

## **Chapter 10.**

# **Mandated Benefit Review and Texas' Basic and Catastrophic Health Plans: Containing Healthcare Costs in Texas**

*by Steve Kester*

While expanding the Children's Health Insurance Plan and Medicaid can dramatically decrease the number of uninsured Texans, fiscal and political realities will require that private health insurance coverage be part of the solution to reduce Texas' large uninsured population. However, both nationally and in Texas, employer-sponsored health care for low-wage workers, the segment of Texas' working population that is most likely to be uninsured, is decreasing.<sup>1</sup> One of the ways states can try to staunch the loss of health insurance coverage is by using their regulatory powers to increase the availability and affordability of private health insurance for both employers and employees.

Of course, how states use their regulatory powers to accomplish this goal is a matter of considerable debate between health care providers, insurance companies, consumer organizations, and regulators. In fact, striking an appropriate balance of regulatory efforts has proven to be difficult, giving rise to tug-of-wars between rising insurance costs associated with regulations and state deregulatory efforts to correct the unintended consequences of those regulations. Over the past decade, states have tried a variety of regulatory changes to try to increase the availability and affordability of private health insurance. Some of these efforts, such as guaranteed issue and guaranteed renewability, have met with considerable success in the states and at the federal level. Others, such as requiring proposed benefit mandates to clear a rigid review process in an attempt to reduce benefit-driven cost increases, have consumed years as states try and try again to find the right formula for balancing issues relating to standards of care and coverage with the realities of costs.

This paper discusses the mandated benefits debate by providing background on mandated benefits review in Texas, describing three recent attempts in Texas to study the impact of mandated benefits on private employer health plans, and reviewing mandated benefits review processes that have been instituted in other states. This paper also looks at Texas' attempt to offer low-cost health insurance alternatives in the form of basic and catastrophic health plans for small employers that are relatively "mandate-free" to reduce costs and increase affordability.

This review is particularly relevant currently as the 77th Texas Legislature considers recommendations by a public/private panel that include instituting a mandated benefits review process in Texas in an effort to reduce costs and administrative burdens often associated with such benefit requirements. By discussing these various regulatory efforts, insight may be gained into ways Texas can use its regulatory powers to improve the availability and affordability of health insurance for small employers and their employees.

## **What are Mandated Benefits?**

While definitions vary, mandated benefits can generally be classified in three distinct groups: process mandates, which require coverage for specific providers or settings; mandatory benefits, which cover specific diseases, conditions, or services; and mandatory offerings, which require insurers to offer specific coverage for insureds who are willing to pay extra for those services.<sup>2</sup> Examples of process mandates include any willing provider provisions, which require insurance plans to reimburse a patient's choice of health care provider rather than the insurer's choice, mandated utilization review requirements, and other administrative requirements. Mandatory benefits are the most common type of mandated benefit, such as requirements that insurers offer coverage for certain mental health services, mammography screenings, and 48-hour minimum hospital stays for birth mothers and their infants. Mandatory offering examples include requirements that insurance companies offer for an additional fee access to mental health care, certain preventive services, and/or extended coverage for certain conditions.

## **To Whom do Mandated Benefits Apply?**

Managed care policies and small group insurance plans are the primary recipients of mandated benefit requirements. Public plans such as Medicare and Medicaid are also subject to mandated benefits, although the situation for these plans is different since the government proscribes the benefits and funds and administers these programs. Interestingly, insurance plans for the majority of the privately insured escape the intended effects of mandates because they are exempt under the federal Employee Retirement Income Security Act (ERISA)—federal legislation which allows employers to establish their own health plans for their employees that are not subject to most federal and state regulation. Since almost 60 percent of people with private health insurance are insured under ERISA plans, most mandated benefits requirements do not apply, although many ERISA plans provide coverage for the most popular mandated benefits.

## **The Debate over Mandated Benefits: Access vs. Cost**

As managed care has become more common in the U.S., so have legislative and administrative mandates for health care coverage. Stakeholders in the debate include insurance companies, health care providers, employers, regulators, health care consumer groups, and consumers themselves. Central to the debate are the issues of cost and access. Insurance companies and many employers and business/trade associations argue that benefits that are mandated drive up the cost of health insurance, making healthcare plans less affordable, less competitive, and less profitable. Many providers and consumer organizations argue that insurance companies will not provide access to some health care services unless they are required. These groups also argue that by mandating certain benefits, health care consumers are guaranteed a minimum standard of quality for health insurance. State and federal legislative bodies and regulatory agencies are in the position of seeking a balance that will ensure access to needed services while keeping costs affordable.

