HOUSE
RESEARCH
ORGANIZATION bill analysis 5/23/97

SB 385
Sibley (Smithee, et al.)
(CSSB 385 by Smithee)

SUBJECT: Health Maintenance Organization regulations

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 11 — 31-0

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: "Managed care" unites health care financing and delivery in health benefit plans that govern both the use and cost of health care services. The best known type is the health maintenance organization, or HMO. HMOs are governed under chapter 20A of the Insurance Code, which contains requirements relating to certification, evidence of coverage, enrollee information, complaint systems, solvency, and management contracts.

Last session, the Legislature considered and passed the "Patient Protection Act," HB 2766 by Smithee. However, the bill was vetoed by the governor. In his veto message, Gov. Bush said the bill would have imposed numerous new regulations and generated significant costs to government and private employers. The governor also instructed state regulators to draft regulations that would do the following:

- require disclosure of information concerning plan terms and conditions to allow enrollees and employers to make informed decisions;
- allow evaluation of managed care plans to ensure consumers are receiving quality care;
- expand HMO 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 HMO contracts; and
- prohibit retaliatory actions by HMOs against patients who filed complaints or appeal decisions.

Several sets of regulations were promulgated by July 1996 by the Texas Department of Insurance and the Texas Department of Health in response to the governor's directive.

DIGEST: CSSB 385 would amend chapter 20A of the Insurance Code and take effect January 1, 1997. Dental point-of-service option provisions would take effect January 1, 1998.

Application of the chapter. The bill would specifically prohibit a person, physician or provider from performing any act of an HMO, without first having a certificate of authority as an HMO and subject to other provisions under the act.

Certification and commissioner authority. In addition to information currently required, an HMO applying for a certificate of authority would have to send to the commissioner a description of health care plan terms and conditions; network configuration information; provider compensation arrangement information; and documentation demonstrating that the HMO would pay for medical-screening criteria for emergency care and emergency care services performed by out-of-network providers. Certificate of authority applications would also be modified, and original filing fees would be increased to $18,000 from $15,000.

"Emergency care" would be newly defined and would 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 is 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.

A copy of any contract or agreement between the HMO and a provider would have to be provided to the commissioner upon request. The

commissioner could also examine HMO records as necessary for enforcement of this act. The information would be confidential and not subject to open records laws.

The commissioner would be specifically authorized to impose administrative penalties, cease and desist orders and other sanctions applicable to other insurance products. The commissioner could also promulgate rules to establish minimum physician/patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting times for obtaining appointments.

Evidence of Coverage. Evidence of coverage available to enrollees would have to also include provisions relating to:

- out-of-network referrals for medically necessary services not provided by HMO network providers;
- approval of nonprimary care physician specialists as the primary care physician for persons with life-threatening, chronic or disabling illnesses;
- access to medically necessary rehabilitation services and therapies, even though they might not result in significant improvement in the enrollee's condition;
- prompt payment of enrollees and providers;
- provision of basic health care services without limitation, except those prescribed by department rule; and
- limitations or denials of health care services coverage based on the religious convictions of the HMO or providers, if applicable.

Basic health care services would be redefined by CSSB 385 to mean health care services that the commissioner determines an enrolled population might reasonably require, and would refer to minimum service requirements under the federal HMO Act, sec. 1302, Title 13, of the U.S. Public Health Service Act.

Information to Enrollees. Each plan application form would have to prominently include a space in which the enrollee at the time of application could make a selection of a primary care provider. An HMO could limit an enrollee's request to change physicians or providers to not more than four changes in a 12-month period.

The HMO would have to provide an accurate written description of health care plan terms and conditions to allow current or prospective enrollees to make comparisons among health care plans. Written descriptions would have to include specified information, including a toll-free number to obtain additional information.

HMOs and approved nonprofit health corporations would have to establish procedures to provide to enrollees member handbooks and materials relating to the complaint and appeals process in the languages of the major populations of the enrolled population and to enrollees with disabilities affecting communication and reading.

Medicare-contracting HMOs would have to disclose to prospective enrollees that they could lose their opportunity to purchase Medicare supplement insurance.

Quality assurance. Each HMO would have to establish procedures to ensure health care services were provided to enrollees under reasonable standards of quality care consistent with prevailing professionally recognized standards of medical practices, and have an ongoing internal quality assurance program to monitor and evaluate its health care services. The commissioner could establish rules regarding the minimum requirements for such internal programs.

An HMO would have to establish a physician review panel to assist in reviewing medical guidelines or criteria and in determining the coverage of prescription drugs. By January 1, 1999, the commissioner would have to adopt rules requiring each HMO to use standardized pharmacy benefit cards for its enrollees that meet all of the requirements of the U.S. Department of Health and Human Services.

