HOUSE RESEARCH ORGANIZATION bill analysis — 5/23/97

SB 383
Cain, et al. (Smithee, Van de Putte, et al.)
(CSSB 383 by Smithee)

SUBJECT: Regulating preferred provider benefit plans

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Van de Putte, Averitt, Bonnen, Burnam, Eiland, G. Lewis, Olivo, Wise

0 nays

0 absent

SENATE VOTE: On final passage, March 6 — 29-0

WITNESSES: (*Witnesses testified for or against individual amendments, which were rolled into a complete committee substitute. No witnesses registered solely for or against the bill as a whole.*)

BACKGROUND: Preferred provider plans, also called preferred provider organizations or PPOs, are health insurance plans that offer more favorable coverage to insureds who utilize the services of "preferred providers," ie., physicians, hospitals and other providers who contract with the plan.

PPOs are generally regulated under chapter 3 of the Insurance Code, which regulates all life, health and accident insurance plans.

Last session the Legislature enacted the "Patient Protection Act," HB 2766 by Smithee, which included health benefit plan requirements that pertained to both HMOs and PPOs. However, the bill was vetoed by the governor, who in his veto message also directed the Texas Department of Insurance to promulgate rules that would require managed care plans to:

- require disclosure of information concerning plan terms and conditions to allow enrollees and employers to make informed decisions;
- allow evaluation to ensure consumers are receiving quality care;
- expand patient choice to allow for continuity of treatment if a patient's physician was terminated from the plan;

- implement reasonable due process procedures for providers who were denied or terminated from contracts; and
- prohibit retaliatory actions against patients who file complaints or appeal decisions.

DIGEST:

CSSB 383 would specifically authorize and regulate PPOs and establish certain provider, continuity of care and other requirements. The commissioner of insurance would have rulemaking authority to implement the bill, including rules to prohibit the use of financial incentives that act directly or indirectly to limit medically necessary services.

The bill would take effect immediately if finally approved by a two-thirds record vote of the membership in each house.

Providers and contract requirements. The PPO would have to offer fair, reasonable and equivalent opportunities for licensed health care practitioners to be designated as preferred providers. For physicians, insurers would have to provide a reasonable review mechanism that notified a physician in writing the reasons for the denial or contract termination, and incorporated an advisory review panel composed of at least three contracted physicians, one who was in the same specialty as the affected physician.

PPOs would have to contract with providers to ensure that all medical and health care services contained in the package of benefits would be provided in a manner that ensured availability and accessibility. Each insured would have the right to treatment and diagnostic techniques that were included in the plan, as prescribed by the physician or health care provider. Insurers would be responsible for ensuring that the plans meet all applicable Insurance Code requirements, including prompt payment of insureds under art. 21.55.

Insurers that use economic profiling to admit or terminate health care providers would have to make the profile available to the provider on request. Economic profiles would have to be adjusted to recognize the characteristics of a provider's practice that may account for variations from expected costs.

An insurer could not require any health care provider to execute hold-harmless clauses in order to shift tort liability from the insurer to the provider. Providers who are paid on a discounted fee-for-service basis could not bill insureds for the full charge.

Availability of preferred providers. Insurers offering PPO plans would have to ensure that preferred provider benefits and basic level benefits were reasonably available to all insureds within the designated service area. If services were not available, a nonpreferred provider would have to be reimbursed at the same percentage level of reimbursement as a preferred provider would have been reimbursed.

Continuity of care. When a provider's contract termination was pending, each insurer would have to notify insureds and establish reasonable procedures for ensuring a transition of insureds to other providers. Pending terminations, except for reasons of medical competence or professional conduct, would not release the provider from treating the insured or arranging for appropriate referrals, or the insurer from the obligation to reimburse the provider or insured if at the time of termination the insured has special circumstances that warranted continued medical treatment, such as a disability, acute condition or life-threatening illness or was past the 24th week of pregnancy. Insurers would not be obligated to reimburse providers or insureds for ongoing treatment after the 91st day of termination, except those with special circumstances.

