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

Small employers face a difficult challenge in finding insurance for their employees. In Texas there are several options available to small employers to obtain health insurance for their employees. The options include the state-regulated small group market, Private Purchasing Co-ops, Health Group Cooperatives, MEWAs, and Association Health Plans, each with its advantages and disadvantages. Although this paper focuses on the options available in Texas, many of these options are available in other states and the basic concepts are applicable in many situations.
This paper looks at each of the options from a "Financial Decision-Making Theory" perspective. The participants in the small employer group health insurance market are

- insurers or carriers,
- employers,
- employees or insureds, and
- agents.

Financial Decision-Making Theory indicates that participants will make decisions based on the best financial outcome for themselves.

Carriers are driven by the need to make a profit. Even non-profit carriers have to avoid losing money. Their decisions to participate in the small employer group health insurance market, as well as their decisions about how to participate, are going to be influenced by the potential financial outcome.

Employers are facing ever-increasing health insurance premiums. Small employers, especially, are not able to afford health insurance for their employees. According to a January 2002 Texas State Planning Grant survey of small employers, 46 percent of small employers that responded to the survey did not currently offer health insurance. When asked the primary reason for not offering insurance, 62 percent responded that cost was the most significant reason. Small employers are going to make decisions that make the most financial sense for their business. However, small employers are driven by more than just cost issues. They have to compete in the job market and must consider the negative implications of not offering heath insurance coverage to employees.

Employees are being expected to share more of the costs of health insurance as the premiums are increasing. Employees are in the unique position of having more knowledge about their own potential health problems than any other participant in the market. This knowledge may lead to anti-selection. Anti-selection occurs when an employee chooses a particular plan or carrier based on which one will be the most financially advantageous to the employee. In turn, that decision can be detrimental to the carrier. For example, employees who know they have health problems are motivated to choose health plans with generous benefits, even if they cost more. On the other hand,

younger, healthier employees, who do not foresee any medical problems, will likely choose plans designed to cover medical contingencies that are more catastrophic in nature.

The agents are also key players in the small employer group market. Although agents may feel a desire to provide a quality product to their clients, agents are primarily motivated by their compensation. If the compensation is not comparable in each of the health insurance options for small employers, Financial Decision-Making Theory indicates that agents will tend to direct people towards the option that results in the best compensation for the agent.

In an ideal world, all of the participants in the small employer health insurance market would equally benefit from participating in the market. However, the needs of the participants often conflict. For example, there is the basic conflict that employers and employees want the lowest premiums possible, while the carriers and agents need to make a profit.

As the small employer health insurance market in Texas exists today, a lot of employers and employees feel like they do not enjoy many of the advantages that large employers and groups do. These include:

- Economies of scale, which some argue can result in administrative savings and bargaining power through bulk purchasing.
- The ability or risk tolerance to self-insure, which eliminates insurance risk charges and profit margins. Self-insuring also allows preemption from state regulation through the Employee Retirement Income Security Act (ERISA), which avoids state mandated benefits, premium taxes and other costs associated with state regulation.
- The unrestricted ability to take advantage of experience rating, which often results in lower premium rates for pools of healthy individuals.

Each of the alternatives to the traditional private small-employer market attempts to capture some or all of the advantages afforded to large employer groups listed above.

One very important consideration in the small employer group health insurance market is that there has to be a level playing field between all the insurance plan options or one option will end up with a disproportionate share of the high-risk individuals. For example, if there are premium restrictions in one market and not in another, the market without restrictions can set premiums to attract healthy individuals. The costs in the restricted markets will need to increase because the carrier will be covering fewer low-risk individuals.

Traditional State-Regulated Small Group Market

The Texas Department of Insurance, as well as federal laws, regulates the small group health insurance market. The Texas Legislature passed reforms for the small employer

health insurance market in 1993 and 1995. The significant provisions of this legislation included:

- Rating restrictions, including limits to the extent carriers can increase rates
- Creation of a statewide purchasing cooperative, as well as the authority to create private purchasing cooperatives
- Creation of standard benefit plans

Effective in 1997, the federal government enacted the Health Insurance Portability and Accessibility Act (HIPAA), which provided for

- Guaranteed issue and renewal, and
- Limitations on pre-existing condition exclusions.

