Report
on
Senate Bill 10, Section 25
Eightieth Legislature, Regular Session, 2007

Healthy Texas
Phase I Report

Submitted by the
Texas Department of Insurance

November 2008

Texas Department of Insurance

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November 3, 2008

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
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The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

The Honorable Tom Craddick
Speaker, Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Governors and Speaker:

This letter conveys the statutorily required *Healthy Texas* report in accordance with Senate Bill 10, Section 25. The bill directed the Department to conduct a study concerning a Healthy Texas Program, under which small employer health plan coverage would be offered through the program to persons who would be eligible for that coverage. The following report is intended as the first phase of this study and makes preliminary recommendations on the Healthy Texas program.

To date, the Department has conducted considerable research and has developed preliminary recommendations and is meeting with stakeholders to obtain input on the program. Further, the Department is working with an actuarial firm to examine the feasibility of the Healthy Texas program as proposed. Later this year, the Department will issue the second phase report that will contain final recommendations shaped by the additional analysis and stakeholder feedback that is ongoing.

Healthy Texas has the potential to provide insurance to a significant portion of the 5.9 million uninsured Texans, especially for small employers, their employees, and their families. While some work on this proposal remains to be completed, initial indications are that *Healthy Texas* would have the flexibility to meet a wide array of needs and could be scaled to fit state budget availability.

Thank you for your consideration of this report. Should you have any questions about this report, please contact me; Carol Cates, Director of Government Relations, at 463-6123; or Katrina Daniel, Associate Commissioner of Life, Health & Licensing, at 305-7342.

Sincerely,

Mike Geeslin

Mike Geeslin
Commissioner of Insurance

xc: Members of the 81st Legislature

Healthy Texas
Phase I Report

EXECUTIVE SUMMARY

Recognizing that Texas has the highest uninsured rate in the nation, the Legislature enacted Senate Bill (SB) 10, which included a number of strategies and directives aimed at lowering the number of uninsured in this state. Included in the bill, the Legislature directed the Texas Department of Insurance to conduct a study and develop recommendations for a program under which small employer health plan coverage would be offered. This provision, along with others in SB 10, and the resulting recommendations in this report are intended to decrease the estimated 5.9 million state citizens who had no insurance throughout the entire year of 2007. [1]

This *Healthy Texas* report fulfills the legislative requirement to make recommendations to the Legislature by November 1, 2008, and is intended to further the extensive discussion needed to shape and refine the program outlined in the report. The Department will issue a follow up report in late December 2008 that contains additional information and findings learned through the last two months of stakeholder meetings and additional analysis completed for this project.

The Department's *Healthy Texas* study and recommendations build on six years of research conducted through the federally funded State Planning Grant. In that research, the Department examined the uninsured population as a whole, determined the most concentrated segment of that population, and learned about the types of health coverage and price points that would prompt them to purchase insurance. Through that research and in exploring other state approaches, the Department determined that publicly funded reinsurance could provide a market-based solution to address the high rate of uninsured Texans.

Preliminary Recommendations

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

[1] U.S. Census Bureau, Current Population Survey, 2007

Healthy Texas
Phase I Report

BACKGROUND

With more than 5.5 million Texans – more than 25 percent of the population – uninsured, the State of Texas has the highest uninsured rate in the nation. Although the State has attempted to increase the number of Texans with health insurance by enacting several programs and multiple insurance reforms, the State's uninsured rate has been well above the national average for more than 15 years.

In June 2007, the 80th Texas Legislature enacted Senate Bill (SB) 10, a comprehensive bill to evaluate critical changes to the health care system in Texas and to ultimately increase the number of Texans with access to primary and preventive care through health insurance coverage.

In recognition that access to and use of employer sponsored health insurance contributes greatly to the issue of the uninsured, SB 10 directed the Texas Department of Insurance (TDI) to make recommendations to create a program to offer health insurance coverage to small employers (those with 2-50 employees) and their employees. Specifically, SB 10 directed the Department to issue a report to the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, and the members of the legislature no later than November 1, 2008 that includes recommendations for a program under which small employer health plan coverage would be offered. To develop program recommendations, the Legislature directed the Department to conduct a study that:

- includes a market analysis to assist in identification of underserved segments in the voluntary small employer group health benefit plan coverage market in Texas;
- includes an analysis and information regarding:
    - the advantages and disadvantages of the proposed program;
    - prospective structure and function of the program and its components;
    - prospective program design and administration, including operational procedures, powers and duties of the commissioner, and program board of directors;
    - recommendations for program eligibility criteria and minimum standards applicable to group health benefit plans that may be included in the program;
    - identification of other program requirements or restrictions and limitations necessary for successful implementation of the program;
    - the potential economic impact that the program would have on the small employer insurance market in this state;
    - the anticipated impact that the program would have on the quality of health care provided in this state; and

- recommendations for any statutory changes to address implementation of the program.

The following report lays out a rationale and status report to-date for *Healthy Texas*, which builds on six years of federally funded research at TDI to evaluate the health care and insurance coverage desires and concerns of Texas small employers and their employees.

