SUBJECT: Regulating delegated services by an HMO and providing penalties

COMMITTEE: Insurance — committee substitute recommended

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

0 nays

1 absent — G. Lewis

WITNESSES: For — Spencer Berthelsen, Texas Medical Association; Lisa McGiffert, Consumer's Union

Against — None

On — Leah Rummel, Texas Association of Health Plans

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

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.

The 76th Legislature enacted SB 890 by Harris, which amended the Texas HMO Act (Insurance Code, ch. 20A) and regulated the relationship between HMO's and delegated networks. SB 890 made a number of changes that will expire September 2, 2003, unless extended by the Legislature.

SB 890 required that HMOs and delegated networks enter into a written agreement that defines each party's roles and responsibilities. The primary contractual duties of the designated network include:

- no limitation of the HMO's responsibility to comply with statutory and regulatory requirements;
- licensure for claims payment and UR delegated functions;
- limitation of the network's collection power to authorized copayments and deductibles;
- filing financial disclosure statements, contract samples, and quarterly data for the HMO with the Texas Department of Insurance (TDI).

The primary contractual duties of the HMO include monthly reporting of patient and billing information and of rate changes.

SB 890 also provided a process of investigation if an HMO believes that the delegated network is not complying with their agreement. This includes notification, network response, and intervention by TDI at an HMO's request. If a TDI investigation finds deficiencies in the network's operations, the network must submit a corrective plan, which is considered a public document. TDI can enforce that plan if it relates to delegated functions of the network or is required to ensure the HMO's compliance with statutory and regulatory requirements. If the network does not comply, TDI may order the HMO to cease referring or transferring enrollees to the network or terminate the contract.

DIGEST:

CSHB 2828 would amend Insurance Code, sec. 20A by continuing the legislation in place that regulates the relationship between a delegated network and an HMO. This bill also would provide new definitions for interested parties; institute financial solvency requirements, monitoring, and penalties; and expand consumer-oriented provisions.

Definitions. This bill would create the following definitions:

- "delegated network" would mean any delegated entity that assumes total financial risk for a group of health services, but not a delegated entity that would share risk with a HMO;
- "delegated third party" would mean a party other than the delegated

network and the HMO that performs some function for the delegated network; and

- "limited provider network" would mean a group of physicians under a network contract.

Financial solvency, monitoring, and penalties. Delegated networks would be required to maintain reserves of 80 percent of potential liabilities or two months of premiums, whichever was greater. The potential liabilities would include the amount of medical, hospital, or pharmaceutical goods or services that the delegated network agreed to provide. These reserve requirements would not apply to a group model HMO.

The agreement between the HMO and the network would include a provision to allow the HMO to monitor compliance with minimum solvency requirements. TDI also would be permitted, at any time, to examine information pertaining to the network's solvency or ability to meet the requirements of the HMO agreement. This would replace the current HMO-initiated process of investigation. Reports from TDI's investigation would not be considered public documents, although a list of delegated entity agreements would be. The HMO would be required to include complaints against limited delegated networks and delegated entities as a part of the HMO's complaint records. Contracts would have to contain dispute resolution procedures for resolving disputes over the necessity for continued treatment by a physician or provider.

Regardless of whether a delegated entity complied with TDI's request for corrective action, TDI could order the HMO to reassume the network's duties, cease assigning new enrollees to that network, transfer enrollees from that network, or terminate the contract. TDI also would publish a report of all complaints and actions against networks. TDI could revoke or suspend TPA or UR licenses for failure to comply. TDI could impose sanctions or penalties against HMOs that do not provide timely reports of data relating to delegated networks. These penalties would not apply to a group model HMO.

Consumer-oriented provisions. This bill would require an HMO to provide an enrollee with information about the enrollee's primary care physician's

limited provider network, if applicable. The HMO would be required to send this information within 30 days of the enrollee choosing that physician.

If a physician were to leave the network for any reason other than medical incompetence, the network would be obligated to continue to reimburse for that physician's services for an enrollee with special circumstances such as pregnancy, an acute condition, or a disability. Continuity of care could continue for 90 days. This bill also would require the network to provide access to and reimbursement for out-of-network services if the delegated network did not provide medically-necessary covered services.

CSHB 2828 would take effect September 1, 2001. The changes in law would apply only to new or renewed contracts after January 1, 2002. Earlier contracts would be governed by prior law.

SUPPORTERS SAY:

CSHB 2828 would permanently codify what all parties agreed to last session. The 76th Legislature enacted SB 890 with an expiration provision so that its measures could be tested. The industry has been amenable to these measures since they were enacted, and no unintended consequences have developed. Areas of improvement that have been identified were included in CSHB 2828. These regulations should be codified without expiration.

Definitions. CSHB 2828 would rectify the problem of confusing terminology used in the Insurance Code to describe these groups. There would be one term and one set of rules for all such similar groups.

Financial solvency, monitoring, and penalties. Delegated networks assume liabilities when they take on service obligations. They should have the requisite solvency reserves to ensure that they can deliver the promised services.

This bill also would provide TDI with the authorization it needs to initiate an investigation of a network. Under the current statute, TDI must wait until a HMO requests an investigation, which makes the process slower and overly complex. Because TDI would receive financial and contractual information, it should be able to act on that information. In the interest of consumer

protection, TDI also should be able to direct HMOs to assume the duties of underperforming networks.

Consumer-oriented provisions. The bill would provide enrollees with clear notice from their HMO that delegated networks were being used to arrange for or provide their health care.

The bill also would extend the protections given to consumers through HMO regulation to consumers served by delegated networks. Because delegated networks perform many of the functions of HMOs and other regulated entities, their delegation contracts should meet certain standards. This bill would ensure that consumers have the same continuity of care and out-of-network protections in a physician network as in a HMO.

OPPONENTS SAY:

CSHB 2828 should stop at codifying what all parties agreed to last session. While the industry has been amenable to these measures since they were enacted, any new provisions also should be subject to expiration until they are tested.

Financial solvency, monitoring, and penalties. It would be inappropriate for TDI to monitor the activities of physicians who did not hold licenses issued by that department. Further, the provision that would allow TDI to order termination of a contract even if the network complied with TDI's recommendations would be onerous.

Consumer-oriented provisions. Documents related to TDI 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.

NOTES:

A similar bill, SB 955 by Harris, has been referred to the Senate Business & Commerce Committee.

HB 2828 as filed would have continued the current statute and included consumer-oriented provisions. CSHB 2828 includes definitions and provisions concerning financial solvency, monitoring, and penalties.