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Three Proactive Health Insurance Reforms for Texas

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Introduction

Texas Governor Rick Perry has said the state will not expand its Medicaid program or set up a health insurance exchange in accordance with the Patient Protection and Affordable Care Act (ACA). The Medicaid expansion and the health insurance exchanges are crucial aspects of the federal law that require state acquiescence and cooperation, and state lawmakers should steadfastly refuse to be deputized into implementing federal policies.

In addition to resisting the law, there are other positive—albeit modest—policy reforms on the state level that lawmakers can and should pursue to lessen the harmful effects of the ACA and improve health care coverage for Texans. State lawmakers can and should enact policy reforms targeting problems that have reduced access to insurance coverage and contributed to increasing health care costs in the Lone Star State.

The reforms include:

- allowing state employees to establish Health Savings Accounts (HSAs);
- reviewing all state health insurance mandates and eliminating those that go beyond the highly-prescriptive and onerous Essential Health Benefits (EHBs) required by the ACA; and
- taking advantage of a provision in the federal health care law that will shield small group employers from the community rating provision until Jan. 1, 2016.

Although these measures alone will not solve the many health care challenges facing the state, they will help to mitigate some of the costly requirements of the federal health care law, even as Texas stands firm with other states in its refusal to implement the most deleterious parts of the ACA.

Recommendations

- Allow state employees to establish Health Savings Accounts (HSAs).
- Review state health insurance mandates and eliminate all those that exceed the Essential Health Benefits mandated in the Affordable Care Act (ACA).
- Redefine the small employer market as employers with one to 50 employees for the years 2014 and 2015, in accordance with the optional provision in the ACA.

History of Health Insurance Regulation in the United States

Employer-sponsored health insurance arose as a reaction to wage and price controls imposed by the federal government during World War II. Unable to offer increased pay, companies instead began offering fringe benefits such as sick leave and health insurance, which the War Labor Board said did not count as wages. As a result, the number of companies offering health insurance plans rose dramatically during the war as employers sought to attract and retain scarce labor.

In the late 1940s, the National Labor Relations Board ruled that employer-sponsored health insurance plans were subject to collective bargaining, and in 1954 the Internal Revenue Service exempted health insurance benefits from income taxation, further incentivizing employer-sponsored coverage.

In Texas, health insurance regulation came into being in 1945 with the enactment of the federal McCarran-Ferguson Act. This legislation exempted the business of insurance from federal anti-trust legislation as long as states regulated it.

Although McCarran-Ferguson left insurance regulation to the states, congressional oversight of insurance has gradually increased over the years. Congress created

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Medicare and Medicaid in 1965 and followed up in 1974 with the Employee Retirement Income Security Act (ERISA), which brought employee benefit plans under federal jurisdiction for self-insured, large employers. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) established minimum federal standards for availability and renewability, which in turn vastly expanded the role of the National Association of Insurance Commissioners (NAIC), the body that promotes uniformity of laws and regulatory standards among states.

Consumer-Driven Coverage: Cost Savings and Choice

The Health Maintenance Organization (HMO) Act of 1973 removed certain state restrictions on HMOs if they were federally certified and also required employers with 25 or more employees to offer federally certified HMO options alongside indemnity insurance, if requested. That provision, known as dual choice, expired in 1995, after which HMOs began adopting a network model. Today, most employer-funded health insurance plans are based in part on the HMO network model, in which the employer pays all or most of the premium, employees pay only a co-pay or a deductible for routine care, and a third party administrator pays the provider.

Employment-based insurance plans now cover about 150 million people nationwide and about 11.5 million in Texas.[1] The majority of Texans have traditional, HMO-style (provider network) plans, but Consumer-Driven Health Plans (CDHP) with features like Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs) have been gaining popularity in the state, and nationwide, since their creation in 2003. Such plans better incentivize consumer-driven coverage that empowers individuals to choose care best-suited to their needs and encourages cost-consciousness and more careful utilization of services.

CDHPs enable employers to apply the mechanisms of 401(k) plans to employee health insurance. In other words, they transform employee health insurance from "defined benefits" to "defined contributions," resulting in controlled costs and minimized risk. According to some estimates, if consumer-driven plans with savings account options accounted for half of all employer-sponsored coverage, national health care costs could drop by as much as $57 billion annually.[2]

With an HRA, an employer can contribute pre-tax dollars to help pay for employee insurance premiums or other health care expenses, and employees are given greater choice to choose a plan that meets their needs. Alternatively, employees can also choose not to purchase coverage at all and simply use the funds in their HRA to pay out-of-pocket medical expenses as needed.