Emergency care. If an insured could not reasonably reach a preferred provider, the insurer would have to provide reimbursement for emergency care services at the preferred provider level of benefits until the insured could be transferred to a preferred provider.

"Emergency care" would be newly defined and include health care services to evaluate and stabilize medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition was of such a nature that failure to get immediate medical care could result in serious impairment, dysfunction or disfigurement, or serious jeopardy to the health of a fetus.

Mandatory disclosure. Each health insurance policy would have to be written in plain language, and the insurer would have to provide an accurate written description of the terms and conditions of the policy to current or prospective insureds so that they may compare benefits among health care plans. Insurers also would have to provide a list of preferred providers annually to insureds.

Prohibited practices. An insurer could not prohibit a provider from discussing with the patient information regarding the patient's treatment options or information or opinions regarding the provisions, terms, requirements or services of the health care plan as they relate to the patient. An insurer could not retaliate against a provider or insured for filing a complaint or appealing an insurer decision.

An insurer could not require the observation of a psychotherapy session or the submission of progress notes or deny mental health benefits on the grounds the patient refused medication for religious reasons or because the patient was receiving group family therapy.

SUPPORTERS SAY:

CSSB 383 would give the force of law to many regulations adopted by the Texas Department of Insurance in compliance with Gov. Bush's mandate. The bill would 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 benefit plan that best meets their needs, and that physicians and other health care providers receive due process during plan application and contract termination processes. PPOs have been in compliance with most of these provisions for almost a year, as set out in regulations.

By removing provisions in the Senate version that would have required all health care practitioners an opportunity for contract denial or termination review by an advisory panel, CSSB 383 would prevent a rise in health care costs associated with significantly increased administrative expenses and with reduced ability to selectively contract with desired practitioners, similar to an "any willing provider" provision. Physicians deserve review panel protections because they are a patient's primary health care service provider and advisor, and are the practitioners with whom patients form the closest

relationship. However, to give the same review panel participation requirements to other practitioners, such as audiologists, nurses, and physical therapists, would require the establishment of special panels, perhaps by recruiting practitioners from other communities, and greatly increase administrative costs and efforts. To require review panels for the termination of other practitioners also would interfere with contract provisions voluntarily agreed to by participating practitioners.

Access to necessary care would be improved by provisions relating to emergency medical situations that were also included in regulations adopted last year. CSSB 383 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 often had not in the past paid for such evaluations, and patients were then penalized for seeking care.

OPPONENTS SAY:

All health care practitioners should receive the same due process protections as physicians in cases of contract denials or terminations, and requiring advisory panel review mechanisms would not increase costs. Physicians are not the only practitioners who form close relationships with their patients, especially patients needing non-medical or specialized medical care, who may most often rely on the services of a social worker, chiropractor, dietician, optometrist, or physical therapist.

By eliminating from the Senate version provisions requiring all health care practitioners an opportunity for contract denial or termination review, CSSB 383 could compromise patient care. Patients may not have sufficient access to needed care if practitioners are denied contracts with PPOs, and patients who are appealing a PPO benefit decision may lose the full support of the practitioner to support their appeal, because the practitioner was at risk of retaliation or termination without due process.

OTHER OPPONENTS SAY:

The consumer information required by this bill should further require that plan information be presented in a specific format to help consumers compare one plan to another.

NOTES: Major changes in the committee substitute included removing practitioners from required inclusion in reasonable review mechanisms that incorporate review panels; adding a definitions of a health care provider, a practitioner and contract termination; and adding prompt payment requirements. The committee substitute also made many nonsubstantive and formatting changes to the Senate engrossed version of the bill.

Other HMO or managed care related bills on the calendar today include SB 382 by Madla, SB 384 by Nelson and SB 385 by Sibley.