas Department of Insurance, *State Planning Grant Interim Report*, 2005, p. 8, www.tdi.state.tx.us/reports/life/documents/spgint05.pdf
- ²¹ Agency for Healthcare Research and Quality, 2005 Medical Expenditure Panel Survey Insurance Component.
- ²² The percentage of Texans covered through Medicare, Medicaid, and CHIP are similar to national averages. The large discrepancies in coverage are in employer-sponsored coverage and the uninsured population. Nationally, 60% of people get coverage through an employer and 16% are uninsured. In Texas, only 52% of people have employer-sponsored coverage and 25% are uninsured. Data from the 2007 Current Population Survey.
- ²³ D. Cohn, E. Martinez-Vidal, and D. Chollet, "More Answers on Reinsurance," *In Focus*, State Coverage Initiatives, June 2005, www.statecoverage.net/pdf/infocus0605.pdf.
- ²⁴ Deborah Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage*, State Coverage Initiatives, October 2004, www.statecoverage.net/pdf/issuebrief1004.pdf; and D. Cohn, E. Martinez-Vidal, and D. Chollet, "More Answers on Reinsurance," *In Focus*, State Coverage Initiatives, June 2005, www.statecoverage.net/pdf/infocus0605.pdf.
- ²⁵ Katherine Swartz, *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers*, Commonwealth Fund, July 2005, www.commonwealthfund.org/publications/publications_show.htm?doc_id=286904.
- ²⁶ Small employer carriers in Texas must either elect to participate in THRS or seek approval from TDI to be a "risk assuming" carrier. Risk assuming carriers must demonstrate to TDI that they are financially able to bear the risks of the groups they enroll and experienced in managing risks in the small employer market.
- ²⁷ Texas Department of Insurance, *Self-Evaluation Report*, 2007, pp. 346-347, www.sunset.state.tx.us/81streports/tdi/ser.pdf.
- ²⁸ Texas Sunset Advisory Commission, *Texas Department of Insurance Staff Report*, May 2008, www.statecoverage.net/pdf/infocus0605.pdf.
- ²⁹ D. Cohn, E. Martinez-Vidal, and D. Chollet, "More Answers on Reinsurance," *In Focus*, State Coverage Initiatives, June 2005, www.statecoverage.net/pdf/infocus0605.pdf.
- ³⁰ Deborah Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage*, State Coverage Initiatives, October 2004, www.statecoverage.net/pdf/issuebrief1004.pdf.
- ³¹ In community rating, insurers cannot use the health status of an individual when setting premiums. With community rating, everyone with the same plan in the same area pays the same premium. Texas does not use community rating and currently allows insurers to use factors like health status and age when setting premiums. Texas does not extend guaranteed issue protections to sole proprietors. Texas defines the small employer market, in which insurers must issue a policy to interested groups, as policies for business with 2 to 50 employees. Sole proprietors are not considered small groups for the purposes of health insurance and are not extended the same rights and protections as small employers.
- ³² State Coverage Initiatives, Reinsurance Institute, www.statecoverage.net/reinsuranceinstitute.htm.
- ³³ State of New York Insurance Department, *2006 Annual Report on Healthy NY*, January 2007, www.ins.state.ny.us/website2/hny/reports/hnyep2006.pdf.
- ³⁴ State of New York Insurance Department, *2007 Annual Report on Healthy NY*, January 2008, www.ins.state.ny.us/website2/hny/reports/hnyep2007.pdf.
- ³⁵ Randall R. Bovbjerg, A. Bowen Garrett, Lisa Clemans-Cope, and Paul Masi, *Reinsurance in State Health Reform*, Reinsurance Institute Project of the Urban Institute, May 2008, www.urban.org/UploadedPDF/411689_state_health_reform.pdf.
- ³⁶ Texas Department of Insurance, 2005 Texas Group Accident and Health Insurance Survey.
- ³⁷ Texas Department of Insurance, Small Employer Health Benefit Plan Rate Guide, revised July 2007, www.tdi.state.tx.us/pubs/consumer/serg01.html.
- ³⁸ Premium data from the Agency for Healthcare Research and Quality, 2005 Medical Expenditure Panel Survey Insurance Component.
- ³⁹ U.S. General Accounting Office (since this report was published, the name has changed to the Government Accountability Office), *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*, September 2003, www.gao.gov/new.items/d031133.pdf.
- ⁴⁰ Texas Department of Insurance, *State Planning Grant Interim Report*, 2005, pp. 35-36, www.tdi.state.tx.us/reports/life/documents/spgint05.pdf.
- ⁴¹ TDI notes that Texas' rate bands are generally considered looser than those in other states. Texas Department of Insurance, *State Planning Grant Interim Report*, 2006, p. 22, www.tdi.state.tx.us/reports/life/documents/spgint061.pdf.
- ⁴² Mila Kofman and Karen Pollitz, *Health Insurance Regulation by State and the Federal Government: A Review of Current Approaches and Proposals for Change*, Georgetown University Health Policy Institute, April 2006, www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf.
- ⁴³ Mila Kofman and Karen Pollitz, *Health Insurance Regulation by State and the Federal Government: A Review of Current Approaches and Proposals for Change*, Georgetown University Health Policy Institute, April 2006, www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf.

⁴⁴ Families USA, *Understanding How Health Insurance Premiums are Regulated*, September 2006 www.familiesusa.org/assets/pdfs/rate-regulation.pdf.

⁴⁵ HIPAA requires states to adopt an approach to guarantee access to non-group coverage without preexisting condition exclusions for “HIPAA-eligible” individuals. Texas fulfills this requirement through the risk pool.

⁴⁶ Texas Health Insurance Risk Pool, www.txhealthpool.org/.