How Federal Tax Policy Drives Employment-Based Health Insurance

The federal government uses the term "tax expenditures" to refer to the theoretical loss of tax revenue relative to what would be collected in the absence of exemptions or deductions (monies not received, rather than paid out). Estimated tax expenditures from employer-based health insurance plans in 2012 were more than $170 billion[3]—the single greatest tax expenditure in the federal budget and nearly twice the size of the next largest expenditure, the home mortgage interest deduction ($87 billion). The estimated total is projected to increase each year, such that the four-year total tax expenditure for employer-based health insurance plans for 2013-17 will be more than $1 trillion. That accounts only for the expenditures for employer contributions to health insurance premiums and care; it does not include tax deductions for employer contributions to HSAs, HRAs, etc. Therefore, the actual total annual tax expenditure is far greater than the amount indicated here.

An HSA is an employee-owned account that can be established as long as the employee also is provided with a qualified high-deductible health plan (HDHP). The HSA enables tax-free contributions by both employees and employers, and tax-free withdrawals for qualified health expenses, including deductibles, co-pays, and out-of-pocket expenses.

The basic difference between an HRA and an HSA is that the former is controlled by the employer while the latter is controlled by the employee; funds in an HRA belong to the employer until a medical expense is incurred, while funds in an HSA can be used at an employee's discretion for qualified health care-related expenses. In addition, HRAs are meant to cover all the costs of employee health benefits, whereas an HSA covers co-pays and costs associated with a deductible, as well as allowable health care-related costs not covered by the policy.

The growing popularity of HSA plans nationwide is due largely to the cost-savings involved for both employers and employees. Annual premiums for families with HSA accounts are on average $2,350 less than a typical PPO plan,[4] and overall medical costs for employees with HSAs are lower than traditional HMO plans.[5]

Short and Medium-Term Reforms for Texas

Faced with rising health care costs and the looming implementation of the ACA, state lawmakers should enact the following market-centered, consumer-driven reforms to reduce the harmful effects of the federal health care law.

Health Savings Accounts for State Employees

The State of Texas can promote employee choice and realize modest savings on health care by allowing state government employees to set up HSAs. Under current law, this option is not available to state employees, despite the steady rise in HSAs and other consumer-directed health plans nationwide over the past decade.

Texas pays for 100 percent of health insurance premiums for state employees. The total number of state employees is estimated to be 235,047 in 2013—an increase of more than 16,700 since 2006. State contributions to employee and retiree group health insurance for 2012-13 will be $4.1 billion, or 2.4 percent of the state budget.[6] This is a $1.5 billion increase from 2000-01, representing an average biennial increase of more than 20 percent, which the state attributes to the rising cost of health insurance and the growing number of participants.

A 2009 study found that HSAs saved enrollees 12 to 20 percent in their first year and thereafter held health insurance inflation to the same rate as the rest of the economy—roughly half what traditional plans experienced.

Current state law does not allow employees to establish HSAs, which could save the state millions of dollars in premiums and other health care costs. Because HSAs allow participants to meet their deductibles by paying medical bills with pre-tax dollars—that is, out-of-pocket from their HSA accounts—deductibles and co-pays are discounted. In addition, patients with HSAs have more control over their own health care and costs. Studies have shown that individuals with consumer-driven health plans such as HSAs are more likely to be cost-conscious than those with traditional plans, and thus utilize care more efficiently.[7]

In a traditional plan, an individual cannot deduct medical expenses until he or she reaches a threshold of a certain percent of their annual income. Most often, policyholders do not reach this threshold and therefore pay more in tax dollars than they would with an HSA. In the past, the effort to allow state employees to choose an HDHP with an HSA has been met with resistance from state employees, who tend to see it as a collective bargaining issue. Defined contribution plans and HSAs are seen, in this context, as an attempt to off-load costs onto the employee—in spite of evidence that indicates employees with HSAs do not pay more than those with traditional plans, and often pay less.[8]

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Redefining "Small Employer"
Texas can take advantage of a clause in the ACA that allows states to redefine "small employer" as a business with one to 50 employees, rather than 100. Currently, this change will apply only for 2014 and 2015, but will allow Texas companies with more than 50 full-time employees to retain their status in the large employer group and thus shield them from the modified community rating rule.

