SUBJECT: Allowing some health insurance policies to exclude mandated benefits

COMMITTEE: Insurance — favorable, without amendment

VOTE: 6 ayes — Smithee, Seaman, Gallego, Keffer, Taylor, Van Arsdale

0 nays

3 absent — Eiland, Bonnen, Thompson

SENATE VOTE: On final passage, April 15 — voice vote (Barrientos, Zaffirini recorded nay)

WITNESSES: No public hearing

BACKGROUND: Texas law mandates the inclusion of many specific treatments or services in health insurance policies regulated by the state. The number of these mandates depends on how they are counted; one study estimates as many as 63 mandates. Each treatment and service was added to law separately, and the evaluation in each enacting bill was based on that particular service's cost-effectiveness and value to beneficiaries' health.

Health maintenance organizations (HMOs) must offer certain minimum benefits based on federal requirements in the Public Health Service Act. That law defines "basic health services" to include physician and hospital services, emergency health services, evaluative and intervention mental health services, addiction treatment, laboratory tests, home health services, and preventive health services, including immunizations.

In 1993, the 73rd Legislature enacted the Health Insurance Portability and Availability Act (Insurance Code, ch. 26), requiring an insurance carrier to offer two health-benefit plans to small employers: a catastrophic plan and a basic health plan. The statute requires the insurance commissioner to create prototype forms that include all the required information and outlines the required benefits section for each policy. An insurer may not offer a plan to a small employer that does not comply with the prototype.

For additional background, see House Research Organization Focus Report Number 78-6, *Mandated Health Benefits: History and Controversy*, January 29, 2003.

DIGEST:

SB 541 would allow HMOs and small business carriers to offer one or more "standard" accident or sickness insurance policies that did not include some or all state-mandated health benefits. The bill would define state-mandated benefits to include required coverage for specific health services, limitations on cost sharing, or inclusion of a specific category of licensed health-care practitioner.

An insurer could not exclude from the standard health-benefit plan benefits mandated by federal law or certain required provisions such as continuity of coverage, coverage of beneficiaries with preexisting conditions, coverage of certain dependents, and diabetic treatment supplies and services. Treatment for serious mental illness could not be excluded from a standard plan issued to a large employer.

An application for or document of a standard health-benefit plan would have to include a standard disclosure to consumers. The disclosure would inform consumers that the plan "does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas" and would provide other information about the plan, including a list of the state-mandated benefits the plan did not include. An employer applying for initial coverage or renewing coverage would have to sign and return the disclosure statement.

An insurer that offered a standard health-benefit plan also would have to offer at least one plan with the state-mandated benefits. Insurers would have to file rates for standard plans with the Texas Department of Insurance (TDI) for informational purposes only.

SB 541 would repeal the requirements that HMOs in small-business purchasing cooperatives comply with the Public Health Service Act and that basic health services include the requirements in that act. It also would repeal references to the catastrophic care benefit plan and basic coverage plan now

required of small employer carriers. These carriers no longer would have to file riders to their plans with TDI.

The bill would take effect September 1, 2003, and would apply to policies issued or renewed on or after January 1, 2004.

SUPPORTERS SAY:

The current package of state-mandated benefits prevents some employers — especially small businesses — from offering health coverage to employees. SB 541 would allow insurers to offer stripped-down policies at a lower price, making health insurance more accessible and affordable. Already, insurers report that their most popular plan for small businesses has the least extensive coverage and costs the least.

Texas' small businesses need a less expensive way to offer health insurance to their employees. Many Texans working for small employers do not have health insurance, accounting for a significant portion of the state's uninsured workers. A TDI survey in 2002 found that almost 70 percent of responding small businesses cited cost as the main reason for not offering health insurance coverage.

Large employers also face difficulty in continuing health insurance for their employees because of rapidly escalating costs. SB 541 would benefit all working Texans by ensuring the availability of health plans that companies could afford.

The bill would ensure fair competition among insurers and would protect consumers' interests. An insurer that offered a plan without the mandated benefits also would have to offer a plan with those benefits. Employers could choose which plan better suited the needs of their employees — a plan with more benefits at a higher cost or a plan with fewer benefits at a lower cost.

Because insurers would have to offer plans with the mandated benefits if they wanted to offer plans without them, consumers would be guaranteed lower rates. If the prices of the two plans were the same, a consumer would have no incentive to choose a plan with fewer benefits. Insurers would have to reduce prices for plans with fewer benefits or not offer such plans at all. Also, while the bill would allow insurers to offer a standard plan without state mandates, they still would have to cover federally mandated benefits.

It is unfair to compare health insurance to homeowners insurance because the markets and regulations are significantly different. Property and casualty insurance history should not be cited as evidence against a proposed change in health insurance.

OPPONENTS SAY:

In the absence of data establishing a strong link between mandated benefits and premium rates, the state should not change the current mandates, which are necessary to maintain minimum standards in health insurance coverage. SB 541 would offer no guarantee that removing mandates would make insurance coverage more affordable.

SB 541 could make health care unaffordable for people who have insurance. Because many services would not be covered under the mandate-free plan, people who need those services, including pregnant women, cancer patients, and others, would have to pay out of pocket for treatment. Texas already has a large uninsured population and should not add an underinsured population.

It is misleading to refer to "consumers" when evaluating the amount of choice that would be available. The employer, not the end consumer, makes the decision about which benefit plan to buy. Because employers' decisions largely are driven by price, consumers' interests often are lost in the process. Mandated benefits ensure that employers cannot promise health coverage while buying policies that do not cover what patients need.

SB 541 would not be limited only to small businesses that otherwise could not afford to offer insurance. Larger employers facing slow economic growth could buy stripped-down coverage, and the mandates would not be in place to protect patients' benefits. This would result in eroding employer-sponsored health care for all Texans.

The basic premise of insurance is pooling the healthy with the sick. This bill would allow insurers to cut out people who need certain services and offer affordable coverage only to the healthy, reducing insurers' risk at the cost of people who are not perfectly healthy.

By allowing insurers to avoid state mandates without repealing the mandates, SB 541 could cause Texas patients to lose the protection of federally mandated benefits. Some federal mandates apply only to self-funded plans or

apply only if a state does not have its own mandate law. Because Texas' mandates would remain in effect yet would be waived for some plans, Texas patients could be denied coverage for some services, including those relating to length of stay after birth, post-mastectomy reconstruction, and certain mental health services.

The bill would not address the fundamental problem of rising health insurance costs. Even if insurers offered price breaks on some plans without mandates, the rising cost of health coverage likely would overwhelm any savings. The main cost drivers in health insurance are prescription drugs and hospital stays, which this bill would not address.

Texas' homeowners insurance crisis offers a lesson in what happens when the state lets insurers decide what to offer. Since January 2001, homeowners insurance rates have skyrocketed, even though most mold and water coverage was stripped from those policies. Comparing mandated benefits in health insurance and homeowners insurance is relevant and fair, because both involve rolling back coverage in the hope of reduced rates.

OTHER OPPONENTS SAY:

Before removing all mandated benefits, the state should evaluate the cost-effectiveness of individual mandates separately. Each mandate was enacted separately, with discrete cost-benefit consideration, and the mandates should not be eliminated as a group. For example, benefits such as prenatal care should not be lumped together with treatment of the temporomandibular joint (TMJ). The Legislature should establish a review process to examine each mandate and consider its effect on affordability and accessibility of health insurance.