SUBJECT: Consumer disclosures required by HMOs and PPOs

COMMITTEE: Insurance — favorable, without amendment

VOTE: 8 ayes — Smithee, Eiland, Averitt, Burnam, G. Lewis, J. Moreno, Olivo, Thompson

1 nay — Seaman

0 absent

WITNESSES: For — Dianne Grussendorf, Baylor Health Care System; Lisa McGiffert, Consumers Union

Against — Will Davis, Texas Association of Life & Health Insurers; Jeff Kloster, Health Insurance Association of America, Humana

BACKGROUND: Texas Administrative Code, title 28, relating to information on health maintenance organizations (HMOs), requires that a current list of physicians and providers, including behavioral health providers, be updated on at least a quarterly basis. The list must include names and locations of physicians and providers, a statement of limitations on accessibility, and referrals to specialists.

Insurance Code, art. 3.70-3C requires lists of preferred providers to be updated and provided to all insureds on an annual basis.

DIGEST: HB 2827 would amend the Texas HMO Act (Insurance Code, ch. 20A) by expanding disclosure requirements for HMOs and preferred provider benefit plans (PPOs). Each HMO and PPO would have to provide an accurate written disclosure of any limitation or condition on enrollee access to a specialty physician or provide in its health care plan terms and conditions, current list of physicians and providers, and handbook.

Such information would be made available in order for a current or prospective group contract holder and current or prospective enrollee to make comparisons and informed decisions before selecting among health care plans.

The bill would require an HMO or PPO to disclose any practice used by either health benefit plan to attempt to persuade, direct, or otherwise encourage an enrollee or an insured to use the services of a particular physician or provider. An HMO or PPO could not limit or condition an enrollee's access to any physician or provider or attempt to persuade, direct, otherwise encourage an enrollee to use the services of a particular physician or provider, unless the HMO or PPO had made the required disclosure. The bill would give particulars for a standard disclosure statement and would not apply to limited provider networks.

This legislation would modify PPO disclosure requirements by stating that a current list of preferred providers would be updated and provided to all insureds on at least a quarterly basis.

The bill would take effect September 1, 2001. It would apply only to an insurance policy, contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2002.

SUPPORTERS SAY:

More explicit information about limitations and conditions that apply to the use of specialty physicians and other aspects of health benefits plans would reduce confusion about services and benefits and be in the best interest of the consumer. HMOs and PPOs usually include a list of physicians and providers divided by specialty or provider type in the material they give to current and prospective enrollees or insureds. Limitations or conditions sometimes apply to certain physicians or speciality providers that do not apply to other physicians or providers listed under the same specialty or provider type. HMOs and PPOs do not always disclose these limitations and conditions; thus, such omissions can mislead people who are selecting a health benefit plan. Also, some HMOs and PPOs currently attempt to encourage enrollees and insureds to use the services of a particular physician or provider without disclosing this information.

OPPONENTS SAY:

Additional reporting requirements could be burdensome and require costly changes in technology. The information that PPOs are providing annually should be sufficient.

OTHER OPPONENTS SAY:

Since HMOs already are required to provide most of this information by administrative rule, it is unnecessary to put it in statute.