Small Group Eligibility

Small-employer groups are those that have two to 50 eligible employees, not total employees. Eligible employees are those who meet the following criteria:

- Are full-time and usually work at least 30 hours,
- Are not classified as temporary, part-time, or seasonal and
- Are not already covered by another health plan.

To be eligible for small employer coverage, at least 75 percent of eligible employees must elect coverage. In the case of a two-person group, both must participate. The laws in Texas do not require employers to contribute toward plan premiums, but many carriers do require some contribution by the employer.

Rate Restrictions

Under Texas rules, premium rates are developed through a two-step process. First, a base premium rate is developed for each class of business. A class of business is the carrier's entire small group market with a few exceptions. The carrier can establish up to nine separate classes of business only to reflect substantial differences in expected claim experience or administrative costs related to the following reasons:

- The carrier has more than one type of sales and marketing distribution system.
- The carrier has acquired a class of business from another carrier.
- The carrier provides coverage to one or more employer-based association groups.

The rates for a particular employer group can vary based on the following case characteristics:

- Age of employees
- Gender

- Group size
- Industry
- Geographic area

Second, carriers can adjust rates up or down on the basis of health status by 25 percent, but the adjustment must be applied to the entire group. The final rate cannot exceed 67 percent of the base premium rate of the plan. Finally, the rates for a single employer cannot be increased due to health factors by more than 15 percent per year.

The problem with rating restrictions is with the healthier employees or groups. Rating restrictions don't mean that insurers will get less in total premium than what they need and everyone will get a "good deal" on premiums. From a Financial Decision-Making Theory perspective, insurance companies will have to act in their own best interest and charge the total amount that they will need for their small groups or they will not stay in the market. The rating restrictions limit how they can spread out the premium between the groups. Because they can't single out certain employees and, to a certain extent, groups and charge them more because they are less healthy, they will have to charge the healthier employees and groups more to make up that difference. The healthier groups are going to have to pay more for their insurance than they would presumably without rating restrictions. Less healthy groups are going to be in a win-win situation because they are paying less for their insurance and getting more out of it. Healthy groups will not be on the winning end of the deal and are more likely to search for lower cost coverage elsewhere.

Rating restrictions can lead to what is known as an "adverse selection death spiral," which is a classic example of Financial Decision-Making Theory. If a carrier ends up with more high-risk groups than it expected, it will lose money. Acting in their best interest, carriers will increase the premium rates. Healthier groups, looking out for themselves, will drop out and find less expensive coverage elsewhere. The higher risk groups know that it will be unlikely to find less expensive coverage elsewhere and will stay in the plan. This will lead to even higher costs than expected by the carrier and more rate increases. The cycle continues until the carrier is left with only the highest cost groups and is ultimately forced to leave the market.

The Final Report of the Texas State Planning Grant indicated that there is some support from employers for more restricted age bands. However, carriers support less restrictive rate bands as a way of reducing overall rates, according to the Texas State Planning Grant's survey of carriers. Some small employers will pay higher rates, but many employers will experience lower rates, perhaps enabling some uninsured firms to purchase coverage. There appears to be some evidence to support this. An October 2001 U.S. General Accounting Office Report, entitled "Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage" found that "overall, average premiums, adjusted for geographic differences in the cost of physician services, were about 6 percent higher in states that did not allow rates to vary for employees' health status than in those that did." At the same time, the report also found that states

that prohibited rating based on health status "did not have a higher proportion of high-risk individuals insured through small employers."

Required Benefit Plans

In the past, carriers offering insurance in the small group market had to make available two plans to employers—a basic care plan and a catastrophic plan. The intent of the legislators was to provide two options with lower costs through limited benefits.

According to a report presented to the 77th Texas Legislature in February 2001, the Texas Blue Ribbon Task Force on the Uninsured found that of the more than 86,000 small employers that purchased health plans in Texas in 1998, only 25 purchased one of the two reduced benefit standard plans. A Texas Department of Insurance survey of carriers found that employers were not interested in purchasing the plans. Also, most carriers didn't like them. The benefits were not flexible enough and they preferred to offer their own unique benefit packages. Surveys of agents indicated that companies discouraged the sale of the plans, while others did not provide quotes on them. There were also reports that agents received lower commissions on those plans as a disincentive to sell them. Following Financial Decision-Making Theory, carriers did not want to market the plans, provided disincentives to agents, and therefore, agents did not market them.

