SUBJECT: Health benefit plan for women and children and other provisions

COMMITTEE: Insurance— favorable, without amendments

VOTE: 8 ayes — Smithee, Van de Putte, Averitt, Bonnen, Burnam, Eiland, Olivo, Wise

0 nays

1 absent — G. Lewis

SENATE VOTE: On final passage, March 6 — 29-0

WITNESSES: None

BACKGROUND: 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 is required to adopt certain provisions of the federal requirements by July 1, 1997, or lose enforcement authority over these plans.

PL 104-204, also enacted by Congress in 1996, contains a wide range of federal proposals, including the Mental Health Parity Act, which requires group health plans on or after January 1, 1998, to provide parity in the imposition of aggregate lifetime limits and annual limits on mental health services with such limits on medical/surgical services.

DIGEST: SB 585 would amend health insurance and HMO laws relating to coverage of adopted children; mental health benefit parity with medical/surgical benefits; the definition of emergency care for all policies that provide any emergency benefit; HMO continuation, conversion and individual health plan coverage; direct access to an obstetrician or gynecologist in managed care plans; and minimum inpatient stay for postnatal maternity benefits.

The bill would take effect July 1, 1997. Mental health benefit parity, direct access to ob/gyn specialists, and postnatal maternity benefit requirements

would apply to coverage issued or renewed on or after January 1, 1998.

Mental health benefit parity. Coverage for mental illnesses provided by an insurer or an HMO to a self-insured employee welfare benefit plan would have to meet certain annual and lifetime aggregate dollar-limit requirements unless the employer only employed two to 50 employees.

For coverage that provided both medical/surgical benefits and mental health benefits, mental health benefits could not include aggregate lifetime or annual limits if the medical/surgical benefits did not include aggregate lifetime or annual limits. Mental health benefits could include the same or greater lifetime or annual limits applied to the medical/surgical benefits for coverage to which aggregate lifetime or annual limits applied to medical/surgical benefits.

For coverage in which different lifetime or annual limits were placed on different categories of medical and surgical benefits, the insurer or HMO would have to follow rules promulgated by the U.S. Secretary of the Treasury under the Mental Health Parity Act of 1996 (PL 104-204).

The bill would specify that none of its provisions could be construed to require an insurer or HMO to offer or provide mental health benefits, or to affect benefit terms and conditions, including cost-sharing, limits on visits or days of coverage, and requirements relating to medical necessity.

The commissioner of insurance could promulgate rules to implement this bill and to coordinate or comply with minimum federal requirements.

Direct access to ob/gyn. SB 585 would require health benefit plans that offer medical and surgical benefits and that require enrollees to obtain specialty health care services through a referral made by a primary care physician to permit women to select an obstetrician or gynecologist to provide health services in addition to a primary care physician. Plans would have to include a sufficient number of obstetricians and gynecologists to ensure enrollee access to services.

Women who designated an obstetrician or gynecologist would be entitled to direct access to the providers without referral or prior authorization from the

plan. Direct access would include but not be limited to: one well-woman examination; pregnancy care; care for all active gynecological conditions; and diagnosis, treatment and referral for any disease or condition within the scope of a properly credentialed obstetrician or gynecologist.

A health care plan would retain the authority to require the designated obstetrician or gynecologist to forward information concerning medical care of the patient. However, failure to provide such information could not result in any penalty, financial or otherwise, being imposed on the obstetrician or gynecologist or the patient.

A plan could not terminate primary care physicians as a result of enrollee access to obstetricians or gynecologists and would have to comply with specified enrollee notification procedures. Violations of ob/gyn direct access requirements would be subject to administrative penalties.

Postnatal benefits. Health benefit plans that provide maternity benefits would have to include coverage for patient care for a mother and her newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a caesarean section and provide maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists or other established medical associations. The hospital length of stay would have to be left to the decision of the provider and the mother.

HMO coverage. An HMO would have to provide group continuation privileges to enrollees whose coverage had been terminated for reasons other than involuntary termination for cause and who had been continuously covered for at least three consecutive months prior to termination.

Continuation of group coverage would have to be requested in writing not later than the 31st day after the date the group coverage would terminate or the date the enrollee was given notice of continuation rights. An enrollee selecting continuation would have to pay the employer a monthly contribution, plus two percent of the group rate. Dates on which continuation could terminate would be specified and would include the 180th day after the continuation election was made; the date on which

failure to make timely payments would result in termination; and the date on which the person was covered by another similar benefit plan.

HMOs also could offer conversion and individual health plan contracts following certain procedures and standards. HMOs could consider age and gender in setting rates for individual health plans, but rating formulas would have to be based on sound actuarial formulas, and the commissioner of insurance would have to issue rules to establish minimum standards for benefits and premium rate increases.

Adopted children. The bill would require health insurance policies and HMOs that provide coverage for immediate family or children to provide full coverage for an adopted child without limiting coverage for preexisting conditions if the application for coverage is made by the 31st day after the date on which the adoption was final or on which the insured became a party in an adoption suit.

NOTES:

SB 585 contains provisions similar to legislation already passed by the House, including HB 1212 by Averitt, HB 1173 by Coleman, HB 102 and SB 54 by Gray.