SUBJECT: Health-care benefit mandates and offer-of-coverage mandates

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Eiland, Averitt, Burnam, G. Lewis, J. Moreno, Olivo, Seaman

0 nays

1 absent — Thompson

WITNESSES: For — Will Davis, Texas Association of Life and Health Insurers; Neill Fleishman, Blue Cross Blue Shield of Texas; Ron Luke, Texas Association of Business and Chambers of Commerce; Lisa McGiffert, Consumers Union; Kim McPherson, The Mental Health Association in Texas

Against — None

On — Richard Spalding, Association of Substance Abuse Programs

BACKGROUND: The 76th Legislature in 1999 enacted HB 1919 by Gallego et al., authorizing a review of the impact of mandated benefits on the access to and affordability of health insurance. Mandated benefits are coverages required by law to be included in health insurance policies sold by commercial insurance companies and health maintenance organizations.

Insurance and business groups have asserted that these mandates increase the cost of health insurance, making it less affordable for consumers. However, consumer and employee advocates contend that these mandates are necessary to maintain minimum standards in health insurance coverage.

These issues, along with Texas' higher than average rate of uninsured people, prompted the Legislature to examine the impact of mandated benefits on the rate of uninsured people. The Legislature established the Joint Interim Committee on Mandated Health Benefits to study the impact of such health benefits and to make recommendations to the 77th Legislature.

DIGEST:

CSHB 3444 would establish a process for the Legislative Budget Board (LBB) to assess the impact of proposed health-benefit plan mandates or offers-of-coverage mandates, and for the Sunset Advisory Commission to review enacted mandates.

The bill would define a health-care benefit mandate as a state law that required a health-benefit plan to provide coverage or reimbursement for a specific service, treatment, or procedure, a specific medical condition or illness, or a particular group of people who otherwise would be excluded, or to reimburse a specific type of health-care provider directly or in a specific amount. It would define an offer-of-coverage mandate as a state law that required a health-benefit plan to offer as part of its benefit schedule coverage that the contract holder could reject and for which an additional premium could be charged.

**LBB impact assessment.** If the chair of a standing committee of the Legislature determined that a bill, if enacted, would create a health-care benefit mandate or an offer-of-coverage mandate, the chair would have to send a copy of the bill to the LBB and request an impact assessment. The LBB would have to prepare a written impact assessment, using information supplied by any person, agency, organization, or governmental unit that the LBB director determined was reliable. The LBB could obtain assistance from any state agency or by contract with a private entity and would have to obtain the assistance of at least one certified actuary who was qualified to provide an opinion relating to an impact assessment. The LBB director would have to submit a requested impact assessment within 21 days after the request.

An impact assessment would have to include, as applicable:

- the level of demand in Texas for the coverage that was the subject of the mandate, including the number and percentage of people affected by the medical condition or illness or who would be likely to use the coverage;
- the extent to which the coverage was available under health-benefit plans in effect at the time the impact assessment was made;
- the extent to which any health-care service, treatment, or procedure that the mandate would require would be available in the absence of health-benefit plan coverage;

- the epidemiological impact and medical efficacy of the health-care service, treatment, or procedure, including the impact on a person's health status of providing or not providing such;
- the direct impact of the mandate on health-benefit plan premiums;
- the net impact of the mandate on premiums, considering the extent to which the coverage already was provided under health-benefit plans that were in effect at the time the impact assessment was made and the extent to which other costs were offset by the mandate;
- the costs to a person of obtaining a health-care service, treatment, or procedure in the absence of health-benefit plan coverage;
- the fiscal impact on the state associated with enacting the mandate and with not enacting it;
- the impact on the economy and society of not providing the health-care service, treatment, or procedure;
- the impact of the health-care service, treatment, or procedure on the use of sick days and disability costs;
- the relative quality and cost-efficiency of the care that was the subject of the mandate in the absence of health-benefit plan coverage; and
- a description of the extent to which the mandate was required by federal law and the consequences of not enacting a mandate that included the minimum requirements of the federal law.

For an offer-of-coverage mandate, the impact assessment also would have to estimate the difference in the cost of a health-benefit plan that provided the coverage and a comparable plan that did not. For a health-care benefit mandate, the impact assessment also would have to estimate the impact of the mandate if the mandate were an offer-of-coverage mandate.

An impact assessment would have to provide a separate analysis of the cost to the Employees Retirement System (ERS) of providing the mandated coverage to the population covered by the Uniform Group Insurance Program, even if the program would not be subject to the mandate. The impact assessment would have to provide a separate analysis of the costs of the mandate for:

- group health-benefit plans as a whole and by type;
- individual health-benefit plans; and
- small-employer health-benefit plans, even if those plans would not be

subject to the mandate.

If the LBB director determined that the impact of a proposed mandate could not be ascertained fully or the director could not develop enough information to prepare a complete impact assessment within 21 days of receiving the bill, the director would have to report that fact in writing to the committee chair and prepare an impact assessment that complied as much as possible with the specified requirements.

Copies of a prepared impact assessment would have to be distributed to the committee before it voted on the bill to which the assessment was related. The assessment would have to be attached to the bill on first printing. If the committee amended the bill in a way that altered a mandate, the chair would have to obtain an updated impact assessment, which also would have to be attached to the bill on first printing. An impact assessment would have to remain with the related bill throughout the legislative process, including submission to the governor.

**Assessment of enacted mandate by the Sunset Advisory Commission.** The insurance commissioner would have to assign a review date to each health-care benefit mandate or offer-of-coverage mandate. In assigning review dates, the commissioner would have to:

- consider the amount of time a mandate had been in effect and any substantial changes or amendments since the mandate became effective; and
- assign review dates to mandates according to the amount of time they had been in effect in substantially the same form, requiring earliest review for the mandates that had been in effect for the longest period.

