

House Bill 09-1143 Authorizing HMO's to Offer Limited Benefit Plans

For the Health District of Northern Larimer County Board of Directors

February 24, 2009

Bill Title:	Concerning the Authority of a Health Maintenance Organization to Offer Basic Health Services Through a Limited Benefit Plan
Issue Summary:	01/14/2009 Introduced In House - Assigned to Business Affairs and Labor 02/04/2009 House Committee on Business Affairs and Labor Refer Amended to House Committee of the Whole 02/09/2009 House Second Reading Passed with Amendments 02/10/2009 House Third Reading Passed 02/13/2009 Introduced In Senate - Assigned to Health and Human Services
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BILL SUMMARY

House Bill 2009-1143 allows health maintenance organizations to offer enrollees basic health care services through a limited benefit plan.

BACKGROUND

The cost of health insurance has grown out of reach for a growing number of Colorado workers and families. In the interest of reducing the cost of health insurance and decreasing the number of people without coverage, some employers and policymakers are turning to what have collectively been called "limited benefit plans." The term "limited benefit plan" is not defined in the bill or in statute, nor does it have a precise definition in the health policy literature, being most often used to describe plans covering less than all state-mandated benefits. However, it encompasses a diverse range of products that vary not only by the types of services they cover ("mandate-free", "mandate-limited" or "barebones" plans), but also by caps on quantity of coverage, either for certain services or on total annual claims (sometimes called "mini-medical" plans). The intent of these latter plans has been to offer a very inexpensive health care plan, with a low weekly premium, to the employee in order to provide for only basic health services, such as doctor visits, prescription drugs, and laboratory expenses. However, these plans often cap annual payouts at \$10,000 or less and provide minimum coverage for hospital and emergency care.ⁱ Some say that they should not be considered to be health insurance.

Limiting benefit mandates: Federal law has minimal benefit requirements for businesses that choose to offer health coverage but states have primary responsibility for regulating insurance. All states mandate certain benefits in the individual, small and large group markets, but they vary from as few as 10 to more than 30. Colorado law currently requires over a dozen benefits to be offered in the small and large group markets and fewer in the individual market. Colorado, along with many other states, allows insurers to offer plans with fewer mandated benefits: Insurers in the small group market are required to offer a "basic limited mandate plan" in addition to "basic" and "standard" plans. This stripped down plan may omit coverage for mammography, non-biologically-based mental illness, offers of hospice and alcoholism coverage, prostate cancer screening and general anesthesia or hospitalization for dental procedures for dependent children. Studies in other states have documented that mandate-limited plans do not substantially lower premiums and have not attracted consumers.ⁱⁱⁱⁱ

Caps on coverage: In Colorado, health insurance mandates do not restrict insurers from offering indemnity or PPO "mini-medical" policies with limits on annual claims. However, health maintenance organizations are prohibited from limiting coverage in this way, a restriction that this bill has been drafted, at least in part, to address.

In the last few years, over a dozen states have passed laws to allow limited benefit plans into the individual and small group markets in an attempt to make health insurance more affordable. Most have been laws allowing policies to be sold without mandated benefits, but some have prescribed caps on benefits and other restrictions.^{iv} Examples include: Florida, where the Health Flex Plan may be offered by HMOs and PPOs with caps on claims paid in areas with a high uninsured

rate; Montana, whose limited benefit plan does not cover in-patient care; and New Jersey where an individual market limited benefit plan is allowed with quantity limits on most services. Because most large employers are self-insured and therefore not subject to state insurance regulation, limited benefit plans have been offered by large self-insured companies for over a decade, many of them in the service sector (Walmart, Circle-K, McDonalds, Target, Lowe's) for their hourly and part-time workers. Enrollments have typically been low (10% to 30% of eligibles) and health insurers have been resistant to offer them, but interest is increasing in this economic climate.

The value of these plans as a strategy to reduce the number of uninsured is unresolved. It is unclear whether these plans create a new alternative for those without coverage, or simply crowd out those who previously had comprehensive coverage.^v

Even as this bill is being considered, a much more comprehensive analysis is about to be presented to legislators. Centennial Choices, Senate Bill 2008-217, passed in the last legislative session in Colorado, called for insurers and other interested parties to submit proposals for providing affordable low-cost, high-value plans to supplement the insurance products currently being marketed in Colorado. The results of this planning and Requests for Proposals process is scheduled to be presented to the General Assembly on March 15, 2009.