Proponents of mandates, or at least specific mandates, charge that cost increases are negligible when compared to the potential benefits of ensuring coverage for cost-effective services such as mammography and osteoporosis screening and other preventive services. Not only is providing care for these populations a quality-of-care issue, but proponents of mandates also argue that it is a cost issue since services for these populations could eventually fall on the taxpayers if private insurance did not cover the service. While it is certainly important to have a good understanding of the costs associated with mandated benefits, it is also important to assess those costs in such a way that all costs and benefits are fully considered—a prospect that is difficult because of the lack of accurate data and the many subjective factors involved when assessing the social or moral value of providing access to a particular service. Many proponents of mandates also argue that slight cost increases are acceptable considering the benefit of certain services.

## **Mandated Benefit Review**

While many factors contribute to rising health insurance costs, mandated benefits—specific treatments or services insurance plans are required by legislation or regulation to provide—are increasingly identified as significant cost drivers for health insurance premiums. Rising insurance costs have an impact on health insurance affordability. In fact, one controversial study of Texas’ health insurance market estimates that approximately 275,000 Texans are uninsured because of health insurance cost increases directly attributable to mandated health care benefits.<sup>3</sup>

Concerns about the cost impact of mandated benefits and their effect on the accessibility of health insurance have brought the issue to the forefront of the health care debate in recent years. In the U.S., 22 states have enacted or adopted some form of review process to determine the cost impact of proposed mandates before legislatures or regulatory agencies adopt specific mandates. Given the dramatic increase in mandated benefits over the years, it is not difficult to understand why many states deem such a process necessary. Nationally, the states have collectively mandated over 1,100 benefits. According to the Texas Department of Insurance, Texas has between 29 and 60 mandates depending on how they are defined. Only Maryland, with 30 mandated benefits under the more conservative definition, has more than Texas. In fact, the number of mandated benefits in the U.S. has steadily increased each year, with 38 mandates passing state legislatures in 1990 and 86 passing in 1998.<sup>4</sup>

Mandated benefits are obviously popular public policy with many legislators. Anecdotal evidence, such as dramatic accounts of children, mothers, and the elderly being denied needed services by their insurance companies, fuels the debate with emotional appeals that, while legitimate, often overshadow issues of cost and potential unintended consequences. As the number of mandates increases and utilization data for mandated benefits becomes available, these issues have become more apparent. According to a report funded by the Texas Association of Business and Chambers of Commerce, the following major unintended consequences are attributable to mandated health benefits: cost increases for employers and their employees, an increase in the number of uninsured,

and a shift of employers from regulated health insurance to self-insured plans exempt from state regulation under ERISA.<sup>5</sup> While the claims of this report are controversial, there is little dispute over the fact that mandated benefits increase costs (although the degree to which costs are increased is a matter of considerable debate), that the number of uninsured is increasing, and that more and more employers are choosing to self-insure under ERISA.

## **Texas' History with Mandated Benefits Review**

In 1993, Texas created the Mandated Benefits Review Panel in an attempt to provide legislators with cost/benefit analyses of existing and proposed mandated benefits. However, a lack of funding, staff resources, and utilization data frustrated the panel's ability to create a credible review process. In addition, scheduling problems with the volunteer panel caused further problems. In 1997 the panel was abolished, causing the debate to begin anew.

Despite the recent failure to create a review process in Texas, such policies are popular among the states. In fact, 22 other states have enacted or adopted some form of review process to determine the cost impact of proposed mandates, although those states report varying degrees of success. Proponents of a review process in Texas are hopeful that the 77th Texas Legislature will adopt a more successful incarnation of the Mandated Benefits Review Panel as recommended by the Joint Interim Committee on Mandated Benefit's report.

