POLICY INSIGHT

A Policy Newsletter on Life and Health Insurance and Financial Security Issues

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Insurers' Ability to Provide Capital to State and Local Governments Could Decline

Life and health insurance companies are a major source of capital for state and local governments in Texas, investing billions in Texas municipal bonds and public projects such as hospital and airport construction, housing, utilities, and water projects. Unfortunately, a sluggish economy and the prospect of additional taxes could jeopardize the industry's ability to continue to serve as a key source of capital for state and local governments.

Because life and health insurance companies are taxed differently than general corporations in Texas, they currently pay significantly higher taxes in Texas than they would if taxed as general corporations. Insurance companies are required to pay a gross receipts tax known as premium tax rather than the state's franchise tax. In fiscal year 2009, insurance companies paid more than $1.4 billion in premium taxes, nearly three times more than what they would have paid if subject to the lower franchise tax.

The premium tax is based on gross premiums received on risk assumed by a company in the state and is equivalent to a gross receipts tax. By contrast, other financial institutions and general corporations are subject to a corporate franchise tax based on net taxable capital or net taxable earned surplus (net income) apportioned to Texas. A study by Ernst & Young in 2005 found that because the premium tax applies to a tax base much larger than the base of the franchise tax, the premium tax, combined with other state and local taxes, imposes a significantly higher tax on life and health insurers than the tax they would pay if they were taxed as general corporations. In fact, that study found that the life and health insurance industry pays excess taxes compared to other industries and that the excess taxation in Texas was higher than estimated amounts in any other state.

New or higher taxes also put the industry at a competitive disadvantage. Increased taxes must be reflected in premium rates. As rates increase, the amounts companies must pay in premium taxes also rises, thus increasing insurers' overall tax burdens disproportionately. Higher taxes in Texas also puts Texas insurance companies at a competitive disadvantage in other states as the other states retaliate and also impose additional taxes.

As the Ernst & Young study notes, policymakers need to better understand the disparity in the taxation of life and health insurers and other corporations. High taxation adversely affects the industry's contribution to economic development in Texas and to the financial security of the state's citizens.

State and Local Taxes and Assessments for Life and Health Insurers

Taxes and Assessments	Explanation of Taxes
Premium Taxes	Taxes imposed on gross premiums collected and paid by all insurers
Retaliatory Taxes	Taxes paid by foreign insurers to Texas based on tax burden in their state of domicile compared to Texas
Sales Taxes	Taxes paid by insurers on capital equipment and on operating inputs including services typically purchased by insurers such as claims adjusting and actuarial services
Property Taxes	Taxes paid by domestic insurers on real property and business tangible personal property
Maintenance Taxes	Taxes assessed to fund the operations of the Texas Department of Insurance
Examination Fees/Overhead Assessments	Assessments paid by insurers to cover financial reviews and other state examinations
Health Insurance Risk Pool Assessments	Assessments levied against health insurers to pay for deficits in the state's Health Insurance Risk Pool
Unemployment Taxes	Taxes paid by insurers to fund the state's unemployment claims
Administrative Services Taxes	Taxes paid by insurers providing services under an administrative contract
TDI and OPIC Fees	Fees assessed against insurance companies for various functions performed by TDI
Guaranty Association Assessments	Assessments levied against insurers to provide funds for claims against insurers that become insolvent

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TALHI
Texas Association of Life & Health Insurers

Will Federal Reforms Destabilize Small Group and Individual Health Insurance Markets?

Uncertainty continues to grow regarding the early effect federal health reforms will have on the availability of insurance coverage in the individual and small group markets. Industry experts have projected that up to one-fourth of the people who obtain their insurance from the individual market could lose their coverage if the smaller insurance companies that cater to that market end up terminating individual product lines as a result of the reforms.[1]

Already, two insurers, American National Insurance Company based in Galveston and National Health Insurance Company located in Dallas, have indicated they are exiting the individual market due to the reforms. Both companies had offered health coverage in Texas.

In announcing their intent to discontinue the sale of individual policies by its subsidiaries, American National Insurance Company stated that its decision was "…based on the knowledge that the companies' individual medical expense plans will not meet the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 recently enacted by the United States Federal Government."

While it is anticipated that most large carriers will be able to meet the reform requirements, smaller carriers that lack the larger economies of scale may not be able to do so.

