SUBJECT: Delegation agreements between HMOs and delegated networks

COMMITTEE: Insurance — committee substitute recommended

VOTE: 5 ayes — Smithee, Eiland, Olivo, Seaman, Wise

2 nays — J. Moreno, Thompson

1 present, not voting — Burnam

1 absent — G. Lewis

WITNESSES: (*On original bill:*)
For — Spencer Berthelson, Texas Medical Association and Kelsey Seybold Clinic; Edna Ramón Butts, PhyCor

Against — Cynthia Leiferman, Advocacy, Inc.

On — Jeff Kloster, Texas Association of Health Plans; Lisa McGiffert, Consumers Union

BACKGROUND: Some health maintenance organizations (HMOs) contract with groups to arrange or provide medical care to health plan enrollees. These groups are called delegated networks, independent practice associations (IPAs), and limited provider networks. Enrollees in an HMO plan often are limited to the providers within a certain delegated network that is a subset of all the providers in the HMO network.

These delegated networks perform many of the functions of an HMO as well functions performed by third party administrators (TPAs) and utilization review (UR) agents. TPAs contract with insurers to handle administrative duties. UR agents contract with insurers to make determinations on whether certain treatments and procedures are medically necessary. While HMOs, TPAs, and UR agents are required to have licenses, the department of insurance has not required delegated networks to be licensed to perform these functions. There are no statutory requirements for delegation contracts between delegated networks and HMOs.

DIGEST:

CSHB 3019 would require delegation agreements between HMOs and delegated networks. The bill would define delegated networks as entities other than HMOs and licensed insurers who arrange for, or provide medical care to, a health plan enrollee in exchange for a set fee per enrollee. This definition includes IPAs and limited provider networks.

CSHB 3019 would not include in the definition individual physicians and groups of physicians practicing medicine under one federal tax identification number and whose total claims paid to providers not employed by the group are less than 20 percent of the total collected revenue of the group annually. This exclusion covers medical practice groups that are delegated networks run by physicians themselves.

Delegation agreements would be filed with the Texas Department of Insurance (TDI) within 30 days of their execution. These agreements would have to include certain provisions regulating the relationship between the HMO and the delegated network. They also would include a monitoring plan with practices for tracking and reporting unreported liabilities, monthly summaries of the total amount paid by the delegated network to health care providers, and monthly summaries of complaints by providers regarding delays in payment and nonpayment of claims.

Delegation contracts could not be terminated by the HMO or the delegated network without 90 days advance written notice.

Delegated network's contractual duties to the HMO. The delegated network and its health care providers could not pursue collection attempts against health plan enrollees for costs other than authorized copayments and deductibles.

The delegated network would affirm that the agreement did not limit the HMO's authority or responsibility to comply with all statutory and regulatory requirements.

The delegated network or third party administrator would provide a license number and certify that the network or third party was licensed as a third party administrator under Art. 21.07-6 of the Insurance Code if the HMO delegated its claims payment function to a network or third party.

The delegated network or third party administrator would provide a license number and certify that the network or third party was licensed as a utilization review agent under Art. 21.58A of the Insurance Code if the HMO delegated its utilization review function to a network or third party.

The delegated network would agree to the following terms:

- The HMO would have to operate under regulatory and statutory standards;
- The HMO could require proof of financial viability from the delegated network;
- The role of the network would be limited to certain delegated functions of the HMO using HMO-approved standards, subject to monitoring by the HMO; and
- The HMO could cancel delegation of responsibilities if the network failed to meet the standards.

The delegated network would provide samples of contracts with health care providers to the HMO to ensure compliance with rules on termination of the contract and collection attempts against enrollees. The delegation agreement could not require the delegated network to make available provisions from its contracts relating to financial arrangements.

The delegated network would have to provide the HMO with data necessary for TDI reporting requirements at least quarterly, to include the following:

- Payment methods used to pay health care providers;
- Length of time that claims and debts for medical services have been pending;
- Documents other than confidential peer review materials relating to an investigation of the network or a provider regarding an enrollee of the HMO; and
- The final resolution of that investigation.

HMO's contractual duties to the delegated network. The HMO would have to provide the following information at least monthly to its delegated networks:

- The name, birthdate or social security number, age, sex, employer, benefit plan, and any riders to that benefit plan for all eligible enrollees;
- A summary of the claims paid by the HMO;
- A summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the network had taken partial risk; and
- Patient complaint data.

The HMO also would have to provide detailed risk-pool data, rates required by the agreement, and any known future facility contract rates for the HMO if hospital or facility costs impacted the delegated network's costs.