THE SMALL EMPLOYER MARKET

As part of TDI's ongoing effort to examine insurance affordability and availability, the Department has completed extensive research within the small employer market to uncover the challenges small business owners face when trying to offer insurance. Some of the most significant findings include:

- Eighty-nine percent of large firms offer insurance, compared to only 32 percent of small firms (with 50 employees or less).
- Less than half (49 percent) of employees in small firms work for an employer offering coverage, compared to 93 percent of employees in large firms.
- Of the 1.9 million employees working in small firms, less than 800,000 (42 percent) are eligible[2] for coverage and less than 650,000 (32 percent) are enrolled.
- The majority of small employers who do not offer coverage report than they can pay $100 or less per-employee-per-month for health insurance.
- The average annual single premium for small employer insurance in 2008 is estimated at $5,109, or $425 per-employee-per-month.

Insurance Reform in the Small Employer Market

An understanding of Texas' small group market is helpful developing a rationale for a *Healthy Texas* program. Texas, like other states, has enacted numerous reforms and initiatives in an effort to encourage more small business owners to offer health insurance. In 1993, the Texas Legislature adopted the Small Employer Health Insurance Availability Act. The Act was subsequently amended in 1995 and minor revisions were adopted in 1997 to comply with federal Health Insurance Portability and Accessibility Act (HIPAA) requirements. The resulting regulations, as they exist today, apply to all small employers (those with 2-50 employees) and include the following provisions:

- Guaranteed issuance of health insurance, which prohibits an insurer from refusing to insure any eligible group, regardless of the health status of employees or dependents or the size of the group;
- Portability and continuation of coverage options for employees who want to keep their coverage when they leave a job;
- Limitations on pre-existing condition requirements;
- Premium rating requirements and limitations on rate increases based on a group's experience;
- Ability to establish purchasing cooperatives that allow small firms to band together for the purpose of purchasing health insurance; and
- Creation of "consumer choice of benefit" plans that allow insurers to offer plans that exclude or limit certain benefits with the expectation that premium costs would be significantly lower.

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[2] Many employees are not considered eligible because they work too few hours or are considered temporary or contract employees.

Since the initial reforms took effect in 1993, the number of small employers with health insurance has more than doubled, from 36,952 in 1993 to 87,510 in 2007. Prior to the reforms, only 10 percent of small employers offered health care benefits, compared to an estimated 32 percent in 2007.

However, although small group reforms have addressed accessibility problems and enabled more employers to obtain coverage, small business owners continue to report two primary obstacles to providing coverage for their employees: the high cost of health insurance coverage and minimum participation requirements.

Insurance Costs

Texas employers, like those across the nation, face increasing difficulty in providing health care coverage to their employees as the cost of health insurance continues to rise. While both large and small employers have experienced significant premium increases in recent years, the increases are often more difficult for small firms to absorb and discourage many small employers from even attempting to obtain coverage. As indicated in Figure 1, average premium costs have more than doubled in the past ten years.

Figure 1: Average Small Business Premium Costs 1997 – 2006

Year	Average Annual Premium for Single Coverage	Average Annual Premium for Family Coverage
1997	$2,172	$5,534
1998	$2,270	$5,575
1999	$2,539	$6,486
2000	$2,955	$6,784
2001	$3,229	$7,974
2002	$3,580	$8,800
2003	$3,793	$9,831
2004	$4,346	$10,253
2005	$4,270	$10,970
2006	$4,463	$11,310

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey – Insurance Component 1997-2006

Although MEPS (Medical Expenditure Panel Survey) rate data are not available for 2007 or 2008, insurance rates in 2007 increased an average of 6 percent followed by average rate increases of 8 percent in 2008. Based on these rate increases, the average cost of single coverage in 2008 is estimated at $5,109 and family coverage is estimated to cost an average $12,947.

While these premium cost increases are dramatic, they are even more compelling when considered in the context of how much employers are willing to spend for employee health insurance. In a 2004 TDI survey of employers not providing health coverage to their employees, the majority of respondents indicated they could afford less than half of the average cost of coverage (Figure 2). While the average monthly premium cost per employee in 2004 was $362, only one percent of surveyed employers reported they would pay at least $300 a month. Only 37 percent reported they would pay at least $100 a month; one-third would pay $50 or less per employee per month.

Figure 2: Monthly Premium Amounts Employers Will Pay for Insurance Coverage

Cost Per-Employee-Per Month Employer Willing to Pay	2001	2004
Less than $50	23%	17%
$50	22%	17%
$100	20%	20%
$150	9%	8%
$200	5%	6%
$250	2%	2%
$300 or more	2%	1%
Would Not Purchase at Any Cost	14%	14%

Source: Texas Department of Insurance Small Employer Surveys, 2001 and 2004

Health Insurance Rating Provisions

Although average premium costs are useful for tracking increases over time as well as for comparing Texas' premiums with those in other states, it is important to note that many small firms will face premiums significantly higher than average rates. Before enactment of state and federal small group insurance reforms, Texas had no rating restrictions or limitations within the group health insurance market. Insurers charged what they estimated to be appropriate. With enactment of the guaranteed issue provisions, regulators across the country were concerned insurers may increase premiums for unattractive groups to a point where the employer simply could not afford the coverage. To address this concern, most, if not all states, also enacted varying forms of insurance rating restrictions that were designed to restrict, to some extent, the amount of premiums that could be charged for a high-risk group.

