SUBJECT: Provider participation in managed care health benefit plans

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Duncan, Averitt, Counts, De La Garza, Driver, Dutton, G. Lewis, Shields

0 nays

WITNESSES: For — Lisa McGiffert, Consumers Union; Joe DaSilva, Texas Hospital Association; 11 people representing physicians and physician organizations; Stephen Yelenosky, Advocacy, Inc; Nancy Epstein, Disability Policy Consortium; Susan Speight, Texas Association of Marriage and Family Therapy; Thomas M. Kozak, Ph.D., Texas Psychological Association; James Willmann, Texas Nurses Association; John S. Findley, Texas Dental Association; six people representing themselves

Against — Ted B. Roberts, Texas Association of Business and Chambers of Commerce; Lane A. Zivley, Texas Public Employees Association; Ed Baxter, Blue Cross/Blue Shield; Kenneth Tooley, Gordon Richardson, Texas Association of Life Underwriters; Geoff Wurzel, Gary Downey, Jeff Kloster, Texas HMO Association; Tammy Cotton, Bud Schaurte, Texas Citizens for a Sound Economy; Will Davis, Texas Life Reserve Officials Association; David Pinkus, Small Business United; Janet Stokes, Texas Association of Life Underwriters

On — Leah Rummel, Texas Department of Insurance; Eileen M. Campbell, Marathon Oil Company; Sabrina Foster, City of Houston; William Phillips, John Kajander, John Rodrigue, Texas Business Group on Health; Dr. Charles Balch, M.D. Anderson Cancer Center.

DIGEST: CSHB 2766 would add to the Insurance Code a Patient Protection Act that would include requirements for managed care health plans governing prospective enrollees, physician and dentist participation and contract termination, and would create penalties and remedies for violations of the act. The act would take effect June 1, 1996.

Enrollee information. Prospective enrollees would have to be provided certain information regarding the terms and the conditions of a plan, including:

• benefits including drug coverage and any exclusions by category of service, provider or physician;
• all authorization requirements, including preauthorization review, concurrent review, postservice review and postpayment review;
• explanation of enrollee coinsurance or out-of-plan payment responsibilities;
• disclosure that enrollees have the right to information about financial arrangements between providers and the plan, plan enrollment size, administrative costs and profit and other information and
• a phone number and address for requests for additional information.

Provider participation. Managed care plans would be required to allow physician and dentist advice on medical or dental coverage of new technology and procedures, the development and utilization of prescription drug formulary, utilization review and other procedures.

Providers would have access to application process and qualification requirements for provider participation in the plan. Each plan would be required to credential physicians and dentists based on identified standards and criteria made available to applicants. Economic profiles of physicians or dentists would be required to be adjusted to reflect characteristics of the practice that could account for variations from expected costs. Economic profiles would be required to be provided to plan physicians and dentists on a periodic basis.

Each dentist or physician not selected for the plan would be given reasons for non-selection, credentialing denial or contract nonrenewal. Plans could not exclude physicians or dentists solely on the basis of specialty practice or anticipated patient characteristics.

Contract termination. Prior to contract termination a physician or dentist would be required to be provided a written explanation of the reasons for termination, and to be given opportunity for discussion and to enter into a corrective action plan. A physician or dentist would be entitled to review

by a plan advisory panel except in cases in which there is imminent patient harm, fraud or action by a state regulating agency.

If the action under consideration is of the type to be reported to the National Practitioner Data Bank or state medical board the physician's procedural rights must meet certain federal standards.

When contracts are terminated the plan would be required to reimburse the physician or dentist the reasonable cost for copies of medical or dental records requested by the patient to be provided to another physician or dentist, except in cases in which the contract is terminated by the physician or dentist.

The plan would be required to establish reasonable procedures for assuring a transition of enrollees to new physicians and dentists.