## **Research on the Cost Impact of Mandated Benefits**

Getting a handle on the actual costs of mandated benefits is a key to the debate. According to the Texas Department of Insurance, obtaining reliable cost data has eluded Texas and other states because data has not been collected historically and data that is self-reported from insurance companies is often biased, incomplete, or inaccurate. An additional problem in determining costs associated with specific mandates is that there is no standard methodology for determining and measuring costs. This means that cost estimates vary, considerably in some cases, between cost impact studies.<sup>6</sup> This lack of reliable data impairs the ability of researchers to predict future costs. In a 1998 report to the Texas Legislature, TDI notes:

As Congress recently debated various managed care reform proposals this summer, consultants studying the proposals predicted widely disparate costs. For example, a provision requiring improved access to emergency care for HMO enrollees was predicted to cost 60 cents per-person-per-month by Milliman and Robertson, but only 13 cents in a study by Coopers and Lybrand for the Kaiser Family Foundation.<sup>7</sup>

The debate over the accuracy of cost impact is alive and well in Texas, not only between consumer advocates, state regulators, and business groups and insurance companies, but even between competing insurance companies. According to TDI, cost estimates of mandated benefits vary as much as 15 percent or more.<sup>8</sup> Who is right? Numerous

studies have been conducted and paid for by entities on all sides of the issue. Predictably, the results vary considerably. Perhaps the only way to address this issue is to achieve consensus on a specific methodology and begin to collect data. In the absence of such a study, policymakers are doomed to rely on existing studies and make their own determinations on the validity of the methodology and conclusions of those studies—the process which created the debate over mandated benefits in the first place.

Issues of cost and access dominate the mandated benefits debate. Mandated benefits do increase costs, and yet without mandated benefits, at least part of the population would not have access to many important health care services. While it is unreasonable to expect that the fix is a complete moratorium on mandated benefits, it is just as unreasonable to demand unlimited benefit mandates. Policy-makers need a process by which to achieve the delicate balance between cost and access that ensures quality health care services at affordable rates.

### **Recent Studies of Mandated Benefits Review**

Since 1997, three important studies on the cost impact of mandated benefits have been conducted in Texas: a 1998 study by the Texas Department of Insurance titled *Health Insurance Regulation in Texas, The Impact of Mandated Health Benefits*; a 1999 study commissioned by the Texas Association of Business and Chambers of Commerce conducted by two professors at Baylor University titled *Report on the Cost of Health Care System Mandates*; and a 2000 study commissioned by the Texas Legislature's Joint Committee on Mandated Benefits conducted by the firm of Milliman & Robertson titled *Cost Impact Study of Mandated Benefits in Texas*.

### ***Health Insurance Regulation in Texas, The Impact of Mandated Benefits—Texas Department of Insurance Study, 1998***

In 1998, TDI conducted a study of information relating to the cost of mandated benefit claims from most insurers in Texas. While the data is not representative of the entire insurance market in Texas, and it only analyzes data on nine mandated benefits required of 80 plans serving the greatest number of people, the findings illustrate how the utilization of mandated benefits impacts the cost of health insurance premiums.

TDI's survey shows that the cost for nine mandated benefits paid by group insurance plans subject to the same mandates was 3.25 percent of the total cost for all claims. About half of that 3.25 percent was for three types of claims: chemical dependency benefits, complications of pregnancy, and newborns with congenital defects. Seven of the benefits (mammography screening, PKU formula, oral contraceptives, handicapped dependents regardless of age, TMJ, newborns with congenital defects, and osteoporosis detection) represented claims of less than one-half of one percent of all claims. HMOs show similar costs for mandates when expressed as a total of all claims. Interestingly, TDI's study showed that the percentage cost of mandated benefit claims from all claims decreased from 5.53 percent in 1992 to 3.25 percent in 1996. Although TDI is not certain why costs decreased during this period, researchers speculate that cost-containment

measures and pre-certification procedures instituted by insurance companies could be responsible for the decline.<sup>9</sup>

***Report on the Cost of Health System Mandates—Baylor Study funded by the Texas Association of Business and Chambers of Commerce, 1999***

The 1999 *Report on the Cost of Health System Mandates* found that while cost increases for mandated benefits vary from state to state for a variety of factors, most mandates increase premium costs. The report states that the most substantial cost increases were from mandates such as the any-willing-provider mandate and mental health mandates. Specifically, any-willing-provider mandates are estimated to cause as much as a 6 to 15 percent increase in insurance premiums while mental health mandates, which include psychiatric hospital coverage, can increase premium costs by as much as 21 percent.<sup>10</sup>

According to the report, most mandated benefits increase costs to some extent, although because of the lack of accurate data the report found that it is difficult to know exactly how much. What is certain, the report concludes, is that mandates are not cost-free and there is evidence to suggest that for each increase in the marginal cost of health insurance, there is a price to pay in terms of reduced wages, benefits, and employment opportunities as employers and employees react to higher premiums for health insurance. In fact, the report concludes, “[w]here mandates have been studied, the evidence is overwhelming that the increased cost of insurance is passed on to workers through decreased wages (or, more commonly, through smaller raises than would have been the case), and/or through loss of jobs. It is also unambiguous that the percentage of uninsured rises in the state population as a response the increased costs.”<sup>11</sup>