Legislative options enacted by states range from requiring approval of health insurance rates to a less restrictive "rate-band" approach, as enacted in Texas. The "rate band" provisions establish some parameters that insurers must follow when setting rates, while still allowing for wide rate variation among groups and insurers. In Texas, rates are not subject to review or approval by TDI. The rate bands also limit the extent to which rates are increased for low-risk groups in order to subsidize rates for high-risk groups that would have likely been denied coverage prior to the guaranteed issue requirements.

Texas' small group insurance rating requirements involve a series of steps. First, a premium rate is determined based on the benefit plan design and the case characteristics of a group, as follows:

- Age and Gender: each employee is assigned to a premium rate based on their age and gender. No limitations apply to rate variations based on age or gender.
- Group Size: insurers may vary rates up to 20 percent based on a group's size. Larger groups generally receive lower rates than small groups.
- Industry Factor: rates may vary by an additional 15 percent based on the employer's type of industry, due to the fact that some industries exhibit higher medical claims costs than others.
- Geographic Area: rates may be increased or decreased based on an area factor that reflects the fact that medical costs may be higher or lower in some areas of the state.

Once the group rate is calculated based on the characteristics described above, the carrier may adjust the rate by a "risk load" to reflect risk characteristics that include the health

status-related factors of the group or any one member of the group. The risk load may be as high as 67 percent and must be applied uniformly to all members of the group in order to comply with the federal non-discrimination provisions under HIPAA. Upon renewal of a policy, rate increases based on the risk load factor are limited to no more than 15 percent per year. Increases due to other factors, such as changes in case characteristics (including the age of employees) may be in addition to any increase due to the risk load adjustment.

These rating provisions will allow some groups to qualify for premiums that are lower than the average stated above in Figure 1, but other groups will be charged premiums significantly higher than average. Rates for older workers can be two or three times higher than rates for younger workers. An employer with even one older employee may be charged premium rates much higher than a competitor with younger workers. In a 2006 TDI data call that is required of the largest insurers in the state, actual annual premiums for individual employees insured under policies issued by the carrier were as high as $19,055; $20,164; $20,610; $26,894 and $62,209. While such extreme costs are not common, these rates illustrate the wide range of premium rates a small employer may be charged depending on the characteristics of the workers. Many groups will encounter rates higher than the average available to other firms.

Minimum Participation Requirements

In addition to creating rating provisions for small firms in order to complement the "guaranteed access" requirements, Texas and other states also enacted "minimum participation requirements" that are designed to ensure enrollment of an adequate number of healthy individuals to offset the costs of high risk enrollees. In Texas, state law allows an insurer to require enrollment of at least 75 percent of eligible employees within a small group in order to qualify for coverage. With guaranteed access, insurers are now required to accept all individuals in a small group, regardless of health status. When the law was first enacted, insurers were appropriately concerned that such a provision would attract a disproportionate number of unhealthy people and would discourage healthy individuals from enrolling in coverage if they knew they could enroll later if they became sick, a practice referred to as "adverse selection". Over time, premiums would continue to increase to cover the claims for the relatively sick groups and healthy individuals would continue to drop coverage, perpetuating the cycle of higher premiums and decreasing numbers of healthy enrollees.

From the perspective of small business employers in Texas, the 75 percent participation requirement has prevented them from offering coverage to any of their employees. This is particularly true for:

- Firms with a higher percentage of low-wage workers who often cannot afford the premium contribution required to enroll in the plan;
- Small businesses with a large percentage of healthy, younger workers who feel that they do not need health insurance coverage or do not want to spend the money;
- Firms located in border communities where employers report many of their workers prefer to seek health care in Mexico, where the cost of medical care is often lower than the cost of insurance.

Despite the "guaranteed issuance" provision, an employer who cannot meet the participation requirements is not eligible for insurance and will be declined by the insurer. Although insurers are allowed to establish participation requirements below 75 percent,

TDI is not aware of any insurers that have allowed a lower participation rate. Carriers are required to apply their participation requirements to all small groups.

TDI Small Employer Insurance Study & the Houston Pilot Project

In 2001, Texas was fortunate to be selected as one of the early federal State Planning Grant (SPG) recipients, receiving $1.3 million to begin an ambitious study of the uninsured population. Working with a diverse and proactive group of stakeholders who served on the SPG Oversight and Implementation Working Group, TDI staff completed a variety of qualitative and quantitative research activities, focusing primarily on the small employer insurance market. The study included multiple focus groups, surveys and regional health fairs attended by small business owners and their employees, which allowed TDI to collect detailed information on the challenges small firms face, as well as recommendations for changes that small employers would support in an effort to provide more affordable health insurance options. During the third phase of the research project, the research data were used to develop a specific insurance program for small employers under the Insure Houston pilot project. The Houston/Harris county area was selected for the pilot because of the high number of small businesses in the area, an estimated uninsured population of 1.3 million residents and a highly motivated business community that was actively seeking solutions for their uninsured workers.

