SUBJECT: Managed care plans and out-of-network health care providers

COMMITTEE: Insurance — favorable, with amendment

VOTE: 8 ayes — Smithee, Martinez Fischer, Deshotel, Eiland, Hancock, Hunter, Taylor, Thompson

0 nays

1 absent — Isett

SENATE VOTE: On final passage, April 16 — 31-0, on Local and Uncontested Calendar

WITNESSES: (*On House companion bill, HB 1442:*)
For — (*Registered, but did not testify:* Bobby Hillert, Texas Ambulatory Surgery Center Society; Patricia Kolodzey, Texas Medical Association; Gregory Mangum; David Marwitz, Texas Dermatalogical Society; Joe Monk, Texas Society of Anesthesiologists; Patrick Reinhart, The San Antonio Orthopaedic Group, LLP; Sam Roberts, Texas College of Emergency Physicians; Jaime Ronderos, Pinnacle Partners in Medicine; William Schlotter, Texas Medical Group Management)

Against — Jared Wolfe, Texas Association of Health Plans; (*Registered, but did not testify:* Shannon Meroney, Aetna; Jay Thompson, Texas Association of Life and Health Insurers)

On — (*Registered, but did not testify:* Dianne Longley, Texas Department of Insurance)

BACKGROUND: A preferred provider benefit plan may reimburse health care providers in the plan's preferred provider network at a different rate than the plan reimburses out-of-network health care providers. A health maintenance organization (HMO) arranges for health care services directly or indirectly through contracts and subcontracts with physicians and providers.

DIGEST: SB 586, as amended, would establish requirements for the conduct of HMOs and insurers offering preferred provider benefit plans with respect

to providers who share information with patients about in-network and out-of-network health care providers.

An HMO would not be allowed to terminate participation of a physician or provider solely because the physician or provider informed an enrollee of the full range of physicians and providers available to the enrollee, including in-network and out-of-network providers, and the enrollee chose an out-of-network provider. An HMO could not, as a condition of a contract with a provider, prohibit or discourage a provider from sharing with a patient in good faith information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition.

The bill would establish that with respect to a preferred provider benefit plan, an out-of-network provider would mean a physician or health care provider who was not a preferred provider. An insurer could not terminate an insured's participation in a preferred provider benefit plan solely because the insured used an out-of-network provider. An insurer could not terminate, penalize, or in any way restrict a preferred provider from communicating with an insured about the availability of out-of-network providers. An insurer could not terminate the contract of a preferred provider solely because the provider's patients used out-of-network providers.

A preferred provider terminated by an insurer could request and receive all information on which the insurer based the termination.

An insurer's contract with a preferred provider could require that before the provider could make an out-of-network referral for an insured, the preferred provider would have to inform the insured of the option to choose a preferred or out-of network provider and that the out-of-network provider could require more out-of-pocket expenses. The preferred provider also would have to tell the patient of any financial interest the provider held in the out-of-network provider.

The bill would take effect September 1, 2009, and would apply only to contracts entered into on or after this date.

SUPPORTERS SAY:

SB 586 would safeguard health care providers and patients against insurer retribution for referral to or use of out-of-network health care providers. Despite terms in most contracts between insurers and health care providers

prohibiting the insurer's influence on a physician's medical care decisions, many physicians inappropriately have been penalized or even have had their contract terminated for making out-of-network referrals. Similarly, some insurers have ceased coverage for consumers seeking out-of-network care.

When physicians feel threatened by insurers for making out-of-network referrals, it can pose a dilemma to physicians who are obligated to make medical decisions in the best interest of their patients yet are financially dependent on the business that contracts with insurers afford. While most contracts require a physician to refer patients to an in-network provider when possible, there are situations in which an out-of-network provider or facility is better equipped to meet a patient's needs or is the only reasonably available provider or facility. Particularly with respect to preferred provider organizations, the insured pays extra for the flexibility of using an out-of-network provider when appropriate, even if the cost is higher. SB 586 would prevent insurers from influencing a physician's medical judgment and would allow the insured to exercise the right to seek medical services where and from whom they prefer.

The bill would not interfere with an insurer's ability to take action against a provider who truly was abusing the system for personal gain. The protections for physicians only would apply when they had informed enrollees of the full range of medical providers available to them. The bill would allow an insurer to require a preferred provider to inform the insured of the available medical providers and the potential to incur higher out-of-pocket costs for out-of-network care.

OPPONENTS SAY:

SB 586 would hinder an HMO or insurer's ability to regulate its provider network in the best interest of patients. As more physician-owned health facilities have been established, physicians increasingly have been encouraging their patients to use services at a facility in which the physician held a financial interest, even if there was a more convenient and less costly in-network facility at which the patient could receive services. Such referrals financially benefit the physician yet can lead to much higher medical bills for patients. For example, an in-network surgeon could see his patients at a private office but encourage the patient to undergo the surgery at his physician-owned surgical center, where the patient would have to pay more because the anesthesiologist was an out-of-network provider.

Although the majority of physicians have their patients' best interests in mind, this bill would equip self-interested physicians with grounds to challenge actions taken by their contracting insurer to curb behaviors that lead to needless out-of-pocket expenses for the insured. It is not clear what information would be sufficient for physicians to argue they had informed an enrollee of the "full range" of in-network and out-of-network providers available to them. Bad actors could provide minimal information regarding in-network providers while advocating for their out-of-network facility services and consumers with limited knowledge of their rights in navigating the health care market would be inclined to trust these doctors. This bill would minimize insurer recourse in such situations.

NOTES:

The companion bill, HB 1442 by Hancock, was heard by the House Insurance Committee on March 24 and was left pending.