**Joint Committee on Mandated Benefits—2000**

House Bill 1919, passed during the 76th Texas Legislature, directed the Lieutenant Governor and Speaker of the House to appoint the Joint Interim Committee on Mandated Benefits to review the following:

- the effect of mandated benefits on the cost and accessibility of health benefit coverage;
- the effect of mandated benefits on improving and maintaining the health of Texans;
- the number and percentage of residents making claims for the mandated benefits; and
- the impact and feasibility of eliminating, revising, or providing alternatives to mandated benefits.<sup>12</sup>

In 2000, the Joint Committee conducted a review of the impact of mandated benefits in preparation for the 77th Texas Legislative session in 2001. The Joint Committee commissioned a report by the actuarial firm of Milliman and Robertson, Inc., to determine the cost-impact of mandated benefits in an attempt to determine the effect of mandates on health insurance costs and employers. The Joint Committee’s recommendations are considered in the conclusion of this paper.

The Milliman & Robertson report commissioned by the Joint Interim Committee on Mandated Benefits provides more detailed data on the cost impact of mandated benefits in Texas. The report surveyed 13 specific mandated benefits to determine costs associated with a benefit and other impacts of the mandate including physical and economic consequences of not provided care and/or treatment, current and future medical cost savings that can be attributed to treatment provided as a result of the mandated benefit, the extent to which the benefit contributes to the quality of an insured's health status, current and future impact of the utilization of sick days or disability benefits attributable to the medical treatment provided as a result of the benefit, and the impact of mandated benefits on employers' ability to purchase health insurance for their employees.<sup>13</sup>

The findings of the Milliman & Robertson report include the following:

- The total premium costs for all 13 mandates studied by the report account for 7.6 percent of costs for large group insurance plans and 7.2 percent for small group premiums.
- Total premium costs for all 13 mandates are reduced to 6.5 percent of large group premiums and 6.3 percent of small group premiums when indirect costs and cost savings such as those associated with earlier detection and treatment of disease are considered.
- The health status of an insured person can be severely impaired if the insured does not have access to the services associated with 6 of the 13 mandates.
- Other costs, such as housing and family assistance and social consequences, may be associated with not providing the treatment or care associated with 6 of the 13 mandates.
- Patients are less likely to receive care or treatment for ailments associated with mandated benefits if the benefits are not covered by a plan. The financial burden on an individual for treatment offered under most of the mandated benefits is high (more than \$1,000) and the quality and cost-efficiency of the care received may be lower for 6 of the 13 mandates if the benefit is not covered under group health insurance.
- If mandates did not exist, Milliman & Robertson predicts that most large and small group plans would offer the benefits at some level, and so removing the mandates does not necessarily result in a significant savings to premium costs.
- The treatments associated with most mandated benefits are generally considered by the medical community to be efficacious.
- Insurance plans offered by self-funded employers may include some coverage for each of the mandated benefits, although sometimes at a lower level.

- The cost of mandated benefits is a consideration for self-funded employers, but in their choice to offer self-funded insurance mandated benefits are not usually the primary reason for their decision.
- Eliminating the 13 mandates studied by Milliman & Robertson would probably not have an impact on the number of uninsured.
- Small employer carriers may not be pricing the basic and catastrophic plans established by Texas law as low as the benefit differentials between the basic and catastrophic plans and other plans warrant.
- Rate differences between the basic and catastrophic plan and other market plans are due to cost-sharing differences like deductibles and do not represent the absence of mandated benefits.
- The low participation rates in the basic and catastrophic plans that have low premiums and that are required to be offered to small employers may be due to factors other than cost that may be preventing more participation.