Using data collected through surveys and focus groups conducted by TDI under the SPG program, TDI staff worked with stakeholders that included the Greater Houston Partnership, insurers, providers, employers and employee representatives to develop a unique, affordable small employer insurance program. Essential elements for program success were identified and included:

- An average cost of no more than $150 per employee per month;
- Inclusion of preventive and primary care benefits as well as protection from catastrophic injuries and illnesses;
- Simplified enrollment and rating processes to minimize the time and effort required of employers to determine prior to application the true cost of coverage and employees to enroll;
- A benefit plan design to appeal to both employers and employees to encourage higher employee participation.

Working with consulting actuaries, two benefit plans were designed for testing. One plan focused on primary and preventive care with limited out of pocket costs and a low annual deductible, but included length-of-stay limits for hospital care and service limits for out-patient care. The second plan included a higher deductible and limited coverage for primary and preventive care, but provided more extensive coverage for catastrophic medical events.

To simplify the application process for employers, agents and carriers, the two benefit plans were priced using a modified community rating process, which is a distinct and significant departure from the rating methodology currently used in the small group market in Texas. A simple rate chart would enable employers and agents to immediately calculate the group rate for their workers without going through a lengthy, time-consuming underwriting process. Rates were to vary only according to the age and gender of the group participants, with a standard rate for all children. Employers interested in enrolling in the plan could

quickly estimate the cost of coverage for their group without submitting paperwork for underwriting review.

After the initial plan design was completed, TDI staff conducted 25 focus groups with employers and employees throughout the Houston area. The prototype benefit plans were presented in detail to focus group participants, who then provided comment and suggestions for improving the benefit plan design. Based on focus group comments, the consulting actuaries made slight modifications to the plan designs and provided final price estimates for the revised plans.

Focus group response to the benefit plan proposal was overwhelmingly positive. Even without the minor modifications, 88 percent or the participants indicated they would purchase the plans if the program were implemented as presented. Key factors that were critical to their approval of the program included:

- Simplified enrollment process;
- Ability to immediately determine the true cost of coverage;
- Availability of two benefit plans to meet the widely diverse medical needs and financial situations of employees; and
- Affordability of the benefit plan.

In December, 2006, TDI hosted an industry conference to present the study findings and pilot proposal and to discuss implementation of the program. The Harris County Healthcare Alliance subsequently issued a Request for Proposal (RFP) in February to solicit an insurance carrier for the benefit plan. The Alliance planned to create a healthcare cooperative that would administer the program for small businesses in the Houston area. However, after discussion with three carriers, the Alliance was unable to reach agreement on the terms of a health care program that would implement the program objectives using the benefit plan designs while meeting the affordability requirements.

HEALTHY TEXAS

Healthy Texas proposes a comprehensive, market-based proposal to assist commercial carriers in providing affordable health care coverage for lower income, working Texans and their families. It has the potential to provide insurance to a significant portion of the 5.9 million uninsured Texans. *Healthy Texas* would give the State the flexibility to build one program to use a range of tools to meet varying levels of need, including reinsurance to lower the overall premium level for small businesses and their workers. For example, *Healthy Texas* would create an option through which the state may provide coverage for low income Texans under the proposed HOP (Health Opportunity Pool), pending Centers for Medicare and Medicaid (CMS) approval. The *Healthy Texas* program would also provide an opportunity for locally designed health coverage plans authorized under SB 10. Local governments that are creating programs (such as three-share initiatives) could use *Healthy Texas* as a foundation for their coverage.

This proposal builds on six years of federally funded research at the Department. Through that research discussed earlier in this report, employers' and employees' opinions and recommendations shaped *Healthy Texas*. The program would serve as an insurance expansion model, creating a new public/private health insurance initiative to provide lower-cost health insurance to uninsured Texans. The *Healthy Texas* model would enable more small employers to offer coverage as a result of the reduction in premium costs from the State's provision of reinsurance for high cost claims. Uninsured small businesses and their workers would be able to afford coverage that previously was unattainable due to high premium costs. In addition, Medicaid reform HOP subsidies may also be available to qualified individuals and employees with access to employer-sponsored insurance (ESI).

STATE FUNDED REINSURANCE – PREMIUM STABILIZATION FUND

A key element of *Healthy Texas* is publicly funded reinsurance, which is insurance coverage for insurance carriers. Reinsurance protects health insurance carriers against losses due to unexpectedly high claims costs or an unexpectedly high volume of claims. Recently, interest in using publicly funded reinsurance as a means of maintaining or expanding private health insurance has grown among states. Specifically, states have looked at reinsurance as a means of spreading risk in insurance markets, improving the predictability of claims and reducing the premium mark-up charged by carriers to protect themselves against unexpected claims.[3]

In 2001, New York implemented a reinsurance program targeting the employers of middle-to low-wage workers, sole proprietors and individuals using tobacco-settlement funds. The success of the Healthy New York program has led many states to consider it a model for reinsurance. The textbox, *Healthy New York*, provides more detail about the program.

