SUBJECT: Increasing plan options for the Rural Community Health System

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Eiland, Burnam, G. Lewis, J. Moreno, Olivo, Seaman, Wise

0 nays

1 absent — Thompson

WITNESSES: For — Sheryl Dacso and B.R. "Skipper" Wallace, Rural Community Health System of Texas; Don Richey, Southwest Texas Health Alliance and Texas Hospital Association; Craig A. Walker, Texas Organization of Rural and Community Hospitals and Texas Rural Health Association

Against — None

On — Lisa McGiffert, Consumers Union

BACKGROUND: The 75th Legislature created a statewide rural health care system to respond to the health care needs of rural communities. Art. 20C of the Texas Insurance Code was added to govern the creation and operation of the Rural Community Health System (RCHS).

Since RCHS was originally envisioned as a type of health maintenance organization (HMO), its function is limited to arranging or providing health care services on a prepaid basis to enrollees. RCHS also must meet the requirements imposed by the Texas Health Maintenance Organization Act and all reserve requirements mandated by the commissioner of insurance. The RCHS does not have to get a certificate of authority to operate as an HMO, but it does have to meet the requirements for such certificate of authority.

The definition of rural area in Art. 20C.02 of the Texas Insurance Code includes a county with a population of 50,000 or less, an area that is not delineated as urbanized by the federal census bureau, or any other area designated as rural by the insurance commissioner.

The board of directors governing the RCHS must appoint an advisory committee, which must be composed of representatives from urban hospital districts, health care teaching facilities, health care specialty facilities, medical resident programs in family practice, rural health clinics, federally qualified health centers, ambulatory surgical centers, and hospital administrators from nonprofit and investor-owned facilities.

The RCHS is still in the organizational phase and has not yet begun to operate as an HMO.

The difference between a prepaid plan, such as an HMO, and a fee-for-service plan is the way the health care provider is paid. In a prepaid plan, the health care provider receives a set amount per patient. In a fee-for-service plan, the health care provider is paid for the particular services provided to a specific patient.

DIGEST:

CSHB 1194 would allow the RCHS to arrange or provide health care either as an HMO with a prepaid plan or as a fee-for-service plan, such as the Primary Care Case Management (PCCM) model. RCHS would be bound by its decision once it began to operate as a prepaid or fee-for-service plan and could only operate as one or the other.

If the RCHS opted to function as an HMO on a prepaid plan, it would have to get a certificate of authority under the HMO Act and meet the reserve requirements of that act rather than requirements set by the insurance commissioner.

The commissioner could make exceptions to the HMO Act for the RCHS regarding mileage, distance, and network adequacy and scope, allowing larger service areas and fewer physicians than normally are allowed under the HMO Act.

CSHB 1194 would add factors for the insurance commissioner to consider in designating an area as rural. Those factors would include whether emergency, acute, speciality, or primary care services are limited, unavailable, or could be made more accessible through contracting with the system or a participating community health network. The commissioner also could make an area eligible if it has a high population of aged, at-risk, or low-income people,

including people with serious mental illness or emotional disturbance, who would be helped by access to RCHS.

CSHB 1194 would make the appointment of an advisory committee by the board of directors optional, and change membership to "representatives of rural, urban, and educational groups and organizations."

Current law, which allows the system to be reimbursed by the Medicaid contracting agency at the state-defined capitation rate, would apply to the RCHS only if the system operated under the HMO act.

CSHB 1194 would take effect September 1, 1999.

SUPPORTERS SAY:

Innovations in the health care market have created alternatives to traditional managed care provided by the HMO model. The RCHS should have the flexibility to operate as either an HMO or one of the new fee-for-service plans such as Primary Care Case Management (PCCM).

In PCCM plans, individual physicians contract with the system to participate as primary care physicians in exchange for a case management fee and guaranteed payment on a fee-for-service schedule. Once the physician becomes a primary care physician, the physician serves as the gate-keeper for patient access to health care. Studies have shown that PCCM plans may offer lower costs and gives individual doctors more control over patient care.

In the HMO model, the HMO is the gate-keeper and must approve any patient referral or procedure. The risk of insolvency and other concerns have made the HMO model less attractive than when the RCHS was first created. However, there are still reasons why the RCHS might choose to operate as an HMO, so that option should remain open.

While the insurance commissioner is allowed to make some exceptions to the HMO Act to permit larger service areas and fewer physicians than normally would be allowed for the RCHS, these exceptions are a necessary to deal with conditions found in rural areas and would not harm consumers.

There were concerns that the original bill was too broad in allowing the insurance commissioner to make special exceptions for the RCHS under the HMO Act and that this could open the door to providing fewer services. The

substitute would allow the commissioner only to make exceptions regarding mileage, distance, and network adequacy and scope.

OPPONENTS SAY:

No apparent opposition.

NOTES:

The committee substitute added the requirement that the RCHS obtain a certificate of authority to operate as an HMO and meet reserve requirements as provided by the HMO Act.

The committee substitute also added the provisions that would delete the exception to contracts under the Texas Medical Assistance Program and allow Medicaid reimbursement at the state-defined capitation rate to the extent the RCHS operated as an HMO. The substitute would allow the commissioner to make exceptions for RCHS under the HMO Act regarding mileage, distance, and network adequacy and scope.

SB 1063 by Fraser, which has the same provisions as CSHB 1194 with additional statements of legislative intent and factors for the commissioner to consider in determining whether an area is rural, was reported favorably, as substituted, by the Senate Economic Development Committee on April 23.