SUBJECT: Establishing integrated health plans

COMMITTEE: Insurance — committee substitute recommended

VOTE: 6 ayes — Smithee, Van de Putte, Averitt, Bonnen, Eiland, Wise

0 nays

2 present, not voting — Burnam, Olivo

1 absent — G. Lewis

WITNESSES: For — Henry Eckert, John Montgomery, Dave Morehead and Jim Rohack, Scott and White Health Plan

Against — Don Gessler and Jeff Kloster, PCA Health Plan of Texas; Lisa McGiffert, Consumers Union

On — Rhonda Myron, Texas Department of Insurance

BACKGROUND: Health maintenance organizations (HMOs) are governed under the Insurance Code, Chapter 20A. As of May 7, 1997, Texas had about 70 licensed HMOs.

Group model health maintenance organizations contract only with a selected provider group, in contrast to the more prevalent network or mixed model HMOs that contract with several provider groups and with individual physicians. There are two recognized group model HMOs in Texas: the Scott and White Health plan in Temple and the Kaiser-Permanente HMO in Dallas.

DIGEST: CSHB 2058 would create a new Chapter 20B of the Insurance Code to establish and regulate integrated health care plans, defined as nonprofit group model health maintenance organizations that meet other specified requirements.

Integrated health plans (IHPs) would be exempt from many insurance laws, but would be subject to applicable insurance and HMO laws as they existed

on January 15, 1997. Integrated health plans that complied with specified medical necessity requirements would not be liable for personal injury, property damage or death arising as a result of the plan's decision to cover or not cover a treatment.

The bill would take effect September 1, 1997.

Certification. An IHP would have to be a full service nonprofit HMO, accredited by the National Committee on Quality Assurance and meeting other specified certification requirements. It would have to provide a majority of its professional medical services through a single group medical practice. No individual or other person could own an interest in a plan.

"Group medical practice" would be defined as a group composed of physicians and other providers as salaried employees or affiliates, with a physician as its chief executive officer that voluntarily supported medical education and research through a formal affiliation with a medical school and provided a majority of the medical services rendered to a plan's members.

The bill also would include provisions relating to certificate revocation and compliance with quality of care and complaint standards.

Plan description. Over a three-year period, IHPs would have to spend an average of at least 85 percent of the revenue received from its members (enrollees) on the provision of member services. Plans could not contain incentives or rewards for denying or limiting necessary care.

Retained earnings would have to be used to serve the plan's health care purposes, meet its financial obligation, and provide benefits to the community at large or support medical education or research. A plan's total net worth would be considered adequate if its average net worth has been at least $10 million.

The bill would specify provider application and credentialing procedures; rights of providers to discuss treatment options with patients; marketing requirements; quality improvement program requirements; service delivery requirements, including payment for emergency services rendered outside of

the group practice; grievance procedures; direct access to specialty care for members who have chronic disabling or life-threatening medical conditions; solvency protection programs; utilization management; procedures for treatment denial and medical necessity determinations.

Liability. IHPs that complied with specified medical necessity requirements would not be liable for personal injury, property damage or death arising as a result of a decision to cover or not cover a treatment.

An IHP also would not be liable for personal injury, property damage or death arising as a result of the decision by the plan to cover or not cover a treatment, if a member or the member's provider failed to request approval from the plan for treatment until after treatment was performed.

An IHP and the group practice could indemnify each other with respect to a negligent act or omission, and the plan could not require any provider not affiliated with the group practice to indemnify the plan for its negligent act or omission.

Applicable laws. An IHP would be subject only to specified laws as those laws existed on January 15, 1997, except for amendments that were specifically applicable to IHPs. The specified list of insurance laws would include:

- the HMO Act (Chapter 20A);
- the small employer health benefits act (Chapter 26);
- the Texas Employees Uniform Group Insurance Benefits Act (art. 3.50-2); and
- the Texas State College and University Employees Uniform Insurance Benefits Act (art. 3.50-3).

Laws or rules could not prohibit or in any way restrict an IHP from selectively contracting with any providers, contracting or declining to contract for an individual health care service, and requiring enrolled members to use the providers specified by the IHP.

SUPPORTERS

CSHB 2058 would establish and regulate a unique and high-quality form of

SAY: HMO, and by doing so would set a higher standard for services in Texas and promote the delivery of high-quality HMO care. By being very difficult to obtain and retain, an IHP status would become a benchmark of distinction and could spur other plans to follow suit. CSHB 2058 would not be removing IHPs from regulation, but placing them under strict requirements that also would grant the commissioner of insurance great latitude in regulating the plans.