Other plan requirements. A managed care plan would be required to provide to the commissioner of insurance an explanation of the targeted physician or dentist network distribution by geographic location and specialty and provider to patient ratio. The information would be required to be filed upon the establishment of a new plan or expansion and modification of an existing plan.

A plan would be required to accept Medicare certification or Joint Commission on Accreditation of Health Care Organization accreditation for hospital participation.

Plans would be required to cover emergency care services and emergency medical screening examinations to covered individuals without regard to whether or not the provider has a contractual arrangement with the plan. Medically necessary services stemming from the treatment of an emergency medical condition would be deemed approved unless denied in a time period appropriate to the delivery of care.

A financial incentive program could not limit medically necessary and appropriate services. HMOs would be subject to utilization review requirements as required for other insurers and subject to maintenance tax requirements to cover the administrative costs of compliance.

Violations. The commissioner after notice and hearing could impose sanctions available under Insurance Code, art. 1.10, including cancelling or revoking any permit, license, certificate of authority and issuing a cease and desist order.

The act would not provide a private cause of action for damages or create a standard of care, obligation or duty or abrogate any statutory or common law cause of action, remedy or defense.

A provider aggrieved by action of the plan could petition the commissioner for relief within 30 days of the action. The commissioner could deny the petition, issue a cease and desist order or decide to conduct a contested case hearing in accordance with the Administrative Procedures Act.

SUPPORTERS SAY:

CSHB 2766 would supply the additional regulation needed to ensure in a growing market of managed care organizations and enrollees that patient access to appropriate care is protected, that physician-patient relationships are safeguarded, that consumers have necessary information to choose the health maintenance organization (HMO) plan that best meets their needs, that physicians and dentists participate in HMO medical policies and receive due process during plan application and contract termination processes. CSHB 2766 would *not* force HMOs to contract with "any willing provider" or significantly increase health care costs.

CSHB 2766 would provide consumers necessary benefit, exclusions and other information prior to enrolling in an HMO. It also would inform consumers of the right to other information not previously disclosed. Existing law makes this kind of information available only after a person enrolls in a plan, leaving consumers unable to adequately compare health benefit plan options being offered by their employer or by a spouse’s employer.

Access to necessary care would be improved by provisions relating to emergency medical situations. CSHB 2766 would address a common situation in which people seek emergency care because they believe they are experiencing a life-threatening condition (such as chest pains) and after evaluation by emergency staff, find that the condition is not serious. Managed care plans usually do not pay for that evaluation and patients are

then penalized for seeking care. CSHB 2766 would also improve access to emergency care by requiring plans to pay for care rendered by a provider who does not contract with the plan and by allowing the physician to determine what is the appropriate amount of time a patient could wait for prior authorization for services.

Patient access to appropriate care would also be ensured by utilization review requirements and other provisions. Utilization review provisions would help establish minimum guidelines for appeals of denial of medically necessary services. Due process requirements for contract termination would prevent plans from refusing to renew contracts with doctors who have a high percentage of very sick patients or other reasons not related to quality of care. Longstanding patient-doctor medical relationships would be safeguarded and, should a doctor be dropped from the plan, record copying costs and patient transition to another doctor would be provided for.

CSHB 2766 would make the application and renewal process more open and fair for physicians and dentists. It singles out physicians and dentists for this special treatment because they are the primary providers of patient care and develop intimate knowledge of their patient's health and lifestyles. Allowing other providers similar rights to advice on policy guidelines and contracting-related processes would significantly increase the cost of health benefits. CSHB 2766 would also provide doctors and dentists the information they need to fully assess the responsibilities and duties they would be agreeing to by contracting with a plan.

CSHB 2766 does not include a "point of service" (POS) mandate and therefore it would contain costs. Point of service plans provide reimbursement for services rendered by an out-of-network provider and significantly increase the employer and employee costs of HMO coverage. They could also further increase costs to patients with POS coverage whose doctors refer to out-of-network providers to keep their in-network referrals low (and to thus benefit from any financial bonuses or other incentives to keep HMO costs low).