Healthy Texas proposes that the state fund reinsurance that would pay a significant proportion of health care claims above a certain threshold and up to a certain point – within a risk corridor. For example, the reinsurance fund could pay 80 percent of an individual's claims between $5,000 and $75,000 incurred in a calendar year. The carrier would then

[3] Chollet, D. "The Role of Reinsurance in State Efforts to Expand Coverage," Washington, DC: AcademyHealth State Coverage Initiatives, Issue Brief, Vol. V, No. 4, October 2004, http://www.statecoverage.net/pdf/issuebrief1004.pdf.

cover 100 percent of claims below the $5,000 threshold and above $75,000, up to the annual benefit limit; the insurer would also cover 20 percent of claim costs between the two thresholds.

Healthy New York

The New York Health Care Reform Act of 2000 included a variety of insurance expansion options, including the Healthy New York reinsurance program. Healthy New York became operational in 2001 and provides state-subsidized reinsurance that reimburses participating health plans for 90 percent of claims costs between $5,000 and $75,000 incurred by any single enrollee within a calendar year. The risk corridor was initially set between $30,000 and $100,000, but was reduced in 2003 after lower-than-expected claims activity. This risk corridor change resulted in an additional reduction in premiums of approximately 17 percent.

The program is open to qualifying small employers, sole proprietors and individuals who have not been insured for the past 12 months. To qualify, at least 30 percent of a small employer's employees must earn $36,500 (adjusted annually) or less. Fifty percent of employees must enroll or have other coverage. Eligible uninsured individuals and sole proprietors must have family incomes less than $25,284 for single adults and $51,384 for a family of four. All HMOs are required to participate in the program and provide standardized benefit plans that include comprehensive coverage. Although the state limits its budgetary commitment to the reinsurance subsidy, the program has never neared the limit. If reinsurance claims ever were to exceed available state funds, Healthy New York would reduce reinsurance payouts pro rata to stay on budget.

Healthy New York Program Highlights:

- **Cost:** Average premium costs have been reduced by approximately 30 percent. Average Healthy New York small group monthly premiums in 2006 were $204 for individuals and $602 for families, compared to $419 and $1,097 for plans outside Healthy New York
- **Enrollment:** In 2006, Healthy New York had 131,546 enrollees: 72,518 (55 percent) enrolled as individuals; 22,559 (17 percent) were sole proprietors and 36,469 (28 percent) were small business employees
- **Risk Corridor:** In 2006, 6.9 percent of all enrollees had claims that reached the $5,000 threshold for the risk corridor. Small employers had the lowest percentage of enrollees that reached the attachment point: 5.7 percent of small employer enrollees, compared to 7.6 percent of sole proprietors and 7.2 percent of individual enrollees
- **Medical Loss Ratio:** With reinsurance payments, the loss ratio for small employer enrollees was 67.1 percent, compared to 85.1 percent for sole proprietors and 88.5 percent for individuals
- **Reinsurance Claims:** in 2006, a total of $92 million in reinsurance claims were paid for all enrollees; $59 million (64 percent) were for individual enrollees, $18 million (19 percent) were for small group enrollees and $16 million (17 percent) were for sole proprietors

Creating a risk corridor allows the state to bear some of the risk, giving the participating carriers some assurance against losses. Also, structured as a corridor instead of stop-loss coverage, which would cover all claims above a certain threshold, it creates an incentive for carriers to continue managing care. Even for the claims that are covered by reinsurance, carriers will continue to manage the treatment and cost of care because the carrier will once again be responsible for paying the claims above the upper threshold.

Reinsurance is an attractive approach for some states because of claims experience in the general population. For example, only about 10 percent of privately insured individuals have claims above $5,000, while less than 0.05 percent of privately insured individuals incur claims above $100,000. As a result, the state can leverage the reinsurance fund to reduce the cost of premiums. In a good year, the state could carry forward funds to subsequent years, retaining the unspent funds to offset the need for future contributions. Conversely, however, the state could experience a year with above average losses, in which it would pay more claims than usual.

KEY POLICY DECISIONS

Numerous decisions remain to be determined about the structure of *Healthy Texas*. Below is a discussion of some of the key decisions that the Department is currently considering in light of information gathered through actuarial analysis and stakeholder input. In the *Healthy Texas* Phase II report, the Department will make recommendations to the Legislature on most of these key points. Appendix C includes a more detailed list of key decisions that will also be addressed in the supplemental report.

Major Assumptions

As a starting point for analysis and discussion, the Department made certain assumptions and is working with an actuarial firm to analyze the potential impact to the State and the benefit for the uninsured. The assumptions are flexible and can be adjusted to affect the ultimate cost of *Healthy Texas* to the State and the price of premiums. Major assumptions for the initial analysis are below.

