HOUSE RESEARCH ORGANIZATION bill analysis 4/10/97

HB 710
Averitt, et al.
(CSHB 710 by Averitt)

SUBJECT: Regulating the health insurance risk pool and other health benefits

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Van de Putte, Averitt, Bonnen, Burnam, Eiland, G. Lewis, Olivo, Wise

0 nays

0 absent

WITNESSES: For — Jon R. Comola, Blue Cross/Blue Shield of Texas; Will D. Davis, Texas Life Insurance Association/Texas Legal Reserve Officials Association; Michael B. Herman, Health Insurance Association of America; Gary Joiner, Texas Farm Bureau; Joy Ryan, John Alden Life Insurance; Janet Stokes, Texas Association of Health Underwriters; Kenneth Tooley, Texas Association of Life Underwriters

Against — None

On — Lisa McGiffert, Consumers Union

BACKGROUND: The Texas Health Insurance Risk Pool was established in 1989 by the 71st Legislature in Insurance Code sec. 3.77 to provide access to health insurance coverage for medically uninsurable Texans. However, the pool has never operated due to lack of funding.

DIGEST: CSHB 710 would amend the Texas Health Insurance Risk Pool law to revise pool funding, eligibility, and benefit coverages and make other changes to the offering of group and individual health insurance and HMO benefits in Texas. It would also update current statute by changing all references from the now-defunct insurance board to the Texas Department of Insurance commissioner.

The bill would take effect July 1, 1997, and pool coverages would have to be made available by January 1, 1998. Insurance issued or renewed before July 1, 1997, would be governed by existing law.

High Risk Pool authority

The pool would be given the authority to provide group insurance coverage along with its current authority to write health insurance that any other insurance company would be authorized to write.

It also could take necessary legal actions to recover or collect assessments or other amounts due the pool and amounts erroneously paid by the pool; contract for stop-loss insurance; recover or collect interim assessments; borrow money; issue additional health insurance policies to provide optional coverages; provide and employ cost containment measures to make benefit plans more cost effective; and utilize or contract with preferred provider organizations and HMOs.

High Risk Pool coverage

Eligibility. Texas residents would have to be U.S. citizens to be eligible for coverage. They would have to provide evidence showing:

- two health insurers had rejected or refused to issue health insurance to the applicant;
- the individual was only offered insurance with conditional riders or at rates exceeding the pool rate;
- the individual had maintained health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days; or
- the individual had a diagnosis that met the conditions for eligibility without first applying for health insurance.

The board would be required to promulgate a list of medical or health conditions for which a person would be eligible for pool coverage without applying for health insurance.

Dependents or resident family members of eligible pool applicants would also be eligible for pool coverage. People eligible for Medicare benefits would not be excluded from pool coverage. Individuals could maintain pool

coverage during the time they were satisfying a waiting period under another health insurance policy that would replace the pool policy.

Coverage would end when the person requested coverage to end, when a covered person died, when state law canceled the policy, on the 31st day after the day on which an unpaid premium was due, when a person no longer met eligibility requirements or, at the option of the pool, 30 days after the pool sent an inquiry concerning the person's eligibility. Coverage also would end when the person was no longer a Texas resident, except for children under the age of 23 who were financially dependent upon their parents.

Benefit provisions. The board would establish, with the approval of the commissioner, pool coverages, benefit schedules, coverage exclusions, and other limitations. The pool would be required to offer coverage consistent with major medical expense coverage to each eligible person who was not eligible for Medicare. CSHB 710 would remove from law specified benefit provisions.

The benefit provisions of the pool's health benefits coverages would be required to include all applicable definitions, a list of exclusion or limitations, a description of covered services and deductibles, coinsurance options, and copayment options.

Pre-existing conditions. Pool coverage would exclude expenses incurred during the first 12, instead of six, months following the effective date of coverage for conditions for which medical advice, care or treatment was recommended or received during the six-month period preceding coverage. Provisions would be removed that excluded expenses for conditions that would cause "an ordinarily prudent person" *to seek* diagnosis, care or treatment.

Pre-existing condition provisions would not apply to individuals who were continuously covered for 12 months by health insurance that was in effect up to 63 days before the effective date of pool coverage. When determining the length of time a pre-existing condition provision would apply, the pool would have to credit any time an individual was covered under health insurance during the previous 12 months.

Premium rates. CSHB 710 would remove provisions requiring the determination of the risk rate to be based on the five largest insurers. Instead, the risk rate would be determined by considering premium rates charged by other insurers offering health insurance coverage and would be established using reasonable actuarial techniques reflecting anticipated experiences and expenses.