OPPONENTS SAY:

CSHB 2766 would raise the cost of doing business and the price of managed care coverage. It would also enact unprecedented contract protection provisions and prior-authorization provisions could invite doctor

abuse of the system. The Mandated Benefits Review Panel reviewed this bill and recommended the appointment of an interim task force because the provisions in this bill are complex and far-reaching. (The review panel was implemented by HB 2055 by Martin last session and is charged with reporting the affect of proposed legislation on the cost, necessity and cost-effectiveness of mandated benefits.)

Disclosure requirements, contract processing requirements and provider participation requirements in the development of policy would increase a managed care plan's administrative costs. Disclosure requirements would also increase administrative costs for large businesses that offer several plans and develop their own employee information manuals.

The fiscal note to the committee substitute estimates that the Texas Department of Insurance will need about an additional $2 million in the next biennium for rule adoption and enforcement, and $800,000 for each year thereafter. Estimates provided by the University of Texas and A&M systems run from $4 million to $12 million. The Employee Retirement System anticipates increased costs of $7 million to 10 million.

Allowing doctors to determine what is an appropriate length of time to wait for pre-authorization for medical services could prompt some doctors to forego pre-authorization altogether or reduce to an impossibly low time period the plan's opportunity to respond. Many delays are caused by the doctors or hospitals themselves when they call the primary care provider instead of the plan. Pre-authorization is an effective, commonly-used method by insurers and managed care plans to pay for medically necessary services only.

The contract termination processes in CSHB 2766 are unprecedented in contract law and unnecessary. In 1994 HMOs terminated the contracts of less than one percent of all doctor contracts. Doctors do not have to be harmful to be poor doctors with sloppy practices and poor patient relationships. CSHB 2766 would reduce a managed care plan's right to hire and fire and to make decisions in the best interest of the company — a tradition fiercely guarded by most businesses in Texas.

OTHER OPPONENTS SAY:

CSHB 2766 would not go far enough to protect and assist consumers and providers. Plan information and provider participation requirements need improvement. The bill may affect only about 12 percent of the managed care market (HMOs); many managed care plans would not be regulated by this bill, such as preferred provider organizations, and the extent to which this bill would affect self-funded managed care plans is unknown.

Managed care plans should be required to be disclosed to consumers in a standardized format with standardized definitions of terms to assist in consumers in plan comparisons. "Prospective enrollee" should be redefined in the bill to include individuals seeking coverage information outside of employment. Some managed care plans offer individual, in addition to group coverage, policies however CSHB 2766 refers only to employer-provided managed care plans. Consumers should also have access to explanations of the financial arrangements between providers and the plan to better prevent situations in which doctors withhold treatment or referrals to profit from any financial incentives.

Consumers should have an established complaint processing and investigation process, similar to the process established in the bill for aggrieved doctors. Most licensing agencies have an 800 telephone number and system established in statute regarding consumer complaint processing. The commissioner also should set standards governing the transition process from one doctor to another when a patient loses a doctor through contract termination.

Providers and consumers could benefit from some sort of point of service requirement. A required offering instead of a mandated providing would not increase health benefit costs on all employers or employees — only for those who elect to purchase the option. A point of service option will ensure that patients have access to a wide selection of doctors and that doctors would not be "closed out" from treating patients enrolled by their employer in a managed care plan.

Other providers, such as chiropractors, podiatrists and pharmacists, should be given the same due process and participation rights as dentists and physicians.

NOTES:

The original version contained provisions removed or altered by the committee substitute relating to:

- managed care plan certification by the commissioner of insurance;
- standardized formats for the disclosure of consumer information;
- access to specialized treatment expertise through contracts with centers of excellence — specialized health facilities designated by the commissioner;
- a direct prohibition from discriminating against enrollees with expensive medical conditions;
- all application or contract decisions being made on the record and available to providers;
- requiring the commissioner to establish a due process appeal mechanism for providers and
- requiring the offering of a point of service contract.