- *Healthy Texas* would be available to small employers that have not offered health care coverage to their employees for the previous 12 months. This assumption guards against adverse selection – the risk that a disproportionate number of unhealthy groups would enroll in *Healthy Texas* and drive the cost of coverage up for healthier groups. It also encourages groups that are currently covered in the commercial market to maintain their current coverage.
- Publicly funded reinsurance would lower the cost of coverage to affordable levels.
- Private insurers would offer approved benefit plans at a cost that is affordable for the target population.
- For this program, insurers would agree to modify rating practices in order to limit rate variations based on age, gender and health status and provide more level premium rates for all eligible participants. Data referenced earlier in this report indicate that the Legislature should consider a means of spreading the risk, rather than creating a program that because of its pricing, does not capitalize on one of insurance's greatest strengths: risk transfer.
- As a means of targeting availability of the program, the state could consider limiting enrollment to employers with a certain percentage of low-wage workers. Targeting specific populations would limit enrollment and lower the cost to the state. Other

strategies to lower costs could include limiting participation to very small groups (with 2 to 20 employees) or creating a pilot program in one or more areas of the state. These strategies may be desirable in the early years of the program to gain experience and guard against unexpected loses.
- If approved by CMS, Healthy Texas could provide an alternative enrollment opportunity for individuals eligible for coverage under the Medicaid HOP waiver.

Benefit Plan Design
The Department also assumed health plans would provide comprehensive coverage, that including primary and preventive health care; prescription drug benefits up to a predetermined amount; and total annual benefits of $100,000 to $300,000 annually. The Department also assumed that out-of-network benefits would be available for emergencies only and would be covered at 50 percent of usual and customary reimbursement levels. While the benefit plan the Department is considering is not as comprehensive as the Medicaid, Children's Health Insurance Program, or Texas state employee plans, the coverage is relatively robust and yet supports an affordable premium.

Alternatively, the possibility exists that participating insurers could offer coverage that closely approximates the state plan. A more detailed list of the initial proposed benefit plan can be found in Appendix B.

Impact on Uninsured Population
The over all impact *Healthy Texas* could have on the uninsured population is uncertain and will largely depend on numerous policy decisions that will determine eligibility requirements and how aggressively the state would market the program. However, using TDI's research into the preferences and motivating factors that influence small employers and their employees when it comes to health care coverage as well as lessons learned from the Houston Pilot Project, the Department is confident small employers and their employees will be interested. Potential enrollees include more than 1.5 million workers in small firms, plus dependents; up to 2.2 million eligible adults and children above 200 percent FPL; and up to 2.1 million low-income adults under 200 percent FPL. The lowest wage workers may also be eligible for additional HOP subsidies.

As the policy decisions about *Healthy Texas* are flexible, premium affordability and availability of funds will determine the size of the reinsurance program and its enrollment.

Program Administration and Funding Options
Several options could be considered for administration and funding. Depending on the size of the program, initial costs to the state would be for administration of the program. To administer the program, the state could require the Department to contract with one or more carriers to provide the health insurance and another carrier to administer the reinsurance component. Another option that should reduce administrative expense is to direct the Department to administer the reinsurance system with commercial carriers providing the health plans. This is the model used to administer the Healthy New York program.

To fund the system, for administration and to provide reserves, the state could fund with:
1) a combination of federal/state money under Medicaid waiver and HOP;
2) private premium payments;
3) general revenue;

4) other resources, such as private insurer assessments or policyholder fees with premium tax credits for payments; or
5) state-issued bonds.

Each approach has its advantages and disadvantages and could best be evaluated when the over all cost of the program is determined.

STATUS TO DATE

In the legislative interim, TDI has been working with a wide array of stakeholders, including the Governor's office, the Lieutenant Governor's office, the Speaker's office, other legislative offices, the Health and Human Services Commission and the University of Texas, Lyndon B. Johnson (LBJ) School of Public Affairs to develop *Healthy Texas*, an insurance expansion model that creates a new public/private health insurance program to provide low-cost health insurance to uninsured Texans. A central goal of the *Healthy Texas* program is to create a market-based approach to engage carriers in addressing the needs of small employers and their employees for health care. Importantly, efforts to-date have focused on creating a flexible program that will meet a diversity of needs.

- To begin the analysis laid out in the SB 10 *Healthy Texas* provision, the Department decided to build on research undertaken through the SPG, including small employer surveys and focus groups, to determine a starting point for making recommendations to the Legislature.
- As a next step, the Department designed a benefit plan that took into consideration lessons learned through the SPG, HHSC's experience in designing a health benefit plan, and input from regional programs
- In addition, through analysis of other state programs to reduce the number of uninsured, the Department settled on publicly funded reinsurance as a tool to accomplish the goal of lowering premiums through a market-based solution.
- Next, the Department began an actuarial analysis of various plan design options. SB 10 allows the commissioner to contract with actuaries and other experts as necessary to conduct the study. This summer and fall, TDI and the LBJ School of Public Affairs have worked together with the actuarial firm, Milliman, Inc., to develop and analyze options for the *Healthy Texas* proposal.
- The general approach has been to develop *Healthy Texas* as an insurance expansion model that would enable more small employers to offer coverage by providing subsidies for qualified, low-income individuals and lowering insurance premiums for all participants through reinsurance.

NEXT STEPS

The Department is continuing its work with Milliman and the LBJ School of Public Affairs to complete its analysis.

