SUBJECT: Regulating HMO solvency

COMMITTEE: Insurance— favorable, with amendments

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

0 nays

0 absent

SENATE VOTE: On final passage, March 6 — voice vote

WITNESSES: (*On committee amendments*)
For — Connie Barron, Texas Medical Association

Against — Lisa McGiffert, Consumers Union

On — Rhonda Myron, Texas Department of Insurance; Rod Bordelon, Office of Public Insurance Counsel

BACKGROUND: Health maintenance organizations (HMOs) are entities that arrange for or provide health care plans on a prepaid basis. The law regulating HMOs, chapter 20A of the Insurance Code, recognizes two types of HMO plans — those that provide "basic health care services" or a "single health care service"— and establishes higher solvency requirements for HMOs that provide basic health care services.

Basic health care services are those an enrolled population might reasonably require in order to be maintained in good health and include at a minimum emergency care, inpatient hospital and medical care, and outpatient medical services.

A single health care service plan arranges on a prepaid basis the provision of a service to prevent or meet the health care need of an illness or injury of a single specified nature. Examples of single service HMO plans include dental HMO plans and vision HMO plans.

DIGEST:

SB 382, as amended, would amend chapter 20A of the Insurance Code to raise solvency requirements. It also would include provision of long-term care services in the definition of a "single health care service plan." Long term care services would be defined as medical, nursing, and other health care-related services, including personal care.

An HMO could not be subject to the U.S. Bankruptcy Code when applying for or receiving a certificate of authority. The minimum surplus of each HMO offering basic health care services would be raised to from the current $500,000 to at least $1.5 million net of accrued uncovered liabilities. For single service HMOs the minimum surplus requirement would be raised from the current $125,000 to $500,000. The bill also would provide a schedule for plans to work up to the minimum surplus level by December 31, 2002.

SB 382 would require the insurance commissioner to equitably allocate an insolvent HMO's group contracts and nongroup enrollees among all HMOs that operate in a service area. The successor HMOs would have to offer coverage to the allocated enrollees at rates determined in accordance with their rating methodology.

If an HMO were insolvent or did not possess the minimum required surplus, the commissioner could bring suit in a Travis County district court to be named receiver, in addition to all other remedies available by law. Also, a court of competent jurisdiction could find that a receiver should take charge of an HMO's assets and name the commissioner as receiver.

The bill would take effect September 1, 1997.

SUPPORTERS SAY:

SB 382, as amended, would help protect consumers and providers by ensuring that an HMO had sufficient reserves to meet the potential future demands of its enrollees who have prepaid for services. It would also give the commissioner sufficient authority to take over insolvent or financially shaky plans and reallocate enrollees so their health care investment was not lost. Texas solvency requirements for HMOs are among the weakest in the nation and are less stringent than those imposed on insurance companies.

The "limited health care service plans" proposed in the Senate-passed version would not be legally recognized or licensed under SB 382 as amended. Creation of such a plan type could be confusing to consumers and purchasers who may not fully understand what types of services would be covered or excluded. Licensing limited health care service plans also could result in HMOs and other networks organizing to provide care only for diseases or conditions that can be treated profitably, leaving expensive and complicated conditions to be covered by health care plans that offer more comprehensive services. Such a "carving out" of the managed care system would siphon premium revenue from relatively healthy patients that is used to pay for relatively sick patients into profits for specialized limited care networks. Authorizing limited plans also could divide medical management of a patient between several providers, instead of maintaining medical service oversight by one primary care "gatekeeper" under a basic health care services plan.

OPPONENTS SAY:

HB 382 as amended would not adequately regulate provider networks or health care plans that offer a limited range of services. Health care delivery systems and finance mechanisms are continually evolving, and the widespread prevalence of limited service HMOs is on the near horizon even if they are not statutorily labeled as such.

Provider networks are now contracting with HMOs and employers to provide certain services on a prepaid basis, such as long-term care services or mental health and substance abuse services, and even the state is developing limited service HMOs in the form of a long-term care service HMO model for its Medicaid population in Houston. The Legislature also has considered a number of bills this session that would allow local mental health/mental retardation centers to establish mental health HMOs, such as SB 276 by Patterson.

The establishment of a limited health care service plan, as proposed in the Senate version of the bill but removed by committee amendment, would have recognized such intermediary plans and the amount of risk they carry by requiring an intermediate level of department deposit — $75,000 compared to $100,000 for basic health care services plans and $50,000 for single health care services plans — and an intermediate minimum surplus requirement of $1 million by December 31, 2002. A limited health care

service plan would also help entities that do not offer a full-range of services compete in the marketplace as HMOs.

By including long-term care service plans under requirements for "single service plans" the bill would not impose sufficient solvency protections. The adequate provision of long-term care services requires a wide array of medical and social services. If a middle licensing level is not desired by the Legislature, long-term care services plans should at least be forced to meet basic health care service solvency requirements because their risk is more comparable to a basic health care services plan instead of a single service plan.

OTHER OPPONENTS SAY:

Raising Texas solvency requirements would not improve patient and provider protection as much as regulating provider networks that accept prepayment or capitation for the provision of services to employers and escape regulation under current state and federal insurance laws.

The provision of mental health and substance abuse services should be included in the definition of a single service HMO. This would give the department clear authority to regulate networks that accept prepayment for providing these services and would place the networks under uniform HMO standards and patient protection provisions.

NOTES:

Committee amendment one would eliminate all references to, and solvency requirements for, a limited health care service plan, which would have been defined as an HMO plan that includes more than a single health care service but less than the full range of basic health care services, at the determination of the commissioner.

Committee amendment two would define long-term care services and would include the provision of long-term care services under the definition of a single service health benefit plan.

Other HMO or managed care related bills on the calendar today include SB 383 by Cain, SB 384 by Nelson and SB 385 by Sibley.