The Milliman & Robertson study concluded that while the costs associated with mandated benefits are relatively low—less than 8 percent of total premium costs—they represent costs that “may make it more difficult for employers and employees to purchase health insurance coverage. The relative weight of the costs compared to the benefits is subject to public policy debate.”<sup>14</sup> Clearly, each mandated benefit included in the study has direct and indirect benefits to patients. And the authors’ conclusion that the cost impact has a minimal relationship to the overall cost of health insurance is difficult to contest. However, the question remains, “are mandated benefits providing the intended benefit legislators and regulators intended?” Larger employers who can afford to create ERISA plans are exempt from mandated benefits and other costly regulations, as are public health plans such as Medicare and Medicaid. The Baylor study on the impact of mandates on state health insurance markets found that the 16 states with the largest number of mandates saw a 25.6 percent increase in the number of uninsured, while the other 34 states saw a 7.3 percent increase in the number of uninsured.<sup>15</sup> If there is a correlation between mandates, cost, and increases in the uninsured, policy-makers need to determine the extent of any unintended consequence.

It is also important to note that the Milliman & Robertson study did not include some 17 other mandates required by the State of Texas, and thus the total cost impact of Texas regulations was not considered. The true cost of all of Texas’ mandated benefits are not determined by the study, and thus the full impact of mandates on affordability for health insurance is unknown. In addition, Milliman & Robertsons’ conclusion that careful review of future benefits appears to indicate that the authors agree that caution is warranted in adding additional mandates because of the potential cost impact.

Texas’ recent attempts to determine the cost impact of mandated benefits has yielded mixed results. Each study has provided information on the cost of some Texas healthcare mandates, but the lack of historical utilization data has made it difficult to determine the

true cost of mandates and the fact that only some of Texas' mandates have been studied means that the total cost picture has yet to be determined. Furthermore, while it is clear that mandates generate cost increases, the Texas studies have not attempted to quantify the positive impact of mandates in terms of the benefits of preventive health services, increased productivity, and other measures. These issues form the crux of the debate over mandates and further complicate the successful development and implementation of a review process for evaluating the costs and benefits of mandated benefits.

The following section looks at mandated benefit review processes used in other states.

## **Cost Benefit Analyses and Mandated Benefit Review Processes**

Other states have adopted policies intended to assess the costs and benefits associated with mandated benefits and report to legislative bodies before legislation is considered. Such mandatory review processes for mandated benefits come in four basic forms: independent standing health care commission or legislative advisory commission/interim committee, administrative agency, legislative research or fiscal staff, and proponents.<sup>16</sup> Standing Independent Health Care Commissions, such as the Health Care Access and Cost Commission in Maryland and the Health Care Cost Containment Council in Pennsylvania, utilize an independent body of appointed experts who review benefit proposals prior to legislative proposals to mandate benefits. At least 22 states have adopted at least one of the aforementioned policies.

### **Independent Boards or Commissions**

Four states ( Maryland, Pennsylvania, Virginia, and Texas) have, or had at one time, a mandatory review process conducted by an independent board or commission.

#### ***Maryland***

With 30 mandated benefits on the books, Maryland is the nation's leader in mandated benefits. Perhaps this is why the Maryland review process model has been cited as a potential model for Texas to consider. In an attempt to address issues of cost and access, the Maryland General Assembly gave authority to conduct mandated benefit reviews to the Health Care Access and Cost Commission in 1998. This Commission is a new and improved version of the Interdepartmental Committee on Mandated Health Insurance Benefits that was created in 1990. Authority for the committee was repealed in 1997 amidst charges that the panel was neither independent nor objective. This lack of credibility led to transferring the authority to the commission, which is also responsible for implementing Maryland's Comprehensive Standard Health Benefit Plan, a public/private partnership which offers standardized health insurance for employers and individuals in Maryland's small group insurance market.<sup>17</sup>

The commission's reviews are made each year and no proposal may be considered by the assembly until the review is submitted, usually in December of each year. The commission evaluates mandated benefit reviews based on several criteria, including a maximum ratio of the total cost of mandated health insurance services to the average state

annual wage, an evaluation of the medical and financial impacts of the proposal on consumers, providers, and third-party payors, and an evaluation of the social costs and benefits of the proposal.<sup>18</sup>

### ***Pennsylvania***

The Pennsylvania General Assembly decided in 1986 to authorize the Health Care Cost Containment Council to conduct reviews of studies and other information submitted by proponents and opponents of a proposed mandated benefit before the assembly. If the council is satisfied with the information provide by proponents and opponents, the council can choose to contract with an independent Mandated Benefit Review Panel of experts who then make a final assessment to the assembly. Only those mandates that are reviewed by the Review Panel may be considered by the assembly.<sup>19</sup>

### **Administrative Agencies**

At least eight states (Colorado, Georgia, Iowa, Kentucky, Maine, South Carolina, Wisconsin, and Virginia) have authorized state agencies to conduct mandated benefit reviews for proposed benefits. While each of the processes differs in some respects, all require mandatory review prior to consideration by their respective legislatures. The following provides examples of how two states have implemented an administrative review process.