- The Department is also conducting stakeholder meetings over the next month to allow the Department to more fully understand the potential advantages and disadvantages and to identify other possible program requirements or restrictions and limitations necessary for successful program implementation.
- Input from stakeholders will likely require additional actuarial analysis to ensure that changes in the program structure still achieve its initial goals.

- Finally, the Department will issue a Phase II report prior to the legislative session and will include the full actuarial analysis, stakeholder feedback, and projected cost impact to the state.

The result of this program should be measured under the proper paradigm. Because this report proposes a market-based solution and because markets tend to correct over long business cycles; the benefits of *Healthy Texas* will likely materialize gradually over time. Second, this program will not provide a panacea to the over all health care coverage issue in Texas. Rather, the goal is to address access to health care, of which a high uninsured rate is both a symptom and one of many root causes. The outcome of this program will be the seeds of a market incentive that will, over time, correct some inefficiencies and provide Texans with affordable options. Further, while not addressed in detail in this report, it is paramount that personal responsibility for health outcomes and better consumer health education and health spending continue as part of our society.

Appendix A – Senate Bill 10

CHAPTER 1508. HEALTHY TEXAS PROGRAM

Sec. 1508.001. STUDY; REPORT.

(a) The commissioner shall conduct a study concerning a Healthy Texas Program, under which small employer health plan coverage would be offered through the program to persons who would be eligible for that coverage.

(b) The study shall include a market analysis to assist in identification of underserved segments in the voluntary small employer group health benefit plan coverage market in this state.

(c) The commissioner, using existing resources, may contract with actuaries and other experts as necessary to conduct the study.

(d) Not later than November 1, 2008, the commissioner shall provide a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature addressing the results of the study concerning the Healthy Texas Program. The report must include an analysis and information regarding:

(1) the advantages and disadvantages of the proposed program;

(2) prospective structure and function of the program and its components;

(3) prospective program design and administration, including fundamental operational procedures, powers and duties of the commissioner, and powers and duties of the program board of directors;

(4) recommendations for program eligibility criteria and minimum standards applicable to group health benefit plans that may be included in the program;

(5) identification of other program requirements or restrictions and limitations necessary for successful implementation of the program;

(6) the potential economic impact that the program would have on the small employer insurance market in this state;

(7) the anticipated impact that the program would have on the quality of health care provided in this state; and

(8) recommendations for any statutory changes to address implementation of the program.

Sec. 1508.002. EXPIRATION. This chapter expires September 1, 2009.

Appendix B – Benefit Plan.

- Premium Goal: $150 to $200 per member per month.
- Hybrid of the two plans: State Planning Grant Houston pilot and Healthy New York.
  - Annual Deductible: $500
  - Coinsurance: 20 percent
  - Annual Out-of-pocket Maximum, including deductible: $2,000
  - Annual Maximum Benefit: consider the difference between setting a $100,000 limit and $300,000 limit
  - Hospital Benefits
    - Inpatient Hospital: Covered
    - Outpatient Hospital Surgery: Covered
    - Hospital Diagnostic Testing: Covered
    - Emergency Room: After a $75 deductible, covered subject to other deductibles and coinsurance
  - Physician Benefits
    - Inpatient: Covered
    - Outpatient Hospital: Covered
    - Office visits and preventive care:
      - Adults: first two visits, $25 copayment only
      - Children: first six visits, $25 copayment only
      - All remaining visits subject to other deductible and coinsurance requirements
    - Behavioral health: First two visits have a $40 copayment; all other visits are subject to other deductible and coinsurance requirements; cap at 20 visits
    - Radiology and pathology: covered
  - Prescription Drug Benefits:
    Consider having a lower and higher drug benefit
    - Deductible: $200
    - Generics: $10 copayment or 30 percent, whichever is less
    - Brand name drugs: 30 percent coinsurance
    - Annual Maximum: None
  - Exclusions:
    - Vision Exam, Glasses, Contacts
    - Dental
    - Chiropractic, Podiatry
    - Private Duty Nursing
    - Home Health Care
    - Durable Medical Equipment (excluding oxygen)
    - Prosthetics
  - Covered subject to copayments:
    - Ambulance
    - Maternity
    - Inpatient psychiatric care
    - Oxygen

Appendix C – Key Decisions

Options for Consideration	Implications for Decisions
Administrative Oversight *Who will oversee the reinsurance system and perform administrative operations?*	
Texas Department of Insurance	●Has insurance experience and data collection capabilities that will be critical to monitoring the experience of the program ●Program could be established relatively quickly if administered internally ●Is positioned to regulate and oversee the provision of private health insurance benefits through the reinsurance program ●Would have to contract for claims reimbursement system ●Has no experience with operating such a program
Health and Human Services Commission/Medicaid	●Has Medicaid experience, but limited private insurance expertise ●Has data collection capabilities that will be critical to monitoring the experience of the program ●Program could be established relatively quickly using existing contractors ●May be able to use existing contractors for various administrative functions
Texas Health Insurance Risk Pool (THIRP)	●Program could be established relatively quickly building on existing administrative infrastructure ●THIRP has experience with individual enrollment, but not group ●May be able to use existing contractor for various administrative functions
Newly created entity	●Would require creation of an entirely new organization, which could delay implementation ●Provides an opportunity to create a unique organization that is singularly focused on the creation and oversight of the reinsurance program
Eligibility *Who will be allowed to enroll in the program?*	
Small Employer groups	●Should income eligibility requirements be based on individual employees' salary? Family salary? ●All small groups (2-50), or only smallest groups (2-10 or 2-25) ●Limit to currently uninsured? ●Must be in business for minimum time period (12

