Financial Decision-Making Theory and the Small Employer Health Insurance Market in Texas

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Financial Decision-Making Theory

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Financial Decision-Making Theory

Participants will make decisions based on the best financial outcome for themselves

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Financial Decision-Making Theory

Participants in the small employer group health insurance market

- Insurers or carriers
- Employers
- Employees or insureds
- Agents

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Financial Decision-Making Theory

- Carriers
  - Driven by need to make profit
  - Even non-profits have to avoid losses
  - Decisions to participate and how to participate are influenced by potential financial outcomes

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Financial Decision-Making Theory

- Employers
  - Facing ever-increasing health insurance premiums
  - Decisions will be made that make the most financial sense
  - Must consider job market and negative implications of not offering insurance

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Financial Decision-Making Theory

- Employees
  - Being expected to share more of the costs
  - Have more knowledge of their own potential health problems – leads to anti-selection

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Financial Decision-Making Theory

- Agents
  - May want to provide quality health products, but are motivated by compensation
  - Agents will tend to direct towards health insurance option with highest compensation

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Financial Decision-Making Theory

- Needs of the participants often conflict
  - Employers and employees want lowest premiums, but carriers and agents need to make a profit
- There needs to be a level playing field between all insurance options
  - Uneven playing field will result in option ending up with disproportionate share of high-risk individuals

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Advantages Enjoyed by Large Employers in Health Insurance Market

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Advantages Enjoyed by Large Employers in Health Insurance Market

- Economies of scale
  - Administrative savings and bargaining power
- Ability and/or risk tolerance to self-insure
  - Eliminates insurance risk charges and profit margins
  - Preemption from state regulation (ERISA)
- Unrestricted experience rating
  - Often lower premiums for pools of healthy individuals

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Options for Small Employers in Texas

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Options for Small Employers in Texas

- State-regulated small group market
- Private purchasing co-ops
- Health Group Cooperatives
- Small Employer Health Coalitions
- MEWA (Multiple-Employer Welfare Arrangements)

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State-Regulated Small Group Market

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State-Regulated Small Group Market

- History
  - Small Employer Health Insurance Availability Act (1993 and Amended in 1995)
    - Rating restrictions, including limits to rate increases
    - Creation of state-wide purchasing cooperative
    - Authority to create private purchasing cooperatives
    - Creation of standard benefit plans
  - Amendments for HIPAA (1997)
    - Guaranteed issue and renewal
    - Limitations on pre-existing condition exclusions

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State-Regulated Small Group Market

- History
  - Senate Bill 510 (2003)
    - Carriers must offer mandated benefit plan and consumer choice plan
    - More flexibility in plan design
    - Must obtain signed form from employer acknowledging receipt of written disclosure about consumer choice plans

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State-Regulated Small Group Market

- Small Group Eligibility
  - Groups with 2-50 eligible employees
  - Eligible employees
    - Full-time, working at least 30 hours/week
    - Not temporary, part-time, or seasonal
    - Not already covered by another health plan
  - At least 75% of eligible employees must participate (both in a two-person group)
  - Laws do not require employer contributions, but many carriers do

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State-Regulated Small Group Market

- Rate Restrictions
  - Base premium rates developed for each class of business
  - Rates for particular employer group can vary by age, gender, group size, industry, and geographic area
  - Can be adjusted up or down on basis of health status by 25% for entire group
  - Final rate cannot exceed 67% of base rate
  - Rate increases for health factors limited to 15% per year.

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State-Regulated Small Group Market

- Required Benefit Plans
  - Prior to 2003, carriers required to make available two plans – basic care and catastrophic plans – intended to lower costs through limited benefits
  - In 2003, SB 510 requires carriers to offer mandated benefit plan and Consumer Choice plan, which can exclude certain mandated benefits

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State-Regulated Small Group Market and Financial Decision-Making Theory

- Rate Restrictions
  - Rate restrictions do not decrease the overall cost of providing coverage – they limit how carriers can spread out premiums between the groups
  - Healthier groups end up subsidizing less healthy groups and will likely search for lower cost coverage
  - Can lead to adverse selection death spiral

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State-Regulated Small Group Market and Financial Decision-Making Theory

- Required Benefit Plans
  - Employers were either not interested or not aware or the plans
  - TDI survey of carriers and agents
    - Carriers wanted to offer own unique benefit packages – did not want to market the plans, provided disincentives
    - Agents did not market them
  - Consumer Choice Plans
    - In 2005, 87,675 Texans were covered under a CCP with 7,325 previously uninsured
    - Lower premiums were more a result of more cost-sharing and coinsurance, not reduction or elimination of mandated benefits

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Private Purchasing Cooperatives

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Private Purchasing Cooperatives

- Small Employer Health Insurance Availability Act – passed by Texas legislature in 1993
- Allows two or more small businesses to join together to form health insurance purchasing cooperatives
- Proponents arguments
  - Employers can rely on cooperative's expertise and relationships with carriers
  - More clout in bargaining with carriers
  - Allows administrative economies of scale
  - Small employers would have more coverage choices

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Private Purchasing Cooperatives

- Six co-ops registered with TDI, but very few are active
- Carriers have shown little interest in participating and do not believe they will result in the expected cost savings

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Private Purchasing Cooperatives

- Texas Insurance Purchasing Alliance (TIPA)
  - Statewide public health care purchasing alliance
  - Created by Small Employer Health Insurance Availability Act
  - At peak, almost 13,000 people covered
  - Dissolved in July 1999

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Private Purchasing Cooperatives