The commissioner could assign the same review date to mandates that were substantially similar or substantively related to each other. Unless provided above, the commissioner could not assign the same review date to more than five mandates. The review date would have to be September 1 of an even-numbered year and could not be earlier than September 1 of the even-numbered year following the fifth anniversary of the date the mandate was adopted. The review date could not be earlier than September 1, 2004.

Before the review date for a mandate, the Sunset Advisory Commission would have to:

- review and take action necessary to verify the reports relating to the mandate submitted by the Texas Department of Insurance (TDI) and the Texas Department of Health (TDH);
- assess the mandate on the basis of the criteria provided and prepare a written report; and
- review any prior commission recommendations relating to the mandate in reports presented to the Legislature in a preceding session.

Between the review date for a mandate and December 1 of the calendar year in which the review date occurred, the commission would have to conduct public hearings on the mandate's assessment. Sunset could hold public hearings before the review date if the required report was complete and available to the public.

Not later than January 1 of the year of a regular legislative session, Sunset would have to present to the Legislature and governor a report on each mandate assessed during the previous year. A report would have to include:

- specific findings regarding each of the criteria;
- recommendations regarding whether the mandate should be continued, modified, or repealed; and
- any other information that the commission considered necessary for a complete assessment of the mandate.

In determining whether a mandate should be continued, modified, or repealed, the commission and its staff would have to consider essentially the same factors as in the LBB assessment.

In considering a mandate's impact on health-benefit plan premiums, Sunset and its staff, if applicable, would have to provide a separate analysis of the impact of a health-care benefit mandate or offer-of-coverage mandate on group health-benefit plans as a whole and by type, on individual health-benefit plans, and on small-employer health-benefit plans.

Sunset could contract with any person to provide actuarial, medical,

economic, or other expertise as necessary to allow Sunset to prepare its report. The commission would have to obtain the assistance of at least one certified actuary qualified to provide an opinion relating to a report.

A health-care benefit mandate or offer-of-coverage mandate would remain in effect until such time as the Legislature acted on Sunset's recommendation. A subsequent review date of the mandate could not exceed 12 years. The Legislature could modify a mandate at the time it was continued. The Legislature could repeal a health-care benefit mandate or offer-of-coverage mandate or could consider any other legislation relating to a mandate.

**Data collection and reporting.** The insurance commissioner by rule would have to define "large health benefit plan carrier" for the purpose of this program. The commissioner would have obtain the assistance of the advisory committee, described below, in formulating the definition. The definition would have to be based on the carrier's premium volume or number of enrollees covered by the carrier's plans and would have to describe enough carriers to fulfill these provisions, but not less than the lesser of 15 carriers or all carriers operating in Texas.

The commissioner would have to require each large health-benefit plan carrier and ERS to submit information annually that the commissioner, with the assistance of the advisory committee, determined was necessary for the assessment of health-care benefit mandates and offer-of-coverage mandates. A large health-benefit plan carrier and ERS both would have to submit information required by the commissioner.

**Advisory committee.** The commissioner would have to appoint an advisory committee of at least seven and not more than 11 members to assist TDI in implementation. The committee members would have to include at least one representative from each of the following groups or entities:

- large health-benefit plan carriers that were insurers;
- large health-benefit plan carriers that were health maintenance organizations;
- consumers;
- health-care providers;
- TDH, and

- the Texas Health Care Information Council.

The committee also would have to include members who had demonstrated actuarial, economic, and information systems expertise.

The committee would have to work with TDI to ensure that:

- collected data was sufficient to evaluate each health-benefit mandate and offer-of-coverage mandate properly;
- compliance with requests for data was both feasible for health-benefit plan carriers and as cost-effective as possible; and
- data collection formats were as compatible as possible with formats required under the federal Health Insurance Portability and Accountability Act of 1996.

**Confidentiality.** TDI could not collect information that reasonably could be expected to reveal the identity of a patient of a health-care provider other than a hospital. Information submitted by an individual health-benefit plan carrier would not be subject to disclosure under the open records act. TDI would have to aggregate information submitted by all health-benefit plan carriers, and that aggregated information would be subject to open records disclosure.

Before July 1 of the calendar year in which the review date assigned to a health-care benefit mandate or an offer-of-coverage mandate occurred:

- TDI would have to report to Sunset:
  - information regarding the costs associated with the mandate, including related claims paid under health-benefit plans and the premiums charged for coverage required by the mandate, and
  - any other information that the commissioner considered appropriate or that Sunset had requested, to the extent that the information was available; and

- TDH would have to report to Sunset:
  - information regarding the epidemiological impact and the medical efficacy of the coverage required by the mandate, if applicable, and
  - any other information that the health commissioner considered

appropriate or that Sunset requested.

TDI and TDH would have to provide, to the extent the information was available to the agencies, any information requested by LBB for the purpose of preparing an impact assessment.

CSHB 3444 would take effect September 1, 2001. Not later than December 1, 2001, the insurance commissioner would have to appoint all members to the advisory committee. Not later than June 1, 2002, the commissioner would have to adopt rules to implement the bill.

NOTES:

The committee substitute changed the filed version by adding requirements for the commissioner to follow in assigning review dates for each health-care benefit mandate or offer-of-coverage mandate. It also added provisions in regard to the continuation of a mandate until the Legislature acted on the sunset recommendation. The substitute also modified the definition of "health benefit plan" and "large health benefit plan carrier" and changed the date by which TDI and TDH would have to report appropriate information to the Sunset Advisory Commission.