Troubleshooting provisions. If an HMO discovered that a delegated network was not operating according to the agreement or state laws, or in a condition hazardous to enrollees, the HMO would have to notify the delegated network and request a written explanation.

The delegated network would have to respond within 30 days, and the HMO would have to cooperate with the network to resolve the problem.

If the HMO did not receive a response or the two entities could not reach a solution, the HMO could request insurance department intervention. The department would have broad powers to review documents and to suspend or revoke the third party administrator or utilization review license of the delegated network or third party administrator.

The department would submit a report to the HMO and the delegated network within 60 days of the intervention request. The delegated network would respond to the department's report with a corrective plan within 30 days. Information required by this series of investigations, reports, and plans would be confidential.

The department could request that a delegated network take corrective action for the delegated network or the HMO to comply with applicable laws. If the delegated network did not comply, the department could require the HMO to cease assignment of enrollees to the network, transfer enrollees from the network, and modify or terminate the delegation contract.

CSHB 3019 would take effect September 1, 1999. The changes made by the bill would expire September 2, 2003, unless extended by the Legislature.

CSHB 3019 would also create a bicameral committee to conduct an interim study of delegated networks which would report to the lieutenant governor, the speaker, and the governor by December 31, 2000.

SUPPORTERS SAY:

CSHB 3019 would extend the protections given to consumers through HMO regulation to consumers served by delegated networks. Since delegated networks perform many of the functions of HMOs and other regulated entities, their delegation contracts should meet certain standards. CSHB 3019 would ensure that delegated networks are accountable for their actions just as the HMOs they contract with are accountable.

The failure of the Houston-based FPA delegated network in July of 1998 brought attention to the risks that occur from a lack of statutory controls on the use of delegated networks. While CSHB 3019 would not create a delegated network license or provide direct regulation by the department, the bill would require communication between the HMO and the delegated network as well as establish guidelines for department intervention.

The use of delegated networks is an extremely complex issue that cannot be fully covered by one bill. CSHB 3019 would be a first step in addressing the concerns related to the use of delegated networks by HMOs. The interim study that would be provided by CSHB 3019 would help to develop and evaluate future delegated network regulation.

Medical practice groups must be excluded from CSHB 3019 at this point because these groups are different from other delegated networks. The physicians themselves operate medical practice groups and should have greater freedom since they rarely have to forward a portion of the fee per enrollee to other health care providers. CSHB 3019 in its current form would not fit these medical practice groups.

CSHB 3019 is not intended to address accessibility issues. The bill does not prohibit or encourage the current practice of limiting enrollees to the providers in a delegated network. Before accessibility can be addressed, the stability and accountability of the delegated networks must be assured.

OPPONENTS SAY:

Delegated networks are essentially mini-HMOs. The best way to regulate them would be to treat them like HMOs. While CSHB 3019 is an important first step, more direct involvement by the department is necessary.

CSHB 3019 continues the practice of regulating insurance entities by their titles rather than their functions. Regulation always lags behind industry practice since new forms of entities with different titles will always appear. Regulation should be based on the functions performed by the insurance entity rather than its title.

OTHER OPPONENTS SAY:

While CSHB 3019 would allow an HMO to require proof of financial viability from a delegated network, there should be statutory net worth requirements or other proof of financial stability required for all delegated networks.

Many large delegated networks are medical practice groups that would be excluded from CSHB 3019. Despite their unique status as physician-run, these medical practice groups should not be excluded from state regulation.

CSHB 3019 continues the confusing terminology used in the Insurance Code to describe groups that are known as delegated networks, independent practice associations, limited provider networks, and medical practice groups. There should be one term and possibly one set of rules for all such similar groups.

Documents related to department intervention other than costs and other confidential information should be available to the public. It is important for consumers to know if a delegated network or an HMO is experiencing problems that might affect their health coverage.

While CSHB 3019 is not intended as an accessibility bill, there should be some measure to prevent enrollees from being restricted to providers from a certain delegated network when there are many more providers available in the HMO network at large. Enrollees at least should be given clear notice from their HMO that delegated networks are being used to arrange for or provide their health care.

NOTES:

The companion bill, SB 890 by Harris, which is similar to CSHB 3603, passed the Senate by voice vote on April 26 and has been referred to the House Insurance Committee.

SB 890 would not exclude certain physician groups from the definition of delegated networks and does not provide for an interim study. SB 890 would authorize the commissioner to develop rules that would allow certain enrollees served by delegated networks to see health care providers outside of the delegated network who are in the larger HMO network. The Senate bill also would require immediate reporting of emergency complaints against the delegated network to the HMO. In SB 890, reports related to department intervention would be public documents with the exception of costs and other confidential information under law.