SUBJECT: Employer-based health benefit revisions

COMMITTEE: Insurance — committee substitute recommended

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

0 nays

0 absent

WITNESSES: For — Jay Thompson, Texas Life Insurance Association; John McCarthy

Against — None

On — Tyrette Hamilton, Texas Department of Insurance

BACKGROUND: In 1993 the Legislature enacted the Small Employer Health Insurance Availability Act (Chapter 26, Texas Insurance Code), which required participating health benefit carriers to issue small employer health benefit plans without regard to claim experience, health status, or medical history, commonly referred to as *guaranteed issue*. It also authorized the establishment of a small employer health benefit purchasing cooperative.

Other provisions of the act state that employers must be located within the carrier's geographic service area, carriers can refuse coverage or renewals under certain conditions, preexisting condition provisions can apply with certain restrictions, premium rates must be set according to specified standards, and health benefit plans must offer certain types of coverage and meet other requirements.

Multiple Employer Welfare Arrangements (MEWAs) are entities composed of two or more employers who have joined to provide employee health benefits. MEWAs may be fully insured, with all risk is held by an insurance company, or not fully insured, with the MEWA holding some risk. Federal law authorizes states to regulate MEWAs that are not fully insured. Texas regulates MEWAs under article 3.95-1 of the Insurance Code.

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.

DIGEST:

CSHB 1212 would change the Small Employer Health Insurance Availability Act, chapter 26 of the Insurance Code, to the Health Insurance Portability and Availability Act and include provisions for large employer health benefit plans. It also would amend small employer provisions in chapter 26, making substantive as well as clarifying and nonsubstantive changes.

CSHB 1212 also would amend other health insurance provisions of the Insurance Code by adding a new article 21.52G, to govern certification and disclosure of coverage, and by amending Multiple Employer Welfare Arrangements (MEWAs) to include additional requirements.

The commissioner of insurance would be required to adopt necessary rules to meet the minimum requirements of federal law and regulation.

The bill would take effect July 1, 1997, if finally approved by the two-thirds record of the membership of each house required for bills to take effect less than 90 days after the session ends, and would apply to all policies issued or renewed on or after that date.

Conforming definitions

CSHB 1212 would amend existing or add new definitions to chapter 26 and article 3.95-1 of the Texas Insurance Code to place into statute federal requirements, including definitions for health status related factor and creditable coverage

A “health status related factor” would refer to an individual’s health status; physical and mental medical conditions; claims experience; receipt of health

care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of family violence; and disability.

"Creditable coverage" would refer to an individual's coverage that could be credited against preexisting condition exclusions under a new health benefit plan. Coverage would be considered creditable if it was provided under a self-funded or self-insured employee benefit plan, a group insurance plan, a group HMO plan, an individual policy, a Medicare policy, a Medicaid policy, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a federal public health plan under the Peace Corp program, and other federal programs.

Creditable coverage could not include such plans as accident-only or disability policies; workers' compensation insurance; automobile medical payment insurance; long-term care insurance; and other coverage that is limited in scope or under which benefits for medical care are secondary to other insurance benefits.

Small employer health benefit plans

The definition of small employer would be changed to one who employs at least two, instead of three, employees, and a partnership would be considered the employer of a partner. (The maximum number of employees to be considered a small employer would remain at 50). A small employer could include a governmental entity that provides group health coverage, including cities, towns and other political subdivisions, associations of school teachers and administrators, and certain state agencies and state retirement programs.

An independent school district could elect to participate in the small employer market without regard to the number of eligible employees of the district, and would be treated as a small employer for all purposes under chapter 26.

CSHB 1212 would specify that each small employer carrier would have to provide small employer health insurance without regard to health status related factors. It also would amend existing law to specify that the 31-day

open enrollment period would last an entire month, beginning on the first day of the month and ending on the last day of the month.

Preexisting condition exclusions could not exceed 18 months from the date of initial application, and genetic information and pregnancies could not be treated as preexisting conditions. A preexisting condition provision could not apply to an individual who was continuously covered for an aggregate, instead of a minimum, of 12 months under creditable coverage. The creditable coverage would have to have been in effect up to 63, instead of 60, days before the effective date of the small employer coverage. Current law allowing carrier-imposed waiting periods in lieu of preexisting condition provisions would be repealed.