In 2003, the Texas Legislature passed Senate Bill 510, creating Consumer Choice Plans. Consumer choice plans allow insurers to offer plans that do not include certain state mandated benefits. Now, instead of the two standard benefit plans, small group carriers must offer a mandated benefit plan and a consumer choice plan. The plans give carriers more flexibility in the design of the plans, but give two options to employers. To make sure that employers are aware that the consumer choice plans are available, carriers must obtain a signed form or document from the employer acknowledging that the employer received a written disclosure about the consumer choice plan.

It is up for debate as to whether the exclusion of mandated benefits will have a significant effect on the uninsured population or whether people even want them excluded. A Milliman USA study found that the direct premium cost associated with 13 Texas mandated benefits accounted for 7.2 percent of small group premiums. It was their opinion that elimination of the 13 mandates would probably have an insignificant impact on the number of uninsureds in Texas. The number of uninsureds is as dependent, if not more dependent, on the income and/or available resources of individuals and/or employers than it is on the cost of health care. It comes back to the Financial Decision-Making Theory premise that individuals and employers will act in their own best interest.

Private Purchasing Cooperatives

Private purchasing co-ops have been around since 1993 when the Texas legislature passed the Small Employer Health Insurance Availability Act. The Act allowed two or more small businesses to join together to form health insurance purchasing cooperatives. The idea behind them is to allow small employers to band together and effectively create

a large group, spreading the financial risk between a larger number of people. The intent of cooperatives is to allow small employers to rely on the cooperative's expertise and relationships with carriers. Proponents of cooperatives argue that with a large group comes more clout in bargaining with health insurance carriers. A single small employer group changing carriers would not have much impact; however, a large group of small employers would. Proponents also argue that administrative economies of scale are another benefit of cooperatives. Finally, large groups typically have more plan choices available to them than in the private small group market. By joining a cooperative, the goal is that employees of small employers will have more coverage choices.

The Small Employer Health Insurance Availability Act also created the Texas Insurance Purchasing Alliance (TIPA), a statewide public health care purchasing alliance. At its peak, almost 13,000 people were covered through TIPA. However, according to the Texas State Planning Grant Issue Brief on Small Business Purchasing Alliances, there were several contributing factors that ultimately led to its demise, which all relate back to Financial Decision-Making Theory.

- **Lack of Agent Use** - Initially, TIPA directly marketed its plans to business and did not use agents in an effort to reduce administrative costs. When it became clear that that method was not effective, it started using agents, but limited commissions and failed to retain very many agents. Following the premise of Financial Decision-Making Theory, agents tended to place their healthier groups in the private market, where the commissions would be higher, and directed higher risk groups to TIPA. Due to the higher proportion of unhealthy members, the TIPA premiums increased significantly over time.

- **Rating Provisions** - At the outset, TIPA plans were subject to rating provisions that were more restrictive than the private market. Carriers were not allowed to adjust rates based on health status, size or type of industry of the group. This initially resulted in lower premiums through the alliance for less-healthy groups. As indicated by Financial Decision-Making Theory, TIPA attracted the less-healthy groups, which in turn resulted in significant increases for their plans over time. After the potential for an adverse selection death spiral became evident, the rating provisions were revised to match the private market.

- **Health Plan Selection** – TIPA allowed every employee to choose not only the type of plan, but their carrier too. This led to considerable anti-selection, that is, healthier employees choosing the less expensive plans, while the less-healthy employees chose the more expensive plans with richer benefits. As certain carriers ended up with a higher proportion of high-risk individuals, they acted according to Financial Decision-Making Theory and withdrew from the alliance.

Due to all of the factors above, the participants in the market acted according to Financial Decision-Making Theory. As the premiums for TIPA plans became more and more expensive, fewer employers enrolled in the alliance. The plans became unprofitable for the carriers, forcing them to withdraw. Eventually the alliance dissolved in July 1999.

There are currently four private purchasing co-ops registered with the Texas Department of Insurance. However, only two of those are active, the Texas Health Care Purchasing Alliance (THCPA) and the Liberty Coalition, Inc. THCPAs membership appears to be declining significantly. According to a Texas State Planning Grant Issue Brief on Small Business Purchasing Alliances, as of July 2001, there were 900 to 1,000 employees enrolled from sixty small businesses. In an August 16, 2003 article published in the *Dallas Morning News*, THCPA reportedly only covered 200 employees from 37 companies.

