HB 1592
HIGHER DEDUCTIBLES AND MORE GATEKEEPERS
COSTLY FOR CONSUMERS

HB 1592, sponsored by Rep. Gosen (R-Ballwin), creates hassles and higher costs for consumers. It allows HMOs to charge high deductibles and copays, and permits Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) to require people to get a referral from a primary care provider before they can see a specialist.

- **HB 1592 takes away consumers’ “full freedom of choice”** to go to any doctor, specialist, pharmacy or dentist within their health plan network. It allows insurance companies to impose gatekeepers, requiring a patient to get a referral from their primary care provider to see a specialist.

  - Two provisions of the bill address gatekeepers and freedom of choice.
    - 375.936(19) allows group EPO plans to impose gatekeepers.
    - 375.936(11)(b) says that “health carriers offering” group EPO plans are not subject to “full freedom of choice.”
      - This seems to mean that any health insurance carrier that offers even one EPO plan would be exempt from “full freedom of choice” and able to impose gatekeepers for all its individual, small and large group plans, including PPOs.

- **Gatekeeper requirements create unnecessary paper work and delay for consumers and providers.** Insurance companies have newer and better approaches to improving quality and controlling costs, and should not fall back on old, discredited, and unfriendly gatekeeper requirements.
- Presently, only HMOs may require gatekeepers. PPOs, EPOs and other types of plans may not require gatekeepers.
- **Permitting EPOs to impose gatekeeper requirements will allow carriers to offer HMO-like plans that lack HMO consumer protections.**
  - EPOs are a new form of closed network plan created by SB 262 in 2013.
  - EPOs now account for 40% of the plans offered on the Health Insurance Marketplace, and are also being sold in the group market.
  - EPOs, like HMOs, pay only for care provided by an in-network provider except in case of emergency and 2 mental health visits.
  - HMOs provide better consumer protections:
    - HMOs also pay for out-of-network care when there is no provider in network.
    - HMOs are held to specific network adequacy standards that seek to assure that patients can find a doctor, hospital, mental health provider and pharmacy close by so they don't have to travel long distances or wait too long to see a doctor.

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• HB 1592 allows HMOs to charge high deductibles and copays of more than 50% of the cost of the service.
  
  • Presently, HMOs may only charge a deductible if the consumer has a fully funded Health Savings Account (HSA) that will cover the maximum out of pocket costs for the health plan. (354.415.1(7))
  
  • HB 1592 would allow HMOs to charge deductibles of up to $6,850 for individual coverage and $13,700 for a family plan in 2016, the maximum amount allowed by federal law. (354.415.1(7)).
  
  • According to a recent Kaiser Family Foundation survey, high deductibles and cost sharing are the major drivers of medical bill payment problems for those with insurance.
  
  • Missouri consumers need the option of a health plan with a low deductible and low cost sharing. Since non-HMO plans can already charge high deductibles and cost sharing, HMOs should remain the low cost sharing, low deductible option.
  
• If HMOs are allowed to offer plans with high deductibles or copayments, the following language should be added to the bill providing that certain routine services are exempt from the deductible. This language is consistent with proposed federal standards for plans offered in the Marketplace in 2017 and should apply to plans offered both on and off the Marketplace in both the individual and group markets.
  
  • A health maintenance organization offering one or more health benefit plans that includes deductibles, coinsurance, coinsurance differential or variable copayments as authorized by this section must also offer at least
    (1) one bronze plan, as set forth in 42 U.S.C. Section18022(d), for which the following routine services are exempt from deductible: three primary care visits, mental health/substance use disorder outpatient services, and generic drugs;
    (2) one silver plan and one gold plan, as set forth in 42 U.S.C. Section 18022(d), with a premium for which the following routine services are exempt for the deductible: primary care visits, specialist visits, mental health/substance use disorder outpatient services, drugs
    (3) one platinum plan, as set forth in 42 U.S.C. Section 18022(d).

Links to the bills as introduced:

HB 1592 (high deductibles) and HB 2061 (high deductibles and gatekeepers).
At the hearing on HB 1592 before the House Health Insurance Committee on January 20, Rep. Gosen indicated that he would merge HB 1592 and SB 2061 together into a substitute HB 1592. The substitute is not yet available online.

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