Complaint system. HMOs would have to acknowledge receipt of a complaint not later than the fifth business day. Resolution of the complaint could not exceed 30 days after the date the complaint was received. Complaints concerning emergencies or denials of hospitalization would have to be resolved in one business day from receipt of the complaint. The HMO would have to notify the complainant of the complaint's resolution, and if the resolution was to deny services, the clinical basis for an adverse

determination would have to be provided, along with a description of the HMO's appeal process.

The complainant would have the right to appeal before a complaint appeal panel, the composition and process of which would be specified by CSSB 385. The HMO would have to maintain a record of each complaint and any complaint proceeding for three years, and a complaint and appeal log of each complaint.

The commissioner could promulgate additional rules regarding the complaint system and could examine an HMO's complaint system for compliance and require corrections considered necessary.

Any person could report alleged violations of the complaint system requirements to the Texas Department of Insurance. TDI would have to investigate a complaint within 60 days, and the investigation could be extended for up to six months.

Prohibited practices. An HMO 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 HMO could not retaliate against a provider, group contract holder or enrollee for filing a complaint or appealing an HMO decision. An HMO could not use financial incentives that would act directly or indirectly as inducements to limit medically necessary services.

An HMO 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 is receiving group family therapy.

Provider contracts. An HMO would have to make available to providers application procedures and qualification requirements for contracting with the HMO. Reasons for application denials would have to provided to providers. Contract terminations would have to follow specified notification and review procedures. Enrollees would have to be given advance notice of

an impending termination of their treating provider. Enrollees with special circumstances, such as pregnancy, disabilities or life-threatening diseases would be able to continue to see the provider for specified durations.

Assignments of enrollees to primary care providers when they did not select a provider at the time of application would be specified, and capitation payments to primary care providers would have to begin within 30 days of provider selection or assignment.

Each contract would have to specify that the provider would hold enrollees harmless for payment of services in the event the HMO failed to pay the provider. An HMO would have to make available to network providers their economic profile, if economic profiling was used by an HMO. Providers would have to be required to post a notice to enrollees about the process for resolving complaints.

Each dental health HMO with more than 10,000 enrollees would have to offer a dental point-of-service (POS) option to employers with 25 or more employees and who help pay for the cost of their employees' dental health plan. Employers could offer the dental POS option to employees to accept or reject on an individual basis. An employer could require an employee who accepts the dental POS to be responsible for premium payment for the POS option and could charge the employee a reasonable administrative fee.

SUPPORTERS SAY:

CSSB 385 would give the force of law to many regulations adopted by the Texas Department of Insurance and Texas Health Department 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 maintenance organization (HMO) plan that best meets their needs, and that physicians and other health care providers receive due process during plan application and contract termination processes.

CSSB 385 would *not* significantly increase health care costs. HMOs have been in compliance with most of these provisions for almost a year, as set out in regulations.

Access to necessary care would be improved by provisions relating to emergency medical situations that were also included in regulations adopted last year. CSSB 385 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.

Access to necessary care also would be ensured by linking state requirements with federal HMO "basic health care services" requirements that define such services to include physician services, including consultant and referral services; inpatient and outpatient hospital services; medically necessary emergency services; short-term outpatient mental health services; medical treatment and referral services for the abuse of alcohol or drugs; diagnostic laboratory and radiology services; home health services; and preventive health services. CSSB 385 also would allow some patients with special circumstances to continue to receive care beyond the 90-day limit from their doctor who is no longer contracting with the HMO.

CSSB 385 would recognize the special beliefs of Catholic and other religious-based organizations and providers that form or participate in HMOs by exempting such HMOs or providers from requirements to provide certain services that would violate the tenets of their religion. Under the clause, for example, Catholic hospitals could not be required to perform abortions.

CSSB 385 would assist pharmacies and consumers when prescriptions are being filled by requiring HMOs to give enrollees uniform cards that would identify enrollee health benefit plan coverage provisions and limitations, copayment requirements, and other information necessary to accurately and in a timely manner process the prescription request. Pharmacists now often must spend time tracking down the patient, insurer or HMO or doctor to find out whether a consumer has prescription benefits and what they include. The cards would also provide increased security for HMOs, pharmacists and consumers from fraudulent or illegal drug purchases.

CSSB 385 would not subject provider networks to HMO certificate of authority amendments because such a requirement would throw into disarray hundreds of contracts now functioning between provider networks and HMOs or employers. Due to the evolving nature and complexity of network-based arrangements, regulation of provider networks, if desired, should not be undertaken without a thorough study of current practices and anticipated health care trends.

CSSB 385 would help increase patient access to dental care by requiring dental HMOs to offer a dental "point of service" POS plan to employers who offer dental benefits to employees. This bill would not increase costs because no one is required to provide or accept a dental POS option; dental HMOs would simply be required *to offer* a POS option to the employer. Dental POS plans are popular plans, and have one of the fastest rising market shares among health benefit plans.