At the center of the speculation is the reform requirement that insurers spend a certain percentage of the premiums they collect on clinical services or activities that improve health care quality. The combination of these expenses divided by total premiums collected is referred to as an insurer's medical loss ratio or MLR. Under the reforms, beginning September 23, 2010, insurers are required to submit to regulators reports on their MLR for specific insurance lines.

MLR guidelines contained in the reforms dictate that 80 percent of health premiums in the individual and small group markets and 85 percent in the large group market must be spent on medically related services and programs. Expenses not deemed to be medically related would be considered administrative. If a health plan's administrative expenses exceed the 15-20 percent threshold outlined in the legislation, the plan would be forced to provide rebates to its customers equal to the amount it exceeds the MLR limits. Providing such rebates could result in the plan operating at a loss for the year and contribute to possible solvency issues for the company. The requirement providing for rebates becomes effective January 1, 2011.

To avoid this scenario, health plans will likely be forced to eliminate the expenses of popular value-added programs that benefit patients and improve the quality of health care delivered. Some may choose to withdraw entirely from a particular market if they are unable to meet the legislation's stringent MLR guidelines.

Discontinuation of certain lines of coverage as a result of unobtainable MLR levels could be of particular concern for those who obtain their coverage from smaller insurers. Disruption in the market resulting from a company's decision to end a particular product line could present challenges for consumers, especially those with pre-existing conditions and those unable to afford a more expensive plan that includes the federally mandated benefits.

Many smaller insurance carriers serve niche markets in small cities and rural areas where businesses and individuals want more choices than are offered by major carriers. If smaller insurers are forced to exit these markets, some fear the void might not be entirely filled.

Because the smaller carriers lack the economies of scale of larger carriers, their administrative expenses are often higher, jeopardizing their ability to meet the new MLR standards.

As a result of serving smaller and specific markets, many small insurers do not own their healthcare provider network and instead may contract with as many as 50 networks to ensure their customers have adequate access to healthcare services at affordable prices. The increased management costs and service cost variability of multiple networks contribute to the higher administrative costs of smaller insurance carriers.

Additionally, smaller carriers' administrative costs increase as a result of their use of local agents and brokers, whom their customers rely on to provide a level of consultative guidance and service that would not be available through a Web site.

The high level of flexibility and choice that smaller insurers are able to

offer also allows small businesses to better structure their health plans to meet their specific employee populations. Some insurers are able to offer indemnity plans with no out-of-network charges to ensure residents in rural areas have timely access to primary and specialty care without being forced to pay higher fees.

Because they typically manage a smaller blocks of business, a reduced member population creates difficulty for smaller carriers in providing statistically meaningful judgments on past and future loss experience. Less predictability presents challenges in pricing and can result in broader swings in the medical loss ratio from year to year. If insurers with smaller blocks of business are forced to provide rebates in years of low claims and absorb losses in years of high claims, industry observers predict they will quickly become insolvent or be forced to exit the market.

The reforms provide the Health and Human Services Secretary the authority to adjust the minimum MLR rate within a specific state if it is determined that the new requirement may destabilize its individual market. The State of Maine has already requested a waiver from the 80 percent MLR requirement for the individual market until 2014. In submitting its request, the state pointed out that it has had a 65 percent MLR limit in place since 1993 and that one of the major carriers in its individual market would likely be forced to discontinue sales if the MLR were increased.

The legislation tasked the National Association of Insurance Commissioners (NAIC) with the job of specifying what expenses may be used in determining a company's MLR. The NAIC decision will likely be the deciding factor for the continuation of many smaller carriers within the small group and individual markets. Final rules on qualifying expenses are expected shortly.

While the new MLR requirements are of growing concern to many carriers within the small group and individual markets, it is not the only reason for pause. According to industry experts, restrictions on rating and underwriting, expanded access to Medicaid, Health Insurance Exchanges that provide a new means of marketing, and the emergence and expansion of other types of plans (CO-OPs, multi-state plans, or association health plans) could all affect a carrier's decision to continue offering a particular product line.[2]

As health reform implementation moves forward, smaller insurers that specialize in serving small cities and rural areas face mounting uncertainty regarding their futures and will continue to look to federal and state governments for relief from restrictions that may eliminate their ability to offer coverage.

Catherine Bresler of Trustmark Insurance Company contributed to this article.