Health maintenance organizations (HMOs) could impose an affiliation period if the period was applied uniformly without regard to any health status related factor. An affiliation period would be defined as a period in which the HMO would not have to provide health care services or benefits to the participant and a premium could not be charged. The authorized duration of an affiliation period would be shortened to two months for enrollees and 90 days for late enrollees, from the current 90 days and 180 days respectively. An affiliation period would have to be credited to any preexisting condition provision period.

CSHB 1212 would prohibit the limitation or exclusion of coverage for an adopted child of an insured. The child could be enrolled 31 days after the insured was a party in a suit for adoption or 31 days of the date the adoption was final. Coverage would be terminated if notification of the adoption and additional premiums were not received by the employer within 31 days of the above dates.

In addition to current allowances, CSHB 1212 would allow small employer health benefit carriers to refuse to renew a small employer health benefit plan if no plan enrollee resided or worked in the carrier's service area or if membership of an employer in an association terminated.

Small employer carriers also could discontinue a particular type of small employer coverage only if the carrier provided notice to each employer 90 days before discontinuation; offered each employer the option to purchase

other small employer coverage; and acted uniformly without regard to the claims experience of the employer or any health status related factors of employees or dependents.

Current law limiting premium rate increases would be amended to allow a small employer carrier to establish premium discounts, rebates or reductions in copayments or deductibles in return for adherence to health promotion and disease prevention programs.

Current law governing disclosure to small employers of small employer carrier premium adjustments and other provisions would be amended to also require the carrier to disclose on request the benefits and premiums available under all small employer coverage for which the employer was qualified. A carrier would not be required to disclose proprietary or trade secret information. Information would have to be disclosed in a manner that was understandable by the average small employer.

Large employer health benefit plans

A large employer would be defined as an employer who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year. A partnership would be the employer of a partner. A large employer could include a governmental entity that provides group health coverage such as cities, towns and other political subdivisions, associations of school teachers and administrators, and certain state agencies and state retirement programs.

Large as well as small employers could form a cooperative to purchase employer health benefit plans. Current provisions governing the duties and powers of a small employer cooperative would be amended to also refer to a large employer cooperative.

Large employer carriers could refuse to provide coverage to a large employer; however, on issuance of a health benefit plan, coverage would have to be provided to all employees who met the participation criteria without regard to an individual's health status related factors. Participation criteria would be defined as criteria or rules established by the large

employer to determine the employees who were eligible for enrollment, including continued enrollment, under the terms of the health benefit plan. The criteria or rules could not be based on health status related factors.

A carrier could require a large employer to meet minimum contribution or participation requirements as a condition of issuance and renewal in accordance with the carrier's usual and customary practices for all employer health benefit plans in the state. A carrier would be authorized to use employer participation requirements that require the percentage of individuals that must be enrolled in the plan. A large employer health benefit plan could not limit or exclude for a specific individual coverage by type of illness, treatment, medical condition, or accident, except that permitted as a preexisting condition.

The carrier would have to obtain a written waiver from each employee who met the participation criteria but who declined coverage. Employees could not be induced or pressured to decline coverage by the employer, and the carrier could not encourage a large employer to exclude an employee who met the participation criteria. A large employer could establish a waiting period for new employees and determine the duration of that period. Dependent coverage, if elected by the employer, would have to meet certain requirements. Late enrollees could be excluded from coverage until the next annual open enrollment period and could be subject to a 12-month preexisting condition provision.

A large employer carrier could not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Adjustments would have to be uniformly applied to the rates charged all employees. Carriers would not be restricted in the amount charged to large employers for coverage.

On request, carriers would have to give each large employer purchasing health benefit plans a summary of all plans for which the employer was eligible. The department of insurance could require periodic reports by carriers and agents regarding the plans issued by those carriers. The reporting requirements would have to conform to federal law and regulation and request information regarding the number of large employer plans in various categories. Third party administrators would be subject to these

provisions if they entered into an agreement with a large employer to provide administrative, marketing or other services related to the offering of large employer health benefit plans.