Health Group Cooperatives

The Texas State Legislature passed Senate Bill 10 in 2003, creating Health Group Cooperatives, which became effective January 1, 2004. The legislation expanded the concept of Private Purchasing Co-ops to Health Group Cooperatives (HGCs). At this writing, the Texas Department of Insurance is still in the process of adopting regulations to support SB10. This discussion is based on proposed regulations that were published on May 7, 2004.

Texas has done extensive research into the problem of the uninsured in the state. Legislators have attempted to address the pitfalls that led to TIPAs demise and are trying to avoid them in the future. HGCs work basically the same as Private Purchasing Co-ops with a few exceptions.

- **Co-op Participation Requirements** – While private purchasing co-ops are only required to have two or more small or large groups, HGCs must have at least 10 participating employers. The requirement is intended to create a larger group of participants that can more effectively spread the insurance risk.

- **Employer Commitment** – Employers that join an HGC must commit to purchase insurance through the co-op for a minimum of two years, unless they can prove that continuation will result in a financial hardship. This rule will help keep administrative costs of issuing to groups down, as well as attempt to lessen the effects of anti-selection by keeping healthier groups in the co-op for a period of time.

- **HGCs Status as Employer** – Both types of co-ops are considered single employers for the purposes of benefit elections and other administrative functions. An HGC made up of only small employers is considered a small employer for all purposes of Chapter 26 of the Texas Administrative Code, which includes rate restrictions and guaranteed issuance. An HGC that allows large employers is considered a small employer in relation to the small employer members. However, the co-op may elect to extend the protections of Chapter 26 and its rules to the large employers, except for guaranteed issuance of coverage.

- **Use of an Agent** – All coverage issued through an HGC must be through an agent. This is not a requirement of private purchasing co-ops. Obtaining a large number of groups is critical for the success of HGCs. Requiring the use of an agent will help HGCs achieve this need and provides incentives for agents to sell through cooperatives, keeping the playing field level. However, there is nothing to prevent a carrier from varying the commission levels between the markets to motivate agents to sell through a certain market.

- **Guaranteed Issuance to HGCs** – A health carrier that has indicated that it will offer small employer health benefit plans to HGCs has to provide coverage to a HGC that requests coverage in its basic geographic service area, unless it is already providing coverage to a different HGC in the county or is actively engaged in assisting an entity with the formation of an HGC. This keeps the carrier from "cherry-picking." If a carrier can refuse coverage, it can exclude higher risk groups.

- **State Mandated Benefits** – A health plan issued by a carrier through a HGC is not subject to state mandated benefits, except diabetes equipment, supplies and services. The passage of SB 541, requiring the offering of Consumer Choice plans that exclude state mandated benefits to small employer groups, was a necessary and prudent step to keep the balance between the traditional market and the HGC market.

- **Service Areas** – Carriers can only provide coverage to one HGC in any county, unless it is providing coverage in an expanded coverage area. There is no similar limitation for private purchasing co-ops.

- **Premium Tax Exemption** – Carriers providing coverage through HGCs are not subject to premium taxes for two years for previously uninsured employees or dependents. This attempts to provide an incentive to carriers to provide coverage to HGCs. It remains to be seen whether this will provide enough incentive for carriers to want to participate in the HGC market.

From the Financial Decision-Making Theory perspective, most of the advantages of HGCs for small employers and their employees translate into disadvantages for carriers. Small employers would have more bargaining clout, which is definitely a good thing for them. However, it is not in the best interest of carriers for smaller, less-healthy groups to have more leverage. Administrative savings could come from the HGCs performing the administrative tasks. However, carriers will lose control over those functions, including the accuracy and potential associated liability related to premium collection and enrollment. Like the Private Purchasing Cooperatives, employees will be able to choose the plan that suits them from the carriers offered plans. Offering employees more choices in health plans is a definite disadvantage to carriers. Choices lead to anti-selection; employees have more knowledge about their health and will choose the plans they need.

Multiple Employer Welfare Arrangements (MEWAs)

Multiple Employer Welfare Arrangements (MEWAs) allow a group of employers to collectively offer health insurance to their employees. Very often, trade, industry or professional associations set up MEWAs for their member employer groups. MEWAs can be fully insured or self-funded. Fully insured MEWAs attempt to achieve the same goal as purchasing cooperatives, which is to negotiate lower rates than what are available through other markets. State insurance departments do not specifically regulate fully insured MEWAs, although the health carriers that insure them are. The focus in this section will be on self-insured MEWAs and any reference to the term MEWA is intended to mean a self-insured MEWA.