### ***South Carolina***

The South Carolina Legislature authorized the Budget and Control Board in 1990 to prepare a fiscal impact statement for any mandated health coverage proposal. No such bill may be reported from a standing legislative committee without an impact statement.

### ***Virginia***

Virginia requires the State Corporation Commission to prepare a consolidated report from cost and utilization reports from insurance companies to the General Assembly. Like South Carolina, no legislation may be considered until the commission issues its report as required by law or commission rule.

### **Legislative Review Processes**

Legislative review processes depend on legislative staff to analyze and report to their respective legislatures on the potential impact of proposed mandates. The following are examples of how certain states have implemented such processes.

### ***Oklahoma***

The Oklahoma Legislature requires Senate and House fiscal staffs to conduct a fiscal impact study on mandated health benefits. These reports, which are required before a bill may be adopted, must also include an assessment of the social impact of the proposal based on a range of factors.

## *Nevada*

The Nevada Legislature, which enacted its mandatory review statute in 1989, used a special subcommittee composed of two members from the Senate Commerce Committee and three from the House Commerce Committee to assess the cost impact of any proposal prior to adoption of the proposal.

### **Statutory Requirements of Mandated Benefit Proponents**

Seven states (Arizona, Colorado, Florida, Kansas, Kentucky, Oregon, and Washington) have statutory requirements that proponents of legislative mandates submit supporting information to the legislative committee of jurisdiction prior to consideration. While such information is usually submitted to legislative committees anyway, the statutory element ensures participation from proponents and arguably places the burden of proof more squarely on the proponents rather than opponents.

## *Kansas*

Legislative committees in Kansas receive reports assessing both the social and financial impact of any proposed coverage by law. In addition, the Commission of Insurance is required to assist the proponents in their efforts to compile the report.

## *Arizona*

In 1985, Arizona required proponents of specific mandates to submit a report assessing both the social and financial impact of the proposed benefit before a bill may be adopted by a committee.<sup>20</sup>

While mandated benefit review processes differ from state to state, the similar elements of the various review processes suggest that many state legislatures prefer to err on the side of caution by trying to ensure some degree of credibility and quality into the review and reporting process. In all of the aforementioned methods of review, the legislature retains the authority to accept or reject the recommendations of a review, an element which protects legislative power and accountability while acknowledging the need for outside information.

When instituted, formal benefit review processes represent recognition on the part of policymakers that mandates do indeed increase costs and that costs and benefits should be carefully considered prior to adoption. Another approach that reinforces recognition of the cost impact of mandates is the creation of basic and catastrophic health insurance plans that are essentially “mandate-free” in the sense that they provide very basic services in an attempt to reduce costs.

## Getting around Mandates: Texas' Basic and Catastrophic Health Insurance Plans for Small Employers

In 1993, the Texas Legislature passed the Small Employer Health Insurance Availability Act to provide small employers with basic, low-cost health insurance plans to offer employees. Improved in 1995 and amended in 1997 to comply with Kennedy-Kassenbaum (the Health Insurance Portability and Accessibility Act of 1996), the act provides two health insurance plans for small businesses with at least two but not more than 50 employees. The Basic Plan provides coverage for the less medically needy and includes some preventive care services. The Catastrophic Plan, which offers several options of coverage, is intended to meet the needs of people with more extensive medical needs. The original intent of these plans, in part, was to provide low-cost alternatives to more expensive health insurance plans—including those subject to mandated benefits that increase the cost of health insurance. Both the basic and catastrophic plans offer the following benefits: physician or other health care provider services, hospital charges, anesthesia and its administration, outpatient services, X-ray and laboratory services, and maternity benefits. In addition, riders are available at additional cost for alcohol and drug abuse, mental health services, and prescription drugs.<sup>21</sup>

Table 10.1 illustrates the major differences in the benefits and riders of Texas' basic and catastrophic plans.

**Table 10.1. Comparison of Benefits between the Basic and Catastrophic Plans**

<b>Benefit</b>	<b>Basic</b>	<b>Catastrophic</b>
Durable Medical Equipment	\$200	no limit (if medically necessary)
Physical Therapy	30 visits	no limit (if medically necessary)
Skilled Nursing Facility	30 days	no limit (if medically necessary)
Home Health Care Services	30 days	40 days
Certain Organ Transplants	no benefit	yes
Hospice	no benefit	yes
Preventive Care Rider	yes	no benefit

Adapted from: Texas Department of Insurance, "Small Employers Health Insurance, Questions and Answers." Online. Available: <http://www.tdi.state.tx.us/consumer/cbo40.html#benefits>. Accessed: March 8, 2001.