Initial pool rates could not be less than 125 percent nor greater than 150 percent of individual standard rates. Subsequent rates would be prohibited from exceeding 200 percent.

High Risk Pool assessments

The board would be authorized to make advance interim assessments, in addition to end-of-the-year assessments, on insurers and HMOs to cover pool organizational and operating costs. An insurer or HMO could petition the commissioner for an abatement or deferment of all or part of an assessment. Provisions would be removed from law that require the state to collect assessments in an amount sufficient to fund the pool's shortage and to reimburse insurers for assessment payments.

Interim assessments would be credited against any regular assessment due at the close of the fiscal year. If assessments exceeded actual losses and expenses, the excess would be held in an interest-bearing account and used by the board to offset future losses or to reduce future assessments.

At the end of the fiscal year, the board would be required to report to the commissioner any net loss for the previous calendar year, and the net loss would be recouped by assessments on insurers and HMOs. The assessment would be determined annually by the board and would be equal to the ratio of gross health insurance premiums collected by the insurer or HMO for health benefits in Texas during the preceding calendar year, not including Medicare supplement premiums and small group health insurance premiums.

High Risk Pool Board

Provisions requiring that the nine-member board be filled with a specific number of individuals representing specific interests would be amended to allow the commissioner of insurance to appoint at least two but not more than four people affiliated with an insurer and at least two people who were insureds or parents of insureds. The other board members could include any number of doctors, hospital administrators, advanced nurse practitioners, or representatives of the general public.

A board member would not be liable for an action or omission performed in good faith, and a cause of action would not arise for such action or omission.

The commissioner of insurance, instead of the board, would be authorized to establish additional board powers and duties and other rules and would be required to provide the procedures, criteria and forms necessary to implement, collect and deposit interim assessments.

The plan of operation required under current law would be amended to also include within the plan procedures for operating the pool, selecting an administrator, creating an administrative fund, auditing funds and assets of the pool, fostering public awareness, creating a grievance committee to review complaints from pool applicants and insureds, and other matters deemed necessary.

CSHB 710 would add financial condition and stability as considerations by the board in its selection of an insurer or third party administrator to administer the pool. The board would be required to make an annual report of pool activities to the governor, lieutenant governor, the speaker and the commissioner of insurance by June 1.

The pool would be subject to an annual special audit by the State Auditor’s Office, and the SAO would have to report the cost of each audit to the board and to the comptroller. The board would have to remit that amount to the comptroller for deposit into the general revenue fund.

Other health benefit amendments

Group coverage. A conversion privilege would no longer be required on group health insurance policies, but continuation privileges would still be required. HMOs would be required to issue continuation coverage and could offer conversion privileges. Continuation coverage would have to be provided for a period of at least six months and could be terminated for failure to make premium payments or if the covered person was eligible for, or covered by, other similar benefits.

The commissioner would prescribe the format for an insurer or HMO to use when giving notice of the right of continuation to an employee, member or dependent. An individual would have to request continuation within 31 days following the date the group coverage would terminate or the date the individual was notified of the continuation benefit, whichever was later.

An enrollee selecting continuation in an HMO contract would be required to pay in advance on a monthly basis to the contract holder or employer the contribution amount plus two percent of the group rate.

The insurer or HMO would be required to notify people covered under a continuation policy that they could be eligible for coverage under the Texas Health Insurance Risk Pool.

Premium rates for conversion coverage could not exceed 200 percent of the group plan or group insurance rate. HMO and insurance conversion policies would have to be issued without evidence of insurability if a written application and premium payment were made not less than the 31st date of termination group policy. Conversion benefits would be subject to minimum standards promulgated by the commissioner.

Individual insurance. HMOs would be authorized to provide individual health plans for which an enrollee paid a premium. An HMO could limit its enrollees to those who lived or worked in its service area.

For individual health insurance policies, pre-existing condition provisions would not apply to individuals who were continuously covered under "creditable coverage" for an 18-month period, up to 63 days before the

effective date of individual coverage. In determining whether a preexisting condition provision applied to an individual, the insurer would have to credit time the individual was previously covered under creditable coverage at any time during the preceding 18 months.

Creditable coverage could include coverage under an HMO plan, self-insured employer health benefit coverage, a state high risk pool, and other public or federal health benefit plans such as Medicare and Medicaid.

Guaranteed renewability. Individual health insurance policies and individual HMO plans would have guaranteed renewability at the option of the individual. The policy could be discontinued or nonrenewed only if the individual failed to pay premiums, committed fraud or misrepresentation or no longer resided in an area in which the insurer or HMO was authorized to provide coverage.