WHY IS THIS ISSUE IMPORTANT?

Currently, there are about 800,000 uninsured Coloradans and that number is expected to increase in the economic downturn. Cost of health insurance is the number one reason employers drop coverage, employees decline it and individuals elect to go uncovered.

REASONS TO SUPPORT BILL:

- Supporters argue that the low premiums for such plans will persuade many uninsured Coloradans to buy into the health care system instead of foregoing coverage. According to the sponsor, "This is not perfect insurance, but something is better than nothing."^{vi}
- Some believe that comprehensive healthcare reform is unlikely to happen in the current economic climate. HMO-based limited benefit plans provide a foundation which could allow for future expansions.
- These plans are intended to compete with current limited benefit indemnity health insurance. Compared with such coverage, HMO plans will offer all the benefits of managed care. Owing to lower cost-sharing for preventive services and chronic care management, they will foster utilization of services that consumers, especially lower income consumers, typically under-use even though they provide extensive social benefits. Given that HMOs generally offer lower premiums than non-HMO plans for the same benefits, these plans may also be less expensive than comparable indemnity policies.
- Unlike mandate-limited basic benefit plans and high deductible health plans, two other health insurance options to reduce premium costs, HMO limited benefit plans could provide front-end coverage for services designed to keep people healthy. Sponsors say this bill is designed to boost the number of low-cost plans that would cover basic medical care, such as checkups and prescription drugs. Low-wage workers are more interested in policies that cover basic expenses as opposed to low-cost policies that cover only catastrophic costs.^{vii}
- Only a small proportion of enrollees have expenses that exceed the annual limits typically found in limited benefit plans.
- Supporters argue that informed and price-conscious consumers in the private insurance market should have the opportunity to make individual choices representing their values and preferences. There is a gap in the current private market for inexpensive policies with coverage for routine care and prevention.

REASONS TO OPPOSE BILL:

- There are many unknowns: The nature of the products that will be offered and the potential reductions in premiums is unknown; likewise, potential marketplace demand for product is unknown. Consumers have generally not purchased limited benefit plans in states with enabling statutes or in large self-insured companies that have offered them. The size of the marketplace will drive the cost to offer the products—low demand will drive high administrative costs.

- This bill is being considered prematurely and without the information on plans, types of limited benefit packages that insurers intend to offer and estimated premium savings that will be released by the SB 08-217 RFP process.
- Lower cost plans are already available in the Colorado market: limited mandate basic benefit plans, with or without high deductibles and health savings accounts, as well as plans with caps on annual claims are potentially available in all markets.
- Medical debt accounts for half of all personal bankruptcies in the U.S. Limited benefit plans leave enrollees unprotected against catastrophic losses, which, particularly in the case of lower income consumers, may lead to deep and long-term medical debt and bankruptcy. House Democrats argued on the floor that such plans typically have low caps -- around \$50,000 -- which wouldn't cover any serious long-term illnesses or injuries. They expressed the worry that people will sign up because of the lower cost, without realizing they wouldn't be fully covered for catastrophic injuries or illnesses. A requirement for clear (bold, 14 pt. font) disclosure of the limitations of coverage in all printed materials distributed to prospective enrollees was added in a House amendment.
- Even with full disclosure of the annual total maximum benefit amount, consumers may lack the information to be able to make an informed decision. Consumers would need to be familiar with both their personal risk of catastrophic injury or illness as well as the potential costs of care for these conditions in order to assess their level of exposure in the limited benefit plan—even then, they may not understand their risk. Some insurers have been reluctant to sell limited benefit plans over concerns that consumers would not understand what they were getting.^{viii}
- Some have argued that limited benefit plans, even if they are not subsidized by public dollars, may nevertheless lead to increases in public expenditures. People whose medical costs exceed the annual limit may seek further care from public facilities or receive uncompensated care the costs of which are passed on to others in the form of higher premiums. (This only holds if one compares these people to those with comprehensive coverage as opposed to those with no insurance).
- Limited benefit plans may erode current, more comprehensive coverage in the state. Their availability may create an incentive for employers to switch to a policy with less coverage. This may be particularly true if limited benefit designs are offered by HMOs with front-end coverage for primary care and preventive services at much lower cost. Following the introduction of a limited benefit plan in Texas in 2006, only 11% of enrollees were previously uninsured.^{ix} Some other states have stipulated that these products can only be offered to those without any insurance coverage to reduce crowd-out.
- These products would be more likely to attract the healthiest consumers, leading to market destabilization and adverse selection for other forms of insurance.
- Like other forms of excessive consumer cost-sharing, benefit maximums transfer financial responsibility from the healthy to the sick and reduce the social pooling of risk. (Relative to limited benefit indemnity insurance, however, HMO type limited benefit plans improve efficiency by covering preventive and chronic care services more generously than acute and episodic care services).
- For those who support the consumer driven framework, this product is particularly inefficient. The narrow provider network of HMO plans limits providers ability to compete broadly on the basis of price and quality, and the front-loaded benefit structure reduces consumer choice at the margin where they can exercise it most—when they are healthy. The general principle that cost sharing should be fostered most extensively for services that are discretionary and sensitive to patient's preferences and minimized for services that are nondiscretionary is turned on its head.