⁴⁷ To be HIPAA-eligible, a person must have had at least 18 months of prior group coverage not interrupted by a gap of more than 63 days in a row, not be eligible for other public or private coverage, and must elect and exhaust any available COBRA continuation coverage or similar state continuation coverage. People with prior coverage through individual insurance are not HIPAA eligible and are not extended the same protections.

⁴⁸ House Bill 2548, 80th Texas Legislature, Regular Session, 2007.

⁴⁹ This exception applies to individuals who either did not elect COBRA coverage during the limited enrollment period or selected COBRA and then lapsed coverage. To be eligible for pool coverage, individuals must still exhaust any available state continuation coverage.

⁵⁰ Texas Insurance Code, § 1506.151.

⁵¹ Texas Health Insurance Risk Pool, *2007 Annual Report*, June 1, 2008, online: www.txhealthpool.org.

⁵² National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individual: A State-by-State Analysis*. 21st edition, 2007/2008.

⁵³ Texas Health Insurance Risk Pool, Active Members High Claims Tracking Report and Canceled Membership High Claims Tracking Report as of May 1, 2008.

⁵⁴ The Texas Health Insurance Risk Pool defines a preexisting condition as, “a disease or condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six months before an insured person’s effective date of coverage; or for which medical advice, care or treatment was recommended or received during the 6 months prior to an insured person’s effective date of coverage.” Texas Health Insurance Risk Pool, *Outline of Coverage, Individual Major Medical Coverage*, effective January 1, 2008.

⁵⁵ Most health coverage is considered creditable coverage including employer sponsored plans, individual insurance, HMOs, COBRA continuation coverage, state or federal employee coverage, coverage from state risk pools, Medicare, and Medicaid. Worker’s compensation, disability insurance, accident-only insurance and limited-scope dental or vision benefits are examples of plans that do not qualify as creditable coverage.

⁵⁶ These members are not HIPAA-eligible because they did not elect and exhaust all available COBRA continuation coverage.

⁵⁷ Steven Browning, Texas Health Insurance Risk Pool Executive Director, testimony to the Senate Committee on State Affairs, March 26, 2008.

⁵⁸ Kaiser Family Foundation, statehealthfacts.org, “State High Risk Pool Pre-existing Condition Exclusion and Look Back Periods, 2007,” www.statehealthfacts.org/comparetable.jsp?ind=604&cat=7.

⁵⁹ Steven Browning, Texas Health Insurance Risk Pool Executive Director, testimony to the Senate Committee on State Affairs, March 26, 2008.

⁶⁰ National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individual: A State-by-State Analysis*. 21st edition, 2007/2008.

⁶¹ Steven Browning, Executive Director, Texas Health Insurance Risk Pool, “Texas Health Insurance Risk Pool Presentation to the Senate Committee on State Affairs,” March 26, 2008.

⁶² About half of the private health insurance market in Texas is “fully insured,” and the other half is “self-insured.” Fully insured plans include individual and group health insurance products in which an individual or employer pays premiums to an insurer for coverage and the insurance company administers benefits, pays claims, and bears the risk for claims. Self-insured plans are generally offered by large employers, which due to their size, can pay their own claims and retain risk. Self-insured companies generally contract with a third-party administrator to administer benefits and sometimes purchase reinsurance to protect against unexpected losses. A provision in the federal Employee Retirement Income Security Act (ERISA) prevents states from regulating or assessing plans offered through self-insured companies, thus state risk pools cannot directly assess self-insured plans.

⁶³ Pool premium rates are set at twice the average rate for commercial individual health insurance sold in Texas. To determine the average market rate, referred to as the “standard risk rate,” the pool’s actuary surveys the five largest commercial individual health insurance carriers to collect current plan and premium information. After accounting for varying benefit designs of individual plans in the market, the actuary determines the standard risk rate. The pool’s actuary updates the standard risk rate twice a year, and pool premiums are adjusted accordingly.

⁶⁴ As of March 2008. Texas Health Insurance Risk Pool, “Board of Directors Summary,” May 21, 2008.

⁶⁵ Steven Browning, Executive Director, Texas Health Insurance Risk Pool, “Texas Health Insurance Risk Pool Presentation to the Senate Committee on State Affairs,” March 26, 2008.

⁶⁶ States include Colorado, Connecticut, Maryland, Montana, New Mexico, Oregon, Utah, Washington, Wisconsin, and Wyoming.

⁶⁷ New Mexico Medical Insurance Pool, www.nmmip.com/2008/monprems.htm.

⁶⁸ CoverColorado, <https://www.covercolorado.org:442/documents/PDR2006.pdf>.

⁶⁹ Maryland Health Insurance Plan, www.marylandhealthinsuranceplan.state.md.us/mhip/attachments/FRM0808MHIPplusApplication.pdf.

⁷⁰ Montana Comprehensive Health Association, www.mthealth.org/plans_and_rates/.

⁷¹ National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individual: A State-by-State Analysis*. 21st edition, 2007/2008; and information from Steven Browning, Texas Health Insurance Risk Pool Executive Director.

⁷² Two federal laws, the Deficit Reduction Act of 2005 and the State High Risk Pool Funding Extension Act of 2006 authorized federal grant funding to states for operations of high risk pools. Texas was awarded \$9.2 million in 2006, which was used to lessen both the premium rate increases for enrollees and assessments for carriers. Funding was not appropriated by Congress in 2007, but \$49 million was appropriated for grants in 2008 and will be awarded to states in July 2008. Texas expects to receive about \$6 million in grant funding. Future grant funding is possible, as federal grant funding up to \$75 million a year was authorized, but not appropriated, through 2010.

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