The policy could also be discontinued or nonrenewed if the insurance company or HMO ceased to offer coverage in the individual market or in accordance with federal law and regulations. The commissioner would adopt rules to implement guaranteed renewability provisions and to meet the minimum requirements of federal law and regulations.

SUPPORTERS SAY:

CSHB 710 would conform Texas law to new federal health benefit requirements and provide new opportunities for health benefit coverage for many of the 4.6 million individuals who are uninsured. Aside from reasonable and minor start-up expenses, the pool would not cost the state money and would actually result in a net gain to general revenue in fiscal 1999 of $120,000 due to reimbursements to the state for the costs of state audits.

CSHB 710 also would maintain state control over individual health benefit coverage regulation by making the high risk pool financially viable and operational in a way that meets federal requirements. State regulation of certain health benefit plans will be preempted by a new federal law if the state does not enact federal reforms. The high risk pool also is the choice of Gov. Bush to meet federal requirements, as stated in his recent letter to the federal Health Care Financing Administration.

In 1996 Congress enacted the Health Insurance Portability and Accountability Act (P.L. 104-191), also known as the Kassebaum/Kennedy law, which created federal standards for insurers, health maintenance organizations (HMOs) and employer plans, among other health insurance provisions. Texas insurers and HMOs will be required to issue individual health coverage to all applicants and adopt other federal requirements unless the state enacts an acceptable alternative to protect individual coverage, such as a high risk pool, by July 1, 1997.

The high risk pool also would benefit a sizeable portion of the uninsured in Texas. At least 13,000 Texans are able to afford insurance but are denied coverage by insurers who deem them "uninsurable" due to medical conditions. Many others are uninsured because the price of coverage is too high. The primary purpose of state high risk pools is to help unhealthy individuals obtain suitable coverage, and this bill would do that by going beyond eligibility criteria that would meet only minimum Kassebaum/ Kennedy standards.

CSHB 710 would help reduce charity and other uncompensated care expenses paid by taxpayers who support public hospitals and public health care programs. The bill also would help defray charity care costs that are passed on to insured individuals through higher medical and health care facility charges. CSHB 710 is not intended to resolve the all the problems associated with uninsured Texans, but it would help solve a portion of the problem.

By capping high risk pool premium rates at 150 to 200 percent of standard market rates, CSHB 710 would set an affordable ceiling on premium prices yet adequately compensate the pool for many of the high-cost medical expenses associated with high risk individuals. Initial premium rates could be as low as 125 percent of standard rates. CSHB 710 also would authorize the pool to offer group coverage, creating additional options for the arrangement of affordable plans.

Access to coverage through the high risk pool would be improved by changes in the eligibility requirements that would allow coverage for individuals who were only offered partial insurance, who had a specific medical condition, or who had health insurance coverage for the previous 18

months with less than a 63-day gap in coverage, in addition to individuals who were refused insurance or were offered insurance at prices above pool rates.

CSHB 710 also would improve access to health care coverage by removing provisions disqualifying individuals eligible for Medicare and allowing disabled Medicare recipients an opportunity to purchase comprehensive supplement coverage through the pool. Credit and waivers for preexisting condition limitations would be offered that are consistent with Texas small business insurance requirements and would help high risk individuals obtain and pay for the medical services they need.

Pool costs would be contained by premium payments, raising the preexisting condition exclusions from six to 12 months and the additional eligibility of healthy individuals, such as healthy family members of an unhealthy individual, or persons who have been virtually continuously covered by another plan. Over half of the high risk pool costs are expected to be covered by premium payments, and assessments would only be needed to cover about 40 to 50 percent of the costs. Requiring subsidies and other methods to expand access to low income families would be too financially risky during the pool's initial development. The pool should focus first on containing costs and ensuring its viability.

CSHB 710 also would prevent the costs of the high risk pool from being a liability on state general revenues by removing the "sleight of hand" provision that required the pool to reimburse insurers and HMOs for assessment payments.

Requiring insurers and HMOs to contribute to the cost of the pool through assessments would be a better alternative than the federal guaranteed issue requirement that insurers issue individual policies to all applicants. The assessment would be spread among health benefit providers fairly and not be limited to the regulated insurers and HMOs because most self-insured employer health benefit plans, which are preempted from state regulation, would be contributing through the assessments imposed on their regulated reinsurers.

Doctors, hospitals and other health care providers would not be assessed

because most of them are already providing some form of charity or uncompensated care. Excluding Medicare supplement premiums and small employer premiums from the calculation of assessments would be fair because those types of policies are already subject to guaranteed issue requirements and an assessment would create an inequitable additional cost.

