SUBJECT: Requiring employee health-benefit plans to offer a non-network option

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Eiland, Burnam, J. Moreno, Olivo, Seaman, Thompson, Wise

0 nays

1 absent — G. Lewis

WITNESSES: For — Cynthia Lieferman, Advocacy, Inc.

Against — Will Davis, Texas Association of Life and Health Insurers; Warren H. Garland; William Jones, III, Texas Association of Business and Chambers of Commerce; David Pinkus, Small Business United of Texas; Jim Plummer; Don Summers; Peggy Venable, Texas Citizens for a Sound Economy

On — Richard Evans, Texas Association of Business and Chambers of Commerce; James Henderson; Shirley Hutzler, Texas Association of Health Underwriters; Jeff Kloster, Texas Association of Health Plans; Rhonda Myron and Kim Stokes, Texas Department of Insurance

BACKGROUND: Employers who offer health-benefit plans can limit those plans to network-based delivery systems such as health-maintenance organizations (HMOs). An HMO-only employee health-benefit plan is not required to offer an alternative non-network plan, such as an indemnity or preferred-provider organization (PPO) plan. A PPO plan offers health benefits on a reduced-fee basis from any health-care provider, with greater fee reductions or complete coverage for services provided by "preferred" providers.

In network plans, employees are covered only for treatment by doctors in the plan's network. In non-network or indemnity plans, the employee can be treated by any physician, though it is less expensive to consult a preferred physician.

No provisions in current law authorize a “blended” contract that provides an insured with a combination of indemnity and HMO benefits. The Insurance Code does not authorize contracts between HMOs and insurance carriers to provide these “blended” contracts to enrollees in health-benefit plans.

DIGEST:

CSHB 1498 would require each HMO in an HMO-only employee health-benefit plan to offer a non-network plan to eligible employees at the time of enrollment and at least annually. The HMOs in an HMO-only plan could agree to allow only one of the HMOs to offer the non-network plan. This requirement would not apply to health-benefit plans offered by employers with fewer than 50 employees.

The non-network plan could be a point-of-service contract, a PPO plan, or any other coverage arrangement that allowed an employee to see physicians outside of the HMO network. The point-of-service contract, as defined in the bill, would be based on an arrangement between the HMO and another insurance carrier to provide out-of-network health benefits on an indemnity basis to the employee. Other coverage agreements could include contracts between the HMO and a group hospital service corporation for the HMO to pay for out-of-network benefits.

Employees who chose the non-network plan would have to pay the premium for the plan as well as any reasonable administrative cost imposed by the employer for providing the plan. Both the premium and copayment could be higher for the non-network plan than for the network plan, but the premium would have to be based on its actuarial value.

CSHB 1498 would authorize point-of-service contracts by amending the Insurance Code to allow an insurance carrier and an HMO to contract with each other to offer blended contracts with a mixture of indemnity and HMO benefits. These blended contracts would have to be filed for approval with the Texas Department of Insurance.

An HMO also could offer its own point-of-service plan and pay for the indemnity benefits itself as long as the cost of the point-of-service plans did not exceed 10 percent of the total medical costs for all plans offered by the HMO. If the cost exceeded 10 percent, the HMO would have to stop offering its own point-of-service plans or obtain an insurance carrier license. The HMO also would have to meet the net-worth requirement promulgated by the

commissioner of insurance based on the risk of the point-of-service plans in relation to existing HMO net-worth requirements.

CSHB 1498 would take effect September 1, 1999, and would apply to evidence of coverage for health-benefit plans delivered, issued for delivery, or renewed on or after that date.

SUPPORTERS SAY:

People should not be forced to give up their personal doctors or specialists when they take a new job with an employer whose health-benefit plan offers only HMO plans. CSHB 1498 would give employees more choices and control over their own health care.

CSHB 1498 would not create a traditional mandated benefit because the employees would bear any additional costs to the employers or HMOs through higher premiums and copayments. The employee rightfully should pay for the greater freedom that comes with a non-network plan, but the additional costs would have to be reasonable and actuarially supported. Since CSHB 1498 would apply only to large employers, enough employees would select the non-network plans to defray all additional administrative costs to the employer and the HMO.

Mandated benefits are necessary because consumers cannot know all of their future ailments at the time they choose their coverage. The state must step in and establish the basic coverage that should be included in all health-insurance policies and plans. Bad insurance with no choices is not much better than no insurance at all. Mandated benefits assure consumers that they will receive at least minimum standards of coverage regardless of what policy or plan they choose. Claims of higher premiums due to mandated benefits have not been proven conclusively.

OPPONENTS SAY:

CSHB 1498 would create a mandated benefit. Mandated benefits force HMOs and other insurance companies to offer certain benefits regardless of market conditions. These mandated benefits ultimately result in increased premiums. Fewer employers will offer health-benefit plans if more mandates are imposed and premiums continue to increase. This would result in more uninsured Texans and would defeat the stated purpose of bills like CSHB 1498.

Health benefits should be provided based on the free market. Employers and employees should be free to contract for whatever health benefits they wish without state-mandated benefits driving up costs. If employees do not like the benefits packages offered by their employers or a potential employers, they can always change jobs or pay for their own insurance.

Few employees would choose the non-network plan because of the higher premium and copayments. The few employees who would choose the non-network plans could not afford to pay high enough premiums and copayments to cover the entire cost of offering the non-network plans to every employee. The HMO and the employer would have to absorb these remaining administrative costs. These costs would translate into higher premiums for all employees and fewer health-benefit plans being offered by employers.

Many employers already offer non-network health benefits. CSHB 1498 would eliminate the competitive advantage in hiring that these employers deserve for giving expanded benefits to their employees.

OTHER OPPONENTS SAY:

CSHB 1498 would create a new type of insurance that is a hybrid of indemnity and HMO benefits. This would make effective regulation harder and would confuse consumers even more than they are now. For employees to have more options without adding to already complex insurance laws, change should come from within the existing insurance system.

NOTES:

The committee substitute differs from the original bill in that it would allow HMOs in an HMO-only benefit plan to agree with each other that one HMO would offer the non-network plan. It also added the provision allowing an HMO to offer its own non-network plan on a limited basis without an insurance carrier’s license.