WAYS TO IMPROVE THE BILL

A definition of what “limited-benefit plan” entails is critical to being able to assess the impact of this bill. A definition has been submitted to the sponsors in the Senate Health Committee by representatives of Colorado’s health plans for consideration. Under their definition, these plans would cover basic health care and state-mandated benefits, but would use annual benefit caps to bring the premium costs down.^x

DEFINITIONS FROM COLORADO REVISED STATUTES

CRS 10-16-102 (23) "*Health maintenance organization*" means any person who: (a) Provides, either directly or through contractual or other arrangements with others, health care services to enrollees; and (b) Provides, either directly or through contractual or other arrangements with other persons, health care services, including as a minimum, but not limited to, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services; and (c) Is responsible for the availability, accessibility, and quality of the health care services provided or arranged.

CRS 10-16-102 (5) "*Basic health care services*" means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including as a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.

CRS 10-16-402 (2) (c) (I) The health maintenance organization will effectively provide or arrange for the provision of basic health care services, through insurance or otherwise, except to the extent of reasonable requirements for copayments, deductibles, and payments for out-of-network services received pursuant to section 10-16-704 (2).

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. Analyses are based on bills or issues at the time of their consideration by the Board and are accurate to the best of staff knowledge. It is suggested that people check to see that a bill has not changed during the course of a legislative session by visiting the Colorado General Assembly web page at www.state.co.us/gov_dir/stateleg.html. To see whether the Health District Board of Directors took a position on this or other policy issues, please visit www.healthdistrict.org/policy.

About the Health District

The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves.

For more information about this analysis or the Health District, please contact Carrie Cortiglio, Policy Coordinator, at (970) 224-5209, or e-mail at ccortiglio@healthdistrict.org

ⁱ Fuhrmans, Vanessa, More Employers Try Limited Health Plans, Wall Street Journal, 17 January 2006, D1-3.

ⁱⁱ General Accounting Office, Private Health Insurance: Federal and State Requirements Affecting Coverage by Small Businesses, September 2003. Additional costs due to state required mandates added 3-5% to the total premium in two states.

ⁱⁱⁱ Congressional Budget Office, Increasing Small-Firm Health Insurance Coverage through Association Health Plans and HealthMarts (Washington: CBO, January 2000; Government Accountability Office, Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses (Washington: GAO, September 2003). By excluding the following mandates: alcoholism treatment, drug abuse treatment, mental health treatment, chiropractor services, and continuation of coverage, premiums decreased by .28 to 1.15%..

^{iv} Robert Wood Johnson Foundation. State Coverage Initiatives. Limited benefit plans accessed on 2/17/2009 at http://www.statecoverage.org/node/47/cs_states.

^v General Accounting Office, 2003.

^{vi} "Bipartisan bill would allow HMOs to offer limited health insurance plans." The Gazette, Colorado Springs, Colorado, February 10, 2009.

^{vii} Fuhrmans, 2006.

^{viii} Limited benefit plans: Expanding coverage or holding your state back? Families USA Issue Brief, October 2008.

^{ix} Mandate-lite plans, the Texas Experience. Presentation at Families USA 2009. Center for Public Policy Priorities. Austin, TX, 2009.

^x Personal communication, Jerry McElroy, Director of Government Relations, Kaiser Permanente, 2/18/2008.