- TIPA demise was the result of several contributing factors
  - Lack of agent use
  - Rating provisions
  - Health plan selection

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Private Purchasing Cooperatives

- Lack of Agent Use
  - Initially directly marketed to reduce admin costs
  - Then used agents but limited commissions
  - Financial Decision-Making Theory
    - Agents placed healthier groups in private market where commissions were higher
    - Directed riskier groups to TIPA
    - Due to higher proportion of high-risk members, TIPA premiums increase significantly over time

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Private Purchasing Cooperatives

- Rating Provisions
  - TIPA plans subject to more restrictive rating provisions – not allowed to adjust rates based on health status, size or industry
  - Initially, lower premiums for less-healthy groups
  - Financial Decision-Making Theory
    - TIPA attracted high-risk groups
    - Significant premium increases over time
    - Potential for adverse selection death spiral became apparent – rating provisions eventually revised to match private market

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Private Purchasing Cooperatives

- Health Plan Selection
  - Allowed every employee to choose type of plan and carrier
  - Led to considerable anti-selection
  - Financial Decision-Making Theory
    - As certain carriers ended up with a higher proportion of high-risk individuals, they withdrew from the alliance

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Health Group Cooperatives and Small Employer Coalitions

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Health Group Cooperatives and Small Employer Coalitions

Feature	***Small Employer Coalition***	***Health Group Cooperative***	***Health Group Cooperative Sub(p)***
Created By	HB 897 (2003)	SB 10 (2003)	SB 805 (2005)
Minimum Number of Employers	2	10	10
Maximum Number of Employers	25	No Limit	25
Composition	Small Employer	Small or Large Employer	Small Employer

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Health Group Cooperatives and Small Employer Coalitions

Feature	***Small Employer Coalition***	***Health Group Cooperative***	***Health Group Cooperative Sub(p)***
Maximum Group Size	50	N/A	50
Considered Single Employer?	Yes - small	Yes – large	Yes - small
Guaranteed Issue	Yes	No	Yes
Guaranteed Renewable	Yes	Yes	Yes

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Health Group Cooperatives and Small Employer Coalitions

Feature	***Small Employer Coalition***	***Health Group Cooperative***	***Health Group Cooperative Sub(p)***
Minimum Employer Commitment	None	2 Years	2 Years
Tax Treatment	None	2 yr exemption from certain taxes	2 yr exemption from certain taxes
Issuance Limits	None	1 per carrier per county, w/ permissive expanded service areas	1 per carrier per county, w/ permissive expanded service areas

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Cooperatives/Coalitions and Financial Decision-Making Theory

- Carriers don't want small groups to have more clout
- There may be admin savings from cooperatives performing administrative tasks, but carriers lose control, including accuracy and potential liability associated with premium collection and enrollment
- Employees can choose plans – more choices leads to anti-selection

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Multiple-Employer Welfare Arrangements (MEWAs)

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Multiple-Employer Welfare Arrangements

- Allow a group of employers to collectively offer health insurance to their employees
- Often set up by trade, industry or professional associations for member employers
- Fully Insured – attempt to negotiate lower rates than available through other markets
- Focus here is on self-funded MEWAs

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Multiple-Employer Welfare Arrangements

- History
  - Originally covered by ERISA and exempt from state regulation
  - Able to avoid reserve requirements, rating restrictions, and other solvency standards
  - Often priced below plans available through regulated insurance companies
  - Many were unable to pay claims and became insolvent
  - Others were set up by individuals who embezzled the assets
  - In 1983, ERISA amended to provide exception

    to preemption provisions and allow for regulation by state insurance laws

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Multiple-Employer Welfare Arrangements

- Regulatory Requirements in Texas
  - Regulated by TDI if one or more employer members domiciled or principle headquarters in Texas
  - Five or more businesses in the same trade or industry
  - Association or group must be
    - Non-profit
    - In existence for at least two years
    - For purpose other than sponsoring welfare benefit plan
  - Must obtain Certificate of Authority from TDI

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Multiple-Employer Welfare Arrangements

- Reserve Requirements
  - Minimum of 20% of total contributions
  - Cash or short-term federally guaranteed investments
  - No surplus requirements
- Stop-Loss Requirements
  - Specific and aggregate with 12-month incurred and 15 month paid periods
  - Specific retention determined annually by actuary
  - Aggregate with retention amount of no more than 125% of expected claims

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Multiple-Employer Welfare Arrangements

- Coverage Requirements
  - Participation – cannot be based on health status factors
  - Coverage – must accept/reject entire group based on underwriting standards and criteria
  - No exclusion of any eligible employee or dependent
  - Minimum contribution/participation requirements must be applied uniformly
  - Annual enrollment period of at least 31 days
  - Waiting period must be predefined

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Multiple-Employer Welfare Arrangements

- Advantages for Employers/Employees
  - Ability to enjoy benefits of self-funded plans
  - Lower cost because exempt from mandated benefits, premium taxes and solvency requirements
  - Elimination of profit margin and risk premium earned by insurers
  - Allow coverage for industries that insurers avoid (e.g., migrant workers)

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Multiple-Employer Welfare Arrangements

- Disadvantages for Employers/ Employees
  - Potential for financial problems
  - No state guaranty association
  - In bankruptcy, creditors usually paid off before participants and providers

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Multiple-Employer Welfare Arrangements and Financial Decision-Making Theory

- Good choice for groups with young, healthy employees – more opportunity for premium savings
- Can cause some instability in state-regulated small group market – can siphon off healthy groups, leaving higher risk groups in insured market

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Conclusions

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