CSHB 710 would help healthy, insurable individuals obtain coverage from providers other than the risk pool, due to preexisting condition amendments on individual health insurance requirements and by authorizing HMOs to offer individual plans. The preexisting condition provisions would be patterned after the federal law to provide consistency with high risk pool eligibility requirements. No preexisting condition requirements were provided for HMOs since HMO plans usually do not contain preexisting condition exclusions.

CSHB 710 would continue to support private market pricing of all health insurance benefits by not establishing premium rates or rate ceilings for group or individual plans. Due to the complex and variable nature of individual health conditions, health benefit providers are in the best position to determine premium prices that will cover risk yet be competitive. The Department of Insurance has never been authorized to regulate health insurance rates, and that authority is not needed now.

The start up costs are estimated to amount to about $500,000, and if "wish list" provisions in the state budget proposals are appropriated by the HB 1 conference committee, the costs would be paid out of a dedicated general revenue account restricted to funding only insurance operations. Unrestricted general revenue that could fund other state priorities would not be used.

Public members would be adequately and appropriately represented on the board. CSHB 710 would require at least two public members and the commissioner would be granted the flexibility to add more. Requiring a specific number of public or private interest members would unnecessarily restrict the commissioner's ability to find and select interested and appropriate parties to govern pool start-up operations and critical decision making.

OPPONENTS SAY:

The high risk pool would ultimately raise premium prices for all insureds and enrollees in state-regulated health benefit plans due to the pool's assessments. It also would require some initial state funding; a provision in the "wish lists" of the state budget proposals would include about $500,000 to cover start-up costs.

If assessments are necessary, the pool could also assess employers who provide self-insured health benefit plans so that the burden of paying for pool expenses could be minimized on state regulated health benefit plans and covered individuals. Most covered Texans are enrolled or insured in unregulated self-insured plans and would be exempt from assisting the funding of the pool. The pool also should spread the burden of health care costs by assessing doctors, hospitals and other health care providers.

CSHB 710 goes too far when trying to meet federal requirements by expanding eligibility criteria to include individuals other than those who have lost employer-based group coverage. The Kassebaum/Kennedy law was primarily intended to help covered individuals who lost their coverage due to job transitions, not solve all of the problems of the uninsured and uninsurable. Expanding pool eligibility would expand the risks and the costs of the pool.

High risk pools lump all individuals into one pool instead of equitably spreading the risk among all health benefit plans and because of their high rates provide no assistance to families or individuals with low or moderate incomes. Requiring all health benefit providers to accept all applicants would be a better and fairer way of spreading health care costs and risks across all Texans.

OTHER OPPONENTS SAY:

CSHB 710 would not go far enough in improving access to coverage for individuals and their families because it would not improve the affordability of individual insurance or HMO policies. Authorizing the issuance of individual HMO plan coverage and improving preexisting condition limitations on individual health insurance policies would not ensure access to care because the bill would not cap or establish an affordable range of

premium rates for these plans. Even if more individual plans are made available, individuals would most likely be unable to afford them.

Premium rates for the high risk pool should be capped at 150 percent of standard market rates and not be allowed to rise to 200 percent in subsequent years. Most people have trouble affording insurance at standard insurance market rates, let alone rates that are double the price. If rates rose to 200 percent, most people would be priced out of coverage.

Additionally, the board should be authorized to create a system of premium subsidies for low-to-moderate income families who earn too much for Medicaid but cannot afford the pool's premium rates.

CSHB 710 would not guarantee access for many of the uninsured who have never had health insurance or who have been uninsured for longer than 63 days. The allowance for a 63-day gap in coverage should be increased in provisions related to high risk pool eligibility and for preexisting condition credits. Just because a person has been without health coverage for a while does not mean they are more sick or a greater health risk than covered individuals. Sixty-three days is the minimum standard under Kassebaum/ Kennedy, not the maximum. Also, people who are losing their coverage now or who have just recently lost their coverage, for example, due to job changes or exhaustion of continuation benefits, would not be eligible for the high risk pool or credit from preexisting condition limitations should CSHB 710 become effective on July 1.

The 12-month preexisting condition exclusions would be unnecessarily punitive. Several states with successful high risk pools use a six-month exclusion with a 90-day waiting period. Tennessee uses neither a waiting period nor a preexisting condition exclusion.

The board composition should be changed to increase the number of public representatives and to ensure the consideration of such consumer concerns as affordable premiums and adequate benefits.

NOTES: The committee substitute reformatted and renumbered several provisions and made clarifying and other nonsubstantive changes.