	months?) ●May require a certain percentage of eligible employees to participate in order to qualify for program
Sole Proprietors/Individuals	●May increase risk of adverse selection ●Sole proprietors often have difficulty buying coverage. In the Healthy New York reinsurance system, they represent the largest enrollment category Note: In Healthy New York, individual enrollees had a higher medical loss ratio (88.5%) than small group enrollees (67.1%); Percentage of members reaching stop-loss threshold: 5.7% of small employer enrollees, 7.6% of sole proprietors; 7.2% of individuals
Individuals	●Would be a problem for insurers if program is guaranteed issuance ●Allowing individuals increases risk of adverse selection and likely would result in higher reinsurance claims costs ●To guard against adverse selection, the state could restrict eligibility for individuals to those without access to ESI ●Would provide a more affordable opportunity than the Risk Pool
Enrollment Period *How frequently will plan be available for enrollment?*	
Continuous enrollment	●Would provide opportunities for individuals to enroll at any time ●Would provide less predictability ●Would provide opportunity for continual growth
Limited enrollment	●Provides more predictability both for insurers and for state funding purposes ●Limits growth; will prevent some employers from participating who do not initially enroll
Crowd Out Protections *How will the plan discourage employers from dropping existing coverage and joining Healthy Texas program?*	
Limit eligibility to those groups/individuals who have been uninsured for 6 or 12 months	●Would discourage employers with existing coverage from dropping coverage to join *Healthy Texas* ●Could be perceived as a "reward" for those employers who have not been offering insurance and a penalty for those who have ●Would create an unfair economic advantage for employers who qualify for program compared to those who do not because they already offer insurance
Limit enrollment to certain group sizes	●Could limit eligibility to all groups of 10 or fewer since these groups are the most likely to be uninsured and insurers often prefer not to insure the smaller groups

	●Would prevent crowd-out among groups of 11 or more employees, who are more likely to already offer coverage than smaller groups
Provide incentives for employers who already offer coverage to continue with existing plan	●Offer tax credits to qualified small employers who offer insurance to offset economic disadvantage ●Provide subsidies for qualified low-income workers, but only if employer maintains existing coverage
Benefit Plan *What benefits must be offered?*	
Create one or more standard plans	●Reinsurance pricing will be dependent on the benefit plan structure; providing standard plans will simplify pricing process ●Employers have indicated they prefer standardized, state-approved plans
Allow any plan that meets minimum standards	●Allowing multiple plans will appeal to insurers and agents ●Multiple plans will create challenges in pricing and predicting claims for reinsurance payments
Rate Oversight *In exchange for reinsurance protection, what rating requirements should be implemented?*	
Limits on annual rate increases and/or minimum loss ratio requirements	●Provides rate stability and predictability for employers ●May discourage some carriers from participating
Insurer Participation *How many and which insurers will participate in the program?*	
Require participation of all insurers and/or HMOs that meet certain financial thresholds	●Participants could be assigned randomly to insurer ●Participants could choose which insurer they prefer
Limit participation to a few selected insurers, based on bidding process	●Insurers prefer large numbers – may increase support for program if only a few insurers are guaranteed a minimum enrollment and voluntary participation ●Limiting the number of insurers will simplify operation of program ●Limiting participation may discourage support/encourage opposition from some insurers
Agent Participation *What role will insurance agents have in the program?*	
Include agents	●Pay a commission based on percentage of premium or fixed fee per person ●Provides an infrastructure for marketing, outreach and enrollment ●Increases cost based on price of commission
Exclude agents	●May impact enrollment if agents are not involved in outreach ●Will likely draw opposition from agents

	●Will save money normally paid for commissions ●In surveys, employers have indicated they prefer to avoid agent and enroll directly on-line if possible ●Agents play a valuable role in education, but may prefer to delegate that responsibility to the entity overseeing the program
Funding *How will the reinsurance pool reserves be funded?*	
General Revenue (GR)	●GR appropriations could be used to establish the initial funding and continued thereafter or could be phased out over a pre-determined time period
Premium Payments	●Premiums for the purchase of reinsurance benefit plans will include partial funding for reinsurance coverage, subsidized with other funds to keep premiums affordable
HOP contributions/participation	●HOP funds could be used to provide reinsurance for HOP-eligible enrollees.
Insurer payments	●All insurers could be charged a reinsurance support fee based on a formula that reflects the insurers' profits or medical loss ratio. Fees would be deductible from premium tax payments
Provider assessments	●Providers – all types or specific types – could be required to pay a reinsurance support fee
State-issued bonds	●Structured similarly to the workers' compensation system when created, the state could issue bonds that would be paid back as reserve funds grow through investments ●The risk of high claims and low yield investments may limit the ability of the reinsurance system to pay back bonds