History

There has been a long, ugly past associated with MEWAs. There have been many financially unstable and sometimes fraudulent MEWAs. Originally, MEWAs were promoted as employee benefit plans, covered by the Employee Retirement Income Security Act (ERISA), and exempt from state regulation under ERISA's preemption provisions. MEWAs were able to avoid reserve requirements, rating restrictions and other solvency standards and often priced the plans below those available through regulated insurance companies. As a result, many MEWAs were unable to pay claims and became insolvent. In other situations, there were individuals who set up MEWAs and embezzled the assets.

In 1983, ERISA was amended to provide an exception to ERISA's preemption provisions and to allow for regulation of MEWAs by state insurance laws. However, there has still been some confusion and uncertainty as to the ability of states to regulate MEWAs.

Regulatory Requirements

Self-insured MEWAs are regulated by the Texas Department of Insurance if one or more of the employer members is domiciled in the state of Texas or has its principal headquarters in the state.

Five or more businesses in the same trade or industry can band together and form a self-insured MEWA. The association or group must be non-profit, have been in existence for at least two years and exist for a purpose other than sponsoring an employee welfare benefit plan. Texas requires that MEWAs file for and obtain a Certificate of Authority from the Texas Department of Insurance.

Reserve requirements for MEWAs include holding a minimum of 20 percent of the total contributions in the preceding plan year or 20 percent of the total estimated contributions for the current plan year. The reserve must be maintained in cash or short-term federally guaranteed investments with a fixed or recoverable principal amount. Texas does not have any surplus requirements for MEWAs.

Texas also requires that MEWAs obtain both specific and aggregate stop-loss coverage with a 12-month claims incurred period and 15-month paid claims period for each policy year. The specific retention amount is to be determined annually by a required actuarial opinion. The aggregate retention amount must be no more than 125 percent of the expected claims.

There are several requirements regarding participation in coverage. Some of the more significant one are listed below:

- **Participation Criteria** – Participation criteria cannot be based on health status related factors.
- **Coverage Requirements** – A MEWA must accept or reject an entire group, based on the MEWA's underwriting standards and criteria. Only those employees who have declined coverage can be otherwise excluded.
- **Exclusion of Eligible Employee or Dependent** – A MEWA cannot exclude an eligible employee or dependent that meets its participation criteria.
- **Minimum Contribution or Participation Requirements** – A MEWA can require an employer to meet a minimum contribution or participation requirement, as long as the requirements are uniformly applied to each employer.
- **Enrollment Period** – There must be an annual open enrollment period of at least 31 days.
- **Waiting Period** – A MEWA can have a waiting period, which is a predefined period of time from the date of eligibility that an employee must wait before being able to purchase health insurance through the employer.

There are currently seven MEWAs with active Certificates of Authority issued by the Texas Department of Insurance. The arrangements represent groups ranging from independent schools to dentists to agricultural workers.

MEWAs can be advantageous for small employers and their employees because they allow them to enjoy the benefits of self-funded plans. They can offer health benefits at lower cost because they are exempt from state mandated benefits and premium taxes and they have lower solvency requirements. By self-insuring, groups can eliminate the profit margin and risk premium earned by insurers. MEWAs also allow coverage for some industries that health insurers tend to avoid, like migrant farm workers.

With respect to MEWAs, the major problem for small employers and employees is the potential for financial problems. There is no state guaranty association to protect the participants. Insolvent MEWAs end up in bankruptcy court, where creditors are usually paid off before participants and providers. Patients are the ones left with the bills when MEWAs go under.

From a Financial Decision-Making Theory perspective, MEWAs can be a good financial decision for employers that have young, healthy employees. There is more opportunity for premium savings as mentioned above. Carriers are not directly involved in the self-insured MEWA market, but MEWAs can cause some instability in the state-regulated

small employer group market. They can siphon off the healthy groups, leaving higher risk groups to be covered by the carriers.

Association Health Plans (AHPs)

Group association health plans, including MEWAs, have been around for decades. For the third time, the U.S. House of Representatives has adopted a proposal (H.R. 660) called the Small Business Health Fairness Act of 2003 that would exempt Association Health Plans (AHPs) from state insurance regulations. The main goal of the legislation is to allow the small-group market to function more like the large group market. The proponents of the current proposed legislation argue that AHPs will allow small employers to enjoy all of the advantages of the large employer market.

