TAHP
The Texas Association of Health Plans

Texas Association of Health Plans
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September 21, 2023

Texas Department of Insurance,

As the statewide trade association representing health insurers, HMOs, Medicaid managed care, and other health plans that serve over 20 million Texans, the Texas Association of Health Plans (TAHP) is committed to ensuring that Texas families and employers have access to affordable, comprehensive, and high-quality coverage. Thank you for this opportunity to provide feedback on HB 290, 88th Legislative Session. This bill impacts self-funded MEWA plans, and specifically bona fide association plans. Generally speaking, our recommendation is to treat these plans in the same manner as fully funded MEWAs to maximize consistency and ensure a level playing field across plan types.

1. What clarifications or distinctions, if any, should TDI consider when implementing HB 290 concerning the definition of "health benefit plan" under Texas Insurance Code (TIC) §846.001(3) and "comprehensive health benefit plan"?

Typically, "comprehensive coverage" is used colloquially to refer to major medical insurance. We feel that the proposal in question two, aligning the definition of "comprehensive health benefit plan" with federal law, is appropriate. The definition should incorporate the meaning of "health benefit plan" and the associated exclusions in Chapter 846.

In addition, we believe there should be mandatory disclosures required for MEWAs that clearly show whether the plan offered is comprehensive or not comprehensive and the impact of that distinction. For example, proposed rules could track similar disclosures for short term plans in Texas contained in Texas Insurance Code 1509.002, sections (4) through (7), around preexisting condition exclusions, cost sharing, and covered essential benefits.

2. TDI is considering defining "comprehensive health benefit plan" to align with current federal and state law, such that comprehensive coverage is a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness. This definition would incorporate the meaning of "health benefit plan" and the associated exclusions under TIC Chapter 846. How should TDI define "comprehensive health benefit plan"?

We agree with aligning the definition of "comprehensive health benefit plan" with current federal and state law. Consistency across federal and state regulations will minimize confusion and

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inconsistency. We also agree that the associated exclusions under Chapter 845 should be incorporated in the definition. We believe a healthy market is one with a level competitive playing field; any requirements for MEWA should be as consistent as possible with requirements for fully insured health benefit plans under current statutory requirements.

3. What are the potential costs and benefits to your organization of pursuing the expanded MEWA path provided in HB 290?

N/A

4. What criteria should TDI consider when determining whether a MEWA that provides a comprehensive health benefit plan is structured like a Preferred Provider Benefit Plan or Exclusive Provider Benefit Plan?

In this context, we believe that the key factor that should be used when determining whether a MEWA is structured like a PPO or EPO is whether it has a network of providers. Having a network of providers differentiates PPO and EPO plans from standard indemnity plans, and we believe this is what the legislature meant when mentioning their structure in statute. Other factors that should be considered in the determination is whether the MEWA provides out-of-network benefits, at least relating to emergency care and facility-based providers. Likewise, different cost-sharing structures for in- and out-of-network services would indicate that a MEWA is structured like an EPO or PPO.

We believe this interpretation also aligns with the remainder of the statute. Section 846.0035(c), Insurance Code, as added by HB 290, requires MEWAs that are structured as EPOs or PPOs to comply with Chapters 1301 and 1467 of the Insurance Code. Chapter 1301 is the EPO and PPO chapter, but a significant portion of that chapter, especially after the passage of HB 3359, is related to network structure and adequacy. Chapter 1467 is the state balance billing law, and specifically addresses out-of-network claim dispute resolution. Thus, for the applicability sections to make sense in the context of a MEWA, there would need to be some sort of established network and set network benefits in the plan.

5. What general documentation should a MEWA be required to provide to demonstrate compliance with applicable state and federal laws?

If a MEWA is a "comprehensive health benefit plan," then they should be required to demonstrate compliance with Chapters 421 and 422, Subchapters C, F, and K of Chapter 1451,

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and Chapter 4201 just as any other major medical plan would. In particular, Chapter 4201 places a significant number of restrictions on plans that should be carried over to MEWAs that provide comprehensive health benefit plans, and the MEWAs should be able to prove compliance.

If a MEWA is structured as an EPO or PPO, they should also be required demonstrate network adequacy, as any other EPO or PPO does. If their networks are inadequate, then they should be required to seek a waiver and go through the processes established in the last legislative session by HB 3359. Similarly, any documents that the agency requires to prove compliance with Chapter 1467 should also be required of MEWAs structured as an EPO or PPO. Maintaining the same standards for health plans and similarly situated MEWAs would carry out the intent of HB 290 and ensure that enrollees are treated fairly when they enroll in these plans.

6. What specific documentation should a MEWA be required to provide to demonstrate compliance with applicable state and federal laws when the MEWA qualifies as an ERISA single-employer employee welfare benefit plan? In other words, the MEWA qualifies as a bona fide employer group or association under ERISA. TDI is considering requiring documentation similar to the requirements in 28 TAC §26.301(g).

We agree that requiring similar documentation to 28 TAC §26.301(g) would be fair. If a MEWA qualifies as a bona fide employer group or association under ERISA, then they should be treated in the same way as a fully funded bona fide association. This would provide consistency across similar MEWA plans. If a MEWA will be aggregating lives, regardless of whether it is fully funded or ERISA, they should be required to comply with §26.3019(g), including subdivision (g)(2).

7. What specific documentation should a MEWA be required to provide to demonstrate compliance with applicable state and federal laws when the MEWA does *not* qualify as an ERISA single-employer employee welfare benefit plan?

HB 290 amended Section 846.052 to require applicants to demonstrate compliance with federal and state laws, rather than include a statement showing compliance with ERISA. We believe that the best way for such a plan to demonstrate compliance would be to require something similar to what is required for bona fide employer group plans, at §26.301(g)(2)(B). That subdivision requires an opinion from an attorney attesting to the fact that an employer group or association qualifies, an explanation of how the arrangement meets all the criteria, and explicit references to relevant language in organizational documents. Likewise, for MEWAs that do not qualify to

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prove that they otherwise comply with federal and state law, the agency should require an opinion from an attorney attesting to compliance with sufficient documentation to prove compliance.

8. For a MEWA that currently holds an initial or final certificate of authority under TIC Chapter 846, how should it elect to be bound by the provisions of TIC §846.0035 as added by HB 290?

We are not very concerned with how a plan will elect to be bound by those provisions, although assumedly some kind of formal letter would be appropriate. More importantly, we ask that the agency require these plans to prove compliance in the same ways that a MEWA that has a structure like an EPO or PPO would. In other words, we ask that the agency require the same submissions that we included in question four.

9. What other criteria or suggestions should TDI consider when implementing HB 290?

HB 290 added Subsection (d-1) to Section 846.053. The subsection allows working owners of businesses without employers to qualify as both an employer and employee, and it provides a definition of working owners. In subdivision (3), the bill requires that the working owner works on average at least 20 hours per week or 80 hours per month. It should be noted that there have been issues on the federal level relating to Data Marketing Partnership, LP, which allows individuals to download an app that tracks their phone usage, then allows those persons to be treated as "partners" in their business. This exploitation of federal MEWA law has led to what is effectively an individual market. We ask that the agency address this by either expressly prohibiting this type of "passive employment" or otherwise stating that the 20 hours required in statute must be 20 hours of undivided attention to the services being provided by the business.

Sincerely,

Jamie Dudensing, RN
CEO
Texas Association of Health Plans