Other large employer health benefit plan requirements would conform to similar small employer health benefit plan requirements in the areas of: applicability; certification; geographic service area; initial enrollment period duration; premium discounts for health promotion/disease prevention program participation; preexisting condition and HMO affiliation provisions; renewability; refusal to renew; agents; and written statements of denial, cancellation or refusal to renew provisions.

Certification and disclosure

Each issuer of a health benefit plan would have to provide a certification of coverage, in accordance with the standards the commissioner of insurance adopted by rule, as necessary to determine the period of applicable creditable coverage of health benefit plans.

MEWAs

Similar to provisions for large employer health benefit carriers, MEWAs could refuse to provide coverage to employers in accordance with underwriting standards and criteria. However, on issuance of coverage to an employer, each MEWA would have to provide coverage to the employees who met the participation criteria established by the terms of the plan document without regard to an individual's health status related factors. Only employees who had declined coverage could be excluded, and written waivers would have to be obtained from those employees. Employees could not be induced or pressured into declining coverage.

Other requirements related to MEWAS would conform to similar requirements for large employer health benefit plans in the areas of: requiring employers to meet minimum contribution or participation requirements; duration of enrollment periods; dependent coverage provisions; late-participating employee coverage and exclusions; prohibitions from excluding specific benefits to a specific individual; renewability and refusal to renew provisions; written notice of cancellation

or refusal to renew; premium rates and adjustments; premium discounts for health promotion/disease prevention program participation; disclosure of other plans to employers; reporting requirements to the department of insurance; preexisting condition provisions; and third-party administrators.

MEWAs would have to file with the commissioner any modified terms of a plan document along with a certification from MEWA trustees that the changes were in compliance with the statutory minimum requirements. If the commissioner determined that a MEWA did not comply with requirements, the commissioner could order the MEWA to correct the deficiencies. If immediate corrective action was not taken by the MEWA, the commissioner could take any other authorized action.

SUPPORTERS SAY:

CSHB 1212 would place Texas in compliance with federal requirements, and maintain state enforcement authority over employer-based health benefit plans. CSHB 1212, by addressing *employer-based* group coverage, is a necessary component to CSHB 710 by Averitt, which recently passed the House and addresses federal requirements related to *individual* health benefit coverage.

The Kassebaum/Kennedy law enacted last year was designed to ensure that people who are moving from one job to another or from employment to unemployment are not denied health insurance because they have a preexisting condition. The federal law made health benefit coverage *portable* by allowing individuals to use evidence of previous coverage as "credit" to reduce or eliminate any exclusions from new coverage due to preexisting medical conditions. CSHB 1212 would add definitions of large employer, health benefit plans and creditable coverage, and would amend waiting period and preexisting conditions to conform to these federal requirements.

The new federal law also improves availability of coverage by prohibiting discrimination against individuals and guaranteeing issuance and renewability to employers under certain conditions. It specifically prohibits group health plans from conditioning enrollment on *health status related factors*. Pregnancy and the use of genetic information not based on diagnosis could not be used as preexisting conditions, and preexisting conditions could not be placed on newborns and newly adopted children.

CSHB 1212 would add to current law the definition of health status related factors and add renewability provisions and other related provisions regarding employer-based insurance to conform to federal requirements.

CSHB 1212 is taking the right approach by enacting little more than what is required to meet federal standards. Consideration of issues that would go beyond federal minimum standards, such as increasing the authorized 63-day lapse in coverage or decreasing preexisting condition exclusion periods, would dramatically increase costs for employers and carriers and should be debated in separate pieces of legislation. The federal law contains highly negotiated provisions that are similar to Texas Small Employer Health Benefit Act provisions and that have been proven to be effective for both carriers and employers in Texas.

CSHB 1212 would not allow the definition of small employer to include self-employed individuals because issuing such policies entails extremely different underwriting and rating procedures. The entire small employer market could be thrown off-balance if self-employed individuals were granted similar protections and provisions as small employer health benefit plans. HB 710, which recently passed the House, would improve availability for individuals through the establishment of a high risk pool and other changes. More study would be needed before enacting changes to the small employer market for self-employed individuals that also would ensure that small employer health benefit costs remain affordable and available.