- AHPs by definition are pooled purchasing arrangements, which will allow purchasing power through fully insured AHPs.
- Coverage offered through AHPs will be preempted from state mandated benefit laws.
- AHPs can offer self-insured plans, subject to reduced solvency standards.
- AHPs will be allowed to experience rate each association group and will not be subject to small-group rating restrictions imposed by states.

The legislation also attempts to improve the current situation and problems with MEWAs. MEWAs will fall under the AHP legislation and will generally become AHPs. However, there will be some grandfathering provision for certain existing MEWAs. They will be required to register with the Department of Labor (DOL) and be subject to federal solvency standards established and administered by the DOL.

The Legislation

Eligibility Requirements - AHPs will be certified by the Department of Labor and must have been in existence for at least three years for purposes other than providing health insurance. A self-insured AHP must have at least 1,000 participants and meet one of the following criteria:

- Offer coverage on the date of enactment
- Represent a broad cross-section of trades, or
- Represent one or more trades with average or above average health insurance risk.

Participation and Coverage - To participate in the health plan, employers must be members or affiliated members of the sponsor. Individuals under the plan must be active or retired employees, owners, officers, directors, partners, or their beneficiaries.

Every employer that is a member of the association must be eligible for the plan. All geographically available coverage options must be made available upon request to eligible employers. Individuals cannot be excluded from enrollment due to health status.

Premium rates for a particular small employer cannot be based on health status or claims experience of participants or by industry.

AHPs are subject to the Health Insurance Portability and Accountability Act (HIPAA), including guaranteed issue requirements.

Health insurance must be distributed to small employers through state-licensed agents. Agents must also be used to distribute self-insured benefit plans to the employer groups if the AHP provides health insurance coverage.

Reserve Requirements and Solvency Provisions - Self-insured AHPs must maintain reserves that are sufficient for unearned contributions, benefit liabilities, expected administrative costs, and any other obligations. An actuary must certify to the appropriate reserves.

AHPs will be required to obtain aggregate and specific stop-loss insurance, as well as indemnification insurance for any claims if the plan is terminated. Annual payments to an Association Health Plan Fund will be required to insure that indemnification insurance is always available. Surplus reserves between $500,000 and $2,000,000 must be maintained, depending on the level of stop-loss coverage.

An AHP can terminate only after providing 60 days advance written notice to participants and beneficiaries and submitting a plan for timely payment of all benefit obligations.

ERISA Preemption - AHPs are exempt from state insurance regulation through preemption from ERISA, except federal or state laws that require coverage of specific diseases, maternal and newborn hospitalization, and mental health. Self-insured MEWAs, providing medical coverage, that do not elect to meet the certification requirements for AHPs may be regulated by states.

Enforcement - The Secretary of Labor is required to consult with states regarding AHPs domiciled in their state. The bill provides criminal penalties for willful misrepresentation as an exempt AHP or collectively bargained status, authorizes the DOL to issue cease activity orders against fraudulent health plans, and establishes responsibility of the board of trustees for meeting required claim procedures. The Secretary of Labor must report to Congress on the impact of AHPs on reducing the number of uninsured individuals.

Impact on Participants

On the surface, AHPs and their promise of lower prices are attractive to employers and employees. However, there may be unintended consequences from the proposed legislation that will result in further problems for higher risk groups.

Economies of Scale – Economies of scale are supposed to materialize through larger pools that result in purchasing power and administrative savings. In order to realize either of these goals, the AHPs need substantial enrollment. However, it is still debatable

whether or not AHPs can achieve administrative savings. As Mark Pauly, PhD at the Wharton School of Business said, "You can't construct a giant by having lots of midgets stand on each others' shoulders." The administrative services that the insurer does not have to perform will have to be performed by someone, namely the AHP. The costs are paid through dues and fees, which may result in higher premiums than large employers pay for the same coverage.

Exemption from State Mandated Benefits – The legislation would allow AHPs to exclude state mandated benefits. Due to the legislation recently passed in Texas, this will not have the same effect of destabilizing the market that it will in other states. However, as was noted above, it is still unclear whether eliminating state mandated benefits will realize the cost savings that have been projected.