OPPONENTS SAY:

CSSB 385, by adding provisions to the Senate version of the bill, would far exceed simple codification of existing rules and cross the line from appropriate regulation to governmental micro management. Prescriptive regulation not only increases costs but also inhibits the use of procedures that could be beneficial to consumers. For example, CSSB 385 would prohibit the use of methods mutually agreed upon by a complainant and a plan to resolve complaints or to expedite a hearing process. The bill also would enact complaint processing deadlines and procedures that are contrary to regulations enacted less than a year ago and would increase the adversarial nature of the process, thereby slowing the process down. Also most HMOs prefer not to assign patients to a primary care physician, so that the patient has full control over such an important choice, but this bill would require the plan to assign an enrollee within 30 days after enrollment. Current rules allow patients maximum control in selecting a primary care physician, and also ensure that the primary care physician receives full capitation for any delayed selections.

Also, some of the new provisions in CSSB 385 would only benefit provider bank accounts and not enrollees. For example, amendments have changed out-of-network provider reimbursement from an agreed upon rate or a usual and customary rate to an undefined "full reimbursement" requirement, which could be an arbitrary or unusually high rate set by the provider. The

bill also would require provider payment within 60 days of the date of service, regardless of previous contractual agreements or of the date the provider submitted a claim to the HMO or the adequacy of claim information submitted.

CSSB 385 provisions, when viewed in light of the recent enactment of the liability provisions of SB 386, would further increase HMO liability, which could result in reduced patient access to care. For example, by allowing enrollees who have a life-threatening illnesses to receive care for an indefinite time period from their doctor who has been terminated from a plan, this bill would make the HMO's liable for the provider's actions even though because the provider could be viewed as an "ostensible agent" of the HMO. Requirements to assign patients within 30 days to a primary care physician could also increase an HMOs liability if the doctor's actions are unsatisfactory to the patient.

CSSB 385 would be inappropriately anthropomorphizing HMOs by enacting a "conscience clause" when in fact they are trade enterprises in the business of providing health care *coverage*. HMOs are not religious institutions, nor are they in the business of providing moral guidance. As written, this clause could be claimed by any HMO entity and be used as an excuse for not providing all sorts of services, not just the reproductive services normally associated with this issue. This kind of clause would prevent both male and female enrollees from receiving needed health care services — both in-network and out-of-network — and could mislead enrollees who think they are receiving coverage for basic health care services that are provided by every other HMO. This provision also would subject the enrollees, who are predominately employees receiving health benefits through the workplace, to inadequate coverage due the religious or philosophical beliefs of their employers.

Provider networks that assume a degree of risk by accepting prepayment for coverage of a particular enrollee population should be required to obtain HMO certificates of authority. A new trend in health care is the formation of provider networks that sell coverage directly to employers, and they are currently unregulated. This would protect enrollees from losing paid-for services due to a network's insolvency or taking on more risk than it could actually handle, and create a more level playing field among provider

networks and single-service and basic-service HMOs.

CSSB 385 should not include a "point of service" (POS) mandate that increases 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. Although this bill would not require employers to offer a dental POS plan to their employees, it would establish precedent that could be changed by subsequent legislatures to change the mandated offering of a dental POS plan to a mandated benefit.

OTHER OPPONENTS SAY:

Consumers need specific additional disclosures about dental HMOs because of significant differences in copayment structures that are typical of dental but not basic service HMOs and because of variances in coverage of dental procedures that make it difficult for people not versed in dental care to judge whether coverage would fit their needs. Consumers often have been charged more than one copayment for a service, or charged individual copayments per procedure.

Accurate and complete pharmacy coverage information is essential for quickly and appropriately processing patient prescriptions, but to require the use of a separate, standardized card is unnecessary. The bill should be amended to require sufficient information on a plan benefit identification card, which could include other plan benefits and copayment explanations.

NOTES:

Among the changes the committee substitute made to the Senate version include requiring HMOs to use standardized pharmacy benefit cards; requiring certain HMOs to offer dental point-of-service plans; adding "mental health" to the definition of health care and "registered optician" to the definition of provider; adding evidence of coverage requirements relating to rehabilitation services; specifying content of written information to enrollees; adding disclosure requirements by Medicare-contracting HMOs; deleting various content and procedural requirements relating to HMO complaint and appeal systems; reducing from 72 hours to one business day the resolution of complaints relating to hospitalization or emergencies; specifying that prohibitions against incentives that would reduce medically necessary care do not prohibit the use of capitation; adding psychotherapy-related prohibitions to the list of prohibited HMO practices; adding provisions for continued treatment for certain patients beyond the

90th day after a provider's termination; and reducing from 90 days to 30 days the maximum time period in which a provider would have to begin receiving capitation once an enrollee selected or was assigned to the provider.

Other HMO or managed care related bills on the calendar today include SB 382 by Madla, SB 383 by Cain and SB 384 by Nelson.