CSHB 1212 includes only a few additional provisions that are not required under federal law that would help address other employer-related health benefit group problems in Texas and cause little impact on the market. School districts have experienced problems similar to small employers in obtaining health benefits for their employees. CSHB 1212 would simply extend access to school districts to a small employer market that is working well, and would not increase health benefit carrier risks.

OPPONENTS SAY:

CSHB 1212 would go too far in amending Texas Insurance Code provisions, in that some of the amendments are not necessary to meet federal requirements.

School districts should not be allowed to participate in the health benefit market as small employers. Many school districts have more than 50 employees, which is the maximum number of employees a business can have to be considered a small employer under current law. Allowing larger groups to purchase plans designed for smaller groups could gut the small employer health benefit market because such plans must conform to strict rating restrictions, guaranteed issue requirements and other provisions that were never designed to apply to large groups. Allowing school districts and other governmental subdivisions to access coverage through small employer health benefit plans could significantly increase carrier risk and costs, and make small employer plans more costly or less available.

OTHER OPPONENTS SAY:

CSHB 1212 would not go far enough to improve health benefit portability and availability. Congress intended the federal reforms to be a minimum state standard, not a maximum, and Texas should take advantage of this opportunity to better address the problem of its 4 million uninsured, which ranks Texas close to the top among all states in number of uninsured individuals.

The 63-day lapse in coverage allowance should be increased. Sixty-three days is the "bridge" that grants health benefit portability to people who have changed jobs by allowing them to be fully covered by the new job's health benefits without preexisting condition exclusions taking effect. However 63 days is the minimum standard under Kassebaum/Kennedy, not the maximum.

According to the Texas Workforce Commission, the average duration of unemployment benefits is about 15.8 weeks; in other words, on the average it takes about 110 days for unemployed Texas workers to find new employment. People who are losing their coverage now or who have just recently lost their coverage, for example, due to job changes or exhaustion of continuation benefits, would not be eligible for credit from preexisting condition limitations when CSHB 1212 became effective on July 1.

Increasing the length of time between jobs and coverage to 120 days or 180 days would *not* increase risk of adverse selection for health benefit carriers because this bill would address employment-based coverage only, not individual coverage that could be purchased when individuals think they are

sick. Also, CSHB 1212 would allow preexisting conditions to be excluded from coverage for up to a year, which would provide sufficient protection to carriers from paying the expenses of any unhealthy employees.

The twelve-month preexisting condition exclusions would be unnecessarily punitive. It would be unfair to pay for services for some employees but not for others. New employees who have medical conditions often need help paying for their treatment, as do employees who have been on the job longer. Twelve months is a relatively arbitrary time period chosen to shelter health benefit carriers from having to pay for treatment for new enrollees.

Congress allows states to include "groups of one" in the definition of a small employer, and Texas should enact a similar provision to extend availability of health benefits to freelancers, solo consultants, and other self-employed professionals, who as a group are not any sicker than the rest of the employed population.

NOTES:

The committee substitute added the following provisions to the original version of the bill: certain governmental entities and subdivisions to the definitions of small employer and large employer; provisions requiring enrollment periods to begin on the first day of the month and to end on the last day of the month; authorization that employer participation requirements could include the percentage of individuals that must be enrolled in a large employer plan; provisions requiring adopted dependent children to be enrolled within 31 days of the adoption date or date the insured is party to a suit; and required MEWA coverage for adopted children only in plans in which dependent children are eligible for coverage.

The committee substitute removed the following provisions from the filed version of the bill: prohibiting large employer carriers from entering into agreements with agents that compensate for the sale of health benefit plans to vary with the claims experience of the large employer; requiring carriers to certify to the commissioner that the carrier is not offering to large employers any coverage that is not a health benefit plan; requiring large

employer carriers to pay the same commission, premium percentage or other amount for renewal of a large employer health benefit plan; and removing from current law provisions that allow MEWAs to have a commissioner's ruling reviewed by the board.