Preemption from State Regulation – AHPs would not be required to follow the laws and regulations of every state in which they do business. Jurisdiction would be consolidated into the DOL and/or the domicile state. For fully insured plans, the domicile state would be the state in which the policy was initially filed and approved. For self-insured plans, the Secretary of Labor will decide on the state of domicile based on the state of residence of the participants and beneficiaries. While the reasoning behind this is to eliminate duplicative jurisdiction, insurers will be able to forum shop for the state with the most lenient laws. In addition, the costs of state regulation would not be completely eliminated. Except for existing associations, states will be able to impose premium taxes on AHPs. Associations will still be subject to solvency standards, even if lower than what is required of insurers. These solvency standards are critical due to the past and continuing problems with MEWAs, but will not allow the cost savings that large self-insured employers enjoy.

Risk Segmentation – AHPs will only be subject to the domicile state's rating rules. In addition, the insurer can segment each AHP into a separate pool. Effectively, insurers will be allowed to base the rates on the claims experience of each AHP. This is a good thing for the healthy, lower risk AHPs. They will be able to purchase health benefits at a lower cost through AHPs. The problem lies with the state-regulated small employer market and the older, higher risk individuals. The operation of AHPs in conjunction with traditional market will result in an uneven playing field. Because AHPs will be able to base rates on the claims experience of the AHP, the higher risk groups will stay in the state-regulated market where rates are restricted. Over time, this will increase costs in the state-regulated market and limit the affordable options for high-risk groups.

Instability of Association Market – Another problem is that the association market is inherently unstable. If premiums increase, there is no incentive for healthy groups to stay in the association. They can shop around for a less expensive option.

Market Churning – There is also the potential for market "churning." Market churning is the practice insurers use to take advantage of the "durational effect" by continually starting new associations and closing old ones. The durational effect is a phenomenon where newer participants tend to be better risks than older participants. The small group

market reforms of the 1990s eliminated this practice by prohibiting insurers from re-entering the market for a period of time if they refuse to renew existing participants. However, the AHP legislation will not prevent this from happening.

There are two ways to look at the impact of AHPs on insurers from the Financial Decision-Making Theory perspective. From the fully insured AHP side, insurers may be more attracted to AHPs because they may benefit from them. The reasoning is as follows:

- AHPs are expected to attract lower risks. Because they will be able to segment risks, they will be able to attract better risks and lower their prices, at the expense of older, less healthy risks.
- AHPs are not structured to solely represent employers and employees, like they are for purchasing cooperatives. Insurers are not allowed to be on the board of an AHP; however, they can establish them and contract to administer them.
- AHPs are not required to offer the products of more than one insurer. Therefore, once an insurer is chosen as the insurer for an AHP, it won't face as much competition within the AHP. This will allow it to have the entire pool of risks within the AHP and will decrease the likelihood of ending up with all the higher risk individuals.

On the other hand, self-insured AHPs may negatively impact insurers. Because AHPs are expected to attract lower risk groups, the state-regulated small group market will be left with the higher risk groups. This will result in an uneven playing field between the two markets.

Conclusion

Financial Decision-Making Theory impacts the behavior of each of the participants in the small group health insurance market.

The traditional state-regulated small group market has tried several different variations to try to balance the needs of each of the participants in the market (e.g., rating restrictions and standard benefit plans). Evidenced by the continuing changes in legislation, that balance has not yet been achieved. It will be interesting to see if employers will purchase the new Consumer Choice plans, or if they will just fall by the wayside like the two standard benefit plans previously required.

As history has shown, each participant in the market will make decisions based on their own needs. The failure of the Texas Insurance Purchasing Alliance was a prime example of Financial Decision-Making Theory at work.

Only time will tell whether Health Group Cooperatives will take hold or if they will follow the road of the private purchasing cooperatives and never materialize. However, the legislation appears to have addressed some of the unbalance that existed between the Texas Insurance Purchasing Alliance/Private Purchasing Cooperatives and the traditional state-regulated small group market.

The proposed Association Health Plan legislation is a very political issue. It remains to be seen whether the legislation will ever be passed. However, in its current state, passage may very well result in consequences that are not intended by its proponents.

Until the needs of all the participants can be met, there will continue to be more potential solutions proposed. When looking at any option, consideration must be given to the interaction between all of the existing options. While a new idea may seem to meet its intended goals, when looking at the market as a whole, it may have serious, unintended effects. Financial Decision-Making Theory can provide a valuable perspective when considering a possible solution to the problems within the small employer health insurance market.

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