Employers may be required to pay a portion of the premium, depending on the insurance carrier's policies. However, the law does not require employers to pay, although it is common for employers to pay a percentage of the premium cost plus deductibles and co-payments. Under the law, premiums for the state's basic and catastrophic plans are

required to meet certain rate band guidelines. Table 10.2 summarizes the deductibles, co-payments, and out-of-pocket expenses that the law requires under the basic coverage and the catastrophic coverage plans.

**Table 10.2. Comparison of Costs of Basic and Catastrophic Plans**

<b>Benefit Plan Coverages</b>	<b>Deductible</b>	<b>Plan Pays</b>	<b>Employee Co-Insurance</b>	<b>Maximum Out-of-Pocket Expenses</b>
<b>BASIC</b>	\$500	80%	20%	\$3,000
<b>CATASTROPHIC</b> <i>Option 1</i>	\$2,500	80%	20%	\$5,000
<i>Option 2</i>	\$2,500	90%	10%	\$5,000
<i>Option 3</i>	\$5,000	80%	20%	\$10,000
<i>Option 4</i>	\$5,000	90%	10%	\$10,000

Adapted from: Texas Department of Insurance, “Small Employers Health Insurance, Questions and Answers.” Online. Available: <http://www.tdi.state.tx.us/consumer/cbo40.html#benefits>. Accessed: March 8, 2001.

While the state’s basic and catastrophic health insurance plans are intended to provide small employers with low-cost alternatives to more expensive plans that may include cost-increasing benefit mandates, small employers have been reluctant to use the plans. According to some insurers, the plans are not utilized because other plans offer more coverage at competitive rates. According to some consumer advocates, although certain insurance carriers are required to offer the plans, they have little incentive to sell the plans and attempt instead to sell small employers other options. In fact, one can argue insurers do not have an incentive at all to sell the state plans if they offer other plans that are competitive yet cover more benefits. In addition, insurers have an incentive to sell plans that are the most compatible with the administrative processes they have in place. The lack of participants in the basic and catastrophic plans creates administrative inefficiencies and other difficulties for insurers, creating another disincentive for insurance companies to sell the plan. Whatever the reason for the lack of success, the plans have not been highly utilized, placing Texas in the position of having to consider ways to improve the plans and to consider other options to provide low-cost insurance for small and mid-sized employers.

### **Options for Consideration**

Texas has a variety of regulatory tools at its disposal that may be used to encourage employers and employees to purchase health insurance. Among the most popular options are those that provide a variety of means of reducing the cost of insurance, thereby making health insurance more affordable. In 2001, the Texas Legislature has several recommendations related to mandated benefits from the Joint Committee on Mandated

Benefits and the Blue Ribbon Task Force on the Uninsured that deserve careful consideration. In addition, the LBJ School of Public Affairs' Conference on the Uninsured held March 23, 2001, brought experts from across the state and nation to discuss ways to reduce the ranks of the uninsured (see Section I of this book). The following options were derived from these sources.

**Option: Establish mandated benefit review in Texas.** The Joint Committee's report made several recommendations to the 77th Texas Legislature related to addressing the impact of mandated benefits on the cost of health insurance. Those recommendations include:

- requiring the Legislative Budget Board (LBB) to conduct impact assessments for proposed mandated benefits prior to legislative committee hearings;
- using the Employee Retirement System (ERS) of Texas as a source for data for fiscal and sunset review processes for mandated benefits;
- establishing a process and scoring system for evaluating future mandates; and
- directing the Texas Department of Insurance (TDI) to determine the type of data that should be collected to effectively measure the impact of mandated benefits and describe appropriate data collection methods.<sup>22</sup>

**Option: Extend private health insurance coverage to dependents up to age 25 regardless of whether they are enrolled in higher education courses.** If required of private health insurance plans, this option recommended by the Blue Ribbon Task Force on the Uninsured could actually reduce overall costs by adding additional premium payments to cover group costs. Because young dependents have relatively low utilization rates, this addition could provide additional coverage for part of the Texas population that has high uninsurance rates while adding additional dollars to help spread risk and subsidize insureds with higher utilization rates.<sup>23</sup>