Nothing in this bill would limit IHP status to Scott and White Health Plan or guarantee that Scott and White received IHP certification from the Department of Insurance. The Scott and White Health Plan serves only as a model because it closely resembles the IHP as profiled in this bill. Other groups have expressed interest in IHP status, and this bill would provide them guidelines to voluntarily structure or restructure a plan in a way that would meet IHP requirements.

CSHB 2058 would be recognizing a special kind of HMO structure. When it comes to regulation and ensuring quality patient care, the structural form of the health care delivery system is important; it can determine how major decisions are made and what kinds of incentives and other influences exist. Also, some of the HMO patient protection proposals being considered this session would probably not fit within an IHP structure; for example, proposed credentialing requirements would not apply to group model HMOs.

Group practice nonprofit HMOs, as described in this bill, can provide a higher level of quality care than most HMOs because they provide a structural approach to ensuring quality: they are doctor-driven, nonprofit and therefore focused on patient care. IHPs would be led by physicians who can provide the kind of medical oversight not possible to other HMOs, which are accused of oversight by administrators and bureaucrats. Physician leadership would also ensure strong quality improvement programs, and would prevent the use of financial and other incentives used by some HMOs to limit patient care. IHPs also would have to conform to higher solvency and net worth requirements than other HMOs.

Community and patient services would be enhanced by significant reinvestment of premiums in patient services and in medical school and

research activities. The bill would enact strict requirements that each IHP spend an average of at least 85 percent of the revenue received on provisions of services to its members. Since the IHP would be a nonprofit, the remaining 15 percent would go not to stockholders but reinvested in community services, medical research and other beneficial activities. An IHP's affiliation with medical schools would not only provide IHP members with physicians knowledgeable about state of the art medical developments, but would also help support the training and research provided by those schools that benefit all Texans.

The Scott and White Health plan models the high quality that could be achieved by an IHP structure, and some experts say it points to the direction of where HMO care is going. It is often compared to the nationally recognized Mayo Clinic in Minnesota, and had been melding doctor, hospital and health insurance long before HMOs came on the scene.

OPPONENTS SAY:

CSHB 2058 would create special exemptions for the Scott and White Health Plan that are not granted to other HMOs and remove the plan from mandates, liability and other patient protection requirements under consideration this session. Scott and White Health plan is not any more "unique" than any other HMO plan, and physician leadership does not ensure a better focus on patient care.

Due to the evolving nature of health care delivery, *all* HMOs can claim they are "unique," because of their mix and nature of provider contracts, the level of benefits offered, built-in patient protections and quality standards and other features. Scott and White does nothing different than what other HMOs do: it still requires prior authorization, referral certification, provider application and medical necessity reviews. Scott and White also has not been proven to deliver higher quality than anyone else; complaints have been filed about the plan comparable to the experience of many other plans.

A doctor-run organization does not mean patients will be treated fairly. Doctors are just as susceptible as nonmedical individuals to self-interest, profit or income motives and other actions that can obstruct the delivery of quality patient care.

Designating certain HMOs as IHPs would not be setting a higher standard;

in fact, it would dangerously remove them from compliance with higher patient protection standards and liability now being considered this session. Although CSHB 2058 includes some provisions that are similar to patient protection provisions now considered, they are not as clearly stated and comprehensive as current proposals and they could not be modified in the future without specific reference to IHP statutes.

By removing Scott and White from patient protection and liability requirements, CSHB 2058 would give this plan a competitive advantage that would not be enjoyed by all HMOs. Although other plans could theoretically restructure to meet IHP qualifications, in practice that would be nearly impossible; local physicians would have to agree to organize themselves into one group sufficiently large enough to take care of plan enrollees, and medical schools and research facilities would have to be willing and available to contract with a plan.

The state should regulate function, not form. Carving out special niches for every nuance in health care delivery makes public oversight and the formulation of public policy more difficult than necessary. Current law and regulations protect patients and should be applied uniformly to all HMOs. They do not limit HMOs from providing high quality care, but create minimum, not maximum, standards that all HMOs are free to improve upon to meet community needs and quality expectations. If Kaiser-Permanente HMO were an approved IHP, the department would not have had the clear, enforceable standards in place on which to base investigations.

OTHER OPPONENTS SAY:

If HMOs want to be recognized as IHPs, they should be allowed to do so, but they should also comply with all of the requirements in the HMO Act. That way they can verifiably say that they do more than just meet minimum state requirements.

NOTES:

Changes in the committee substitute included requiring qualified group medical practices to be affiliated with a medical school and authorizing the commissioner to revoke the certification of an IHP that failed to meet or maintain complaint, quality of care or financial viability standards.

The companion bill, SB 1052 by Harris, has been referred to the Senate Economic Development Committee.