By allowing state employees the option of choosing an HDHP plan with an HSA, the state would empower its employees to be active, cost-conscious participants in their health care, and would likely see overall savings in the long term.

usually rollover unspent savings account funds, they begin to build a "nest egg" for future medical expenses and eventually have enough to meet the full cost of their deductible without additional contributions. At that point, the employee enters the health care market as a bona fide consumer with purchasing power on his or her own terms. By allowing state employees the option of choosing an HDHP plan with an HSA, the state would empower its employees to be active, cost-conscious participants in their health care, and would likely see overall savings in the long term.

Reexamine Mandated Benefits in Texas

Texas lawmakers should closely examine all state health insurance mandates to determine if any of them might be eliminated or relaxed, thus increasing competition among insurers. Whatever mandates that go beyond those included in the ACA should warrant special scrutiny. Texas has one of the six most heavily-regulated health insurance markets in the country, with 62 different mandated coverage benefits that health insurance companies must supply.[10]

Although a single regulation or mandate does not generally increase the cost of premiums significantly—on average, less than one percent[11]—the cumulative effect of many mandates significantly increases costs.

In 2009, health insurance claims from mandated benefits in Texas numbered more than 3.5 million and accounted for more than $462 million.[12] These claims, while representing a relatively small proportion of the total, drove up the price of premiums by an average of $365 for those on a family health insurance plan. Mandated benefits also carried a corresponding increase in administrative costs of more than $84 million.[13]

In the context of overall health insurance expenditures, these figures are small. Yet they increase every year, gradually driving up the cost of health insurance for employers and employees alike. The number of mandates, moreover, has increased with each legislative session. In 2008, Texas had 55 legislative mandates; it now has 62, and it is likely that more will be proposed in the current session. The rate of growth in costs will accelerate if the number of mandates grows.

Re-Define Small Employer Group

The ACA requires health insurers to comply with the "modified community rating" (MCR) effective Jan. 1, 2014 for plans in the individual and small employer group markets. Texas insurance law currently defines a small employer as a business with two to 50 full-time employees, but the ACA redefines the small group market to include businesses with one to 100 full-time employees—calculated using different standards for what constitutes "full-time"—effective Jan. 1, 2014.

The MCR rules in the ACA restrict the amount insurers in the small group market can charge for premiums. For example, insurance companies cannot charge different premiums to policyholders based on their personal health, gender, etc. In addition, insurers cannot charge the oldest people in the small group market more than three times what they charge the youngest person. These federal requirements will likely accelerate premium increases for most small employer group plans, which have risen 97 percent over the past decade.[14]

But Texas can and should take advantage of a clause that allows states to delay these changes by choosing to define "small employer" as a business with one to 50 employees.[15] As the federal law is currently written, this provision will apply only for the years 2014 and 2015, but the status of the provision might change between now and Jan. 1, 2016. State lawmakers might also challenge the provision's expiration date. At the very least, it will allow Texas companies with more than 50 full-time employees to retain their status in the large employer group for two years and thus shield them from the modified community rating rule.

Conclusion

Although the ACA robs states of much of their regulatory authority over the business of health insurance, the measures recommended here will bolster consumer participation and cost-consciousness, as well as shield employers from punitive federal fines in the near term.

The most effective way for state lawmakers to lower health insurance costs in Texas is to resist implementation of the ACA by refusing to set up a health insurance exchange and by opting out of the Medicaid expansion.

Of course, the most effective way for state lawmakers to lower health insurance costs in Texas is to resist implementation of the ACA by refusing to set up a health insurance exchange and by opting out of the Medicaid expansion. While holding the line on those two fronts, state lawmakers can also push for market-based reforms that will lower the cost of coverage and expand consumer choice for all Texans. ✯

Endnotes

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About the Author

John Davidson is a health care policy analyst in the Center for Health Care Policy at the Texas Public Policy Foundation. He joined the Foundation in October 2012. John began his career in journalism, and has worked as a print and online reporter, managing and executive editor, and freelance writer for a wide variety of publications.

Prior to joining TPPF, he was Executive Editor for Issue Media Group, where he oversaw nineteen weekly publications in the U.S. and Canada covering the creative economy, business innovation, and urban growth and design. A graduate of Hillsdale College, where he served as Editor-in-Chief of the *Hillsdale Collegian* and participated in the DOW Journalism Program, John's writing has appeared in the *Claremont Review of Books, First Things, n+1, Texas Monthly, The Philadelphia Inquirer, The Philadelphia Daily News*, and elsewhere.

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