1 Issue Brief, "Recognizing Destabilization in the Individual Health Insurance Market," Robert Wood Johnson Foundation, July 2010

2 Ibid

Texas Insurance Insight

Life insurance companies invest approximately $260 billion in stocks and bonds that help finance business development, job creation, and services in the state.

Source: ACLI

Insurers Caught in Middle of Fed's Massive Overhaul of Financial Industry

Life insurers weren't the targets of the federal government's Wall Street reforms, but the insurance industry did find itself working vigorously to explain how it operates and differs from banks and investment firms. The industry's actions were necessary to highlight how a bank-centered approach to regulation does not always synchronize with a state-based insurance regulatory structure and how the industry differs in addressing consumer needs.

While the industry believes the reforms will not unduly interfere with the state's regulatory role, the industry, or consumers, the legislation does leave several important life insurance industry issues to be resolved through the formal rulemaking process. Until that process has been concluded, the complete picture of the reform's impact upon insurers will not be known.

One such measure with unintended consequences involved an expansion of what is known as the Volcker Rule. The rule was originally adopted to prohibit federally insured depository institutions from engaging in excessively risky investment activities to make a profit for themselves. A proposed expansion of the Volcker Rule was considered that would apply it to all subsidiaries and affiliates within a holding company that includes a depository institution. Since a number of insurance holding companies include depository institutions, such an application of the rule would have prevented certain insurers from making

Insurers Caught in Middle *(continued from previous page)*

investments that are ordinary and essential to ensuring that funds exist to pay benefits when they come due.

To protect consumers, state insurance investment laws severely restrict and limit insurance companies from making investments that jeopardize the solvency of the company. The industry was pleased that the final reforms did not subject life insurers to the proprietary trading prohibitions as long as trades originate from general accounts or are done on behalf of customers.

To protect consumers from possible insolvencies, life insurance companies are required under state laws to participate in guaranty associations in every jurisdiction where they are licensed to do business. Should an insurer become insolvent, guaranty associations have the authority to impose assessments against other licensed insurers and to use the proceeds to pay customer claims against the failing company. Although the new federal law may subject life insurers to assessments in the event of a financial company's failure, the law makes clear that insurance company insolvencies will continue to be resolved under state law. While the new law does allow the Federal Deposit Insurance Company the authority to step in to wind down a systematically important insurance company if the insurance commissioner where the company is domiciled fails to take appropriate steps, life insurers believe such a scenario is highly unlikely.

In an attempt to ensure financial institutions have adequate amounts of liquid assets and cash to withstand a financial crisis, the reforms impose new minimum risk-based requirements on banks, bank holding companies, and other nonbank financial firms. The new standards are intended to address a bank's growth and engagement in risky investments. The measure, known as the Collins Amendment, could apply to life insurance companies even though they were not the target of the amendment and calculate risk-based capital much differently than banks. Insurance industry officials point to the Collins Amendment as an example of how the bank-centered approach to the reforms can be misapplied to life insurers, which face their own rigorous state regulations on investment risk.

It's the lack of industry insight that led insurers to strongly support the creation of the Federal Insurance Office (FIO) proposed by the legislation. The FIO will exist within the Department of the Treasury and will be the first ever federal office to develop expertise on insurance issues with the intent of advising Congress and the administration on insurance-related issues. The office will also play a prominent role in helping negotiate international regulatory equivalency agreements.

Some of the information contained in this article was obtained from the ACLI.

Texas Insurance Insight

$20 billion was paid to Texas residents in the form of death benefits, matured endowments, policy dividends, surrender values, and other payments in 2008.

Source: ACLI

ABOUT TALHI: Texas Association of Life and Health Insurers

TALHI is the trade association for life and health insurers doing business in Texas. It was formed when Texas Life Insurance Association and the Texas Legal Reserve Officials Association merged in 1997.

Now representing the majority of insurers doing business in the state, TALHI has emerged as a leading voice for life and health insurers on legislative and regulatory matters.

TALHI is an open-door trade association boasting some of the most progressive life and health insurance company officials throughout the country. We are united for the mutual benefit and development of a healthy and competitive insurance market.

The work that TALHI does in the public policy arena is intended to strengthen the insurance market by enhancing insurers' ability to provide Texans financial security for their future.

We welcome the opportunity to work with you.

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