**Option: Review product designs of Texas' basic and catastrophic health insurance plans and work with insurers and agents to develop new basic and catastrophic options for small employers.** This option would build upon the research TDI is currently conducting on the product design options for affordable health insurance for small employers. By encouraging active participation by small businesses, health care consumers, insurance companies, and organizations representing consumers, insurance companies, insurance agents, and business organizations, TDI can enhance the review of Texas' unsuccessful basic and catastrophic plans and develop health insurance product options that are more attractive to small employers and their employees. In addition, TDI can ensure that the process includes plans to address incentives and disincentives for insurance agents to sell basic and catastrophic insurance plans and for insurance companies to effectively and efficiently administer such plans. The final product or product options should be agreed upon by the stakeholders and presented to the 78th Legislature in 2003 as a replacement for the existing basic and catastrophic plans.

## **Conclusions**

The aforementioned proposals are not without controversy, and adoption by the Texas Legislature will be difficult for a variety of reasons. However, installing additional informational and analytical tools deserves careful consideration. At best, a formal review process would provide accurate information that could assist legislators and policy makers in determining the cost impact of proposed mandates and more fully discuss both cost and social impacts involved. At worst, a formal review process could actually undermine the legislative process through biased and inaccurate information. Indeed, one can argue that the worst-case scenario would in fact be no different from the current process, and so the legislature would do well to err on the side of more information about mandates rather than less.

## Notes

<sup>1</sup> Stanford University, *The Increasing Problem of the Uninsured and Possible Prescriptions for Change*. Online. Available: [http://www.stanford.edu/class/e297c/poverty\\_prejudice/soc\\_sec/increasing.htm](http://www.stanford.edu/class/e297c/poverty_prejudice/soc_sec/increasing.htm). Accessed: March 5, 2001.

<sup>2</sup> J. Allen Seward and James W. Henderson, *Report on the Cost of Health Care System Mandates* (Waco, Texas.: Baylor University, January 1999), pp. 3-4.

<sup>3</sup> *Ibid.*, p. 1.

<sup>4</sup> *Ibid.*, pp. 24, 35.

<sup>5</sup> *Ibid.*, p. 43.

<sup>6</sup> Texas Department of Insurance, *Health Insurance Regulation in Texas: The Impact of Mandated Benefits; Report to the Texas Legislature* (Austin, Texas, December 1998), p. 3.

<sup>7</sup> Joint Interim Committee on Mandated Health Benefits, *Report to the Texas Legislature* (Austin, Texas, February 2000), p. 25.

<sup>8</sup> Texas Department of Insurance, *Health Insurance Regulation in Texas*, p. 3.

<sup>9</sup> *Ibid.*, pp. 34-37.

<sup>10</sup> Seward and Henderson, *Report on the Cost of Health Care System Mandates*, pp. 28-30.

<sup>11</sup> *Ibid.*, p. 27.

<sup>12</sup> Joint Interim Committee on Mandated Health Benefits, *Report to the Texas Legislature*, Forward.

<sup>13</sup> Milliman & Robertson, Inc., *Cost Impact Study of Mandated Benefits in Texas, Report # 2* (Austin, Texas, September 2000.), pp. i – iii.

<sup>14</sup> Seward and Henderson, *Report on the Cost of Health Care System Mandates*, p. iv.

<sup>15</sup> *Ibid.*, pp. 43-45.

<sup>16</sup> Daniel P. Gitterman and Robert Nordyke, *Providing Credible Information and Improving Health Insurance Regulatory Impact Analysis in California: A Report to the California Health Care Foundation* (Oakland, California, 1999), p. 6.

<sup>17</sup> *Ibid.*, pp. 7-11.

<sup>18</sup> *Ibid.*, p.10.

<sup>19</sup> Ibid., pp. 11-13

<sup>20</sup> Ibid.

<sup>21</sup> Texas Department of Insurance, *Questions and Answers for Basic and Catastrophic Health Insurance Plans for Small Employers*. Online. Available: <http://www.tdi.state.tx.us>. Accessed: March 8, 2001.

<sup>22</sup> Joint Interim Committee on Mandated Health Benefits, *Report to the Texas Legislature*, pp. 8-9.

<sup>23</sup> Texas Blue Ribbon Task Force on the Uninsured, *Report to the 77th Texas Legislature* (Austin, Texas: February 2001), p. 45.

