SUBJECT: Regulating exclusive provider benefit plans.

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Eiland, Hancock, Sheets, L. Taylor, Torres, Vo, Walle

0 nays

1 absent — Nash

WITNESSES: For — Pati McCandless, Texas Association of Health Plans; (*Registered, but did not testify:* Lee Manross, Texas Association of Health Underwriters; Shannon Meroney, Aetna; John Oates, CIGNA; Kandice Sanaie, Texas Association of Business; Kay Simonton, Blue Cross Blue Shield of Texas; Jared Wolfe, Texas Association of Health Plans)

Against — None

On — Stacey Pogue, Center for Public Policy Priorities; (*Registered, but did not testify:* Douglas Danzeiser, Texas Department of Insurance)

BACKGROUND: Under Insurance Code, sec. 1301, a preferred provider is a health care provider or group who contracts with an insurer to provide health services to a plan's insureds. A preferred provider plan (PPO) is a health plan in which an insurer provides levels of coverage that differ according to whether the insured person uses a preferred provider (in-network) or nonpreferred (out of network) provider.

DIGEST: CSHB 1772 would authorize the regulation of exclusive provider health plans (EPOs) in the same manner as the state now regulates preferred provider plans (PPOs). The bill would not regulate CHIP or Medicaid managed care plans. It would authorize the commissioner of insurance to determine to what extent existing PPO laws applied to EPOs.

The bill would define an EPO as a plan that excluded benefits for some or all services, other than emergency services, from providers who were not preferred providers. An EPO would not be required to compensate a nonpreferred provider for services rendered for nonemergency care. The bill would specify that similar to a PPO, if services were not available

through a preferred provider within the EPO service area, the insurer would have to reimburse nonpreferred providers at a preferred provider rate.

CSHB 1772 would not apply to EPOs existing PPO provisions that limit insureds' coinsurance to nonpreferred providers or require insurers that offer PPOs to also offer a basic level plan in the service area.

EPOs would have to establish specified procedures to ensure quality of care consistent with prevailing professionally recognized standards, including mechanisms to ensure continuity of care, a continuing quality improvement program, a physician review panel, and patient record keeping and review.

In addition to PPO requirements on information and marketing to prospective insureds, an insurer would have to provide to a prospective insured notice that the EPO plan included limited coverage for services provided by a *non*preferred provider.

This bill would take effect September 1, 2011, and would apply only to an exclusive provider benefit plan delivered, issued, or renewed on or after January 1, 2012.

SUPPORTERS SAY:

CSHB 1772 would authorize the operation and regulation of EPO plans, thereby creating another, lower-cost option for employers and consumers seeking health coverage. EPOs are commonly used products by self-funded (usually large) employers. EPOs combine the access features of a PPO and with the limited out-of-network benefits of a health maintenance organization (HMO). They would be subject to the same regulations as PPOs and HMOs. EPOs, like PPOs, allow insureds to see any provider without a referral (no gatekeeper), but like HMOs require use of network providers, except in cases of emergency or where the plan does not have sufficient providers in the network. By excluding coverage for most non-preferred (or out-of-network) providers, EPOs have the potential to lower premiums.

This bill would help many employers and individuals obtain health care at no cost to the state, which is especially important given the state budget situation, the economy, and the fact that some employers are dropping health coverage due to rising insurance rates. Some employers have seen

savings of 20 percent to 30 percent as a result of transitioning to an EPO model.

CSHB 1772 would contain many protections for consumers by requiring that prospective insureds understand that their policies would have little coverage for nonpreferred providers. EPOs would be required to cover services that were not available through a network provider in a given service area and pay for emergency services. The bill also would require EPOs to have in place quality of care processes and procedures to protect the safety of the insured and to ensure that EPO services were delivered according to professionally recognized standards.

The author will be offering a floor amendment that would put into place additional protections for consumers, such as on balance billing.

OPPONENTS SAY:

While EPOs present consumers and employers with lower-cost health insurance premiums, because most out-of-network care is not covered, consumers could face overall higher and less predictable out-of-pocket costs than when covered by an HMO or PPO plan. This bill also would offer no protection from balance billing (when the provider bills the patient for costs not covered by the health insurance plan).

Because EPOs — similar to HMOs — will have few out-of-network benefits, existing HMO consumer protections should be extended to EPOs. For example, EPO insureds should have the same protection as HMO enrollees against balance billing for emergency care because the EPO insured received care for medically necessary services that were beyond the insured's ability to plan for or obtain from a preferred provider.

OTHER OPPONENTS SAY:

EPOs should be required to give more information to prospective insureds. Employers and others seeking health coverage must fully understand the implications and limitations of an EPO plan. Most people are used to situations in which they have more access to nonpreferred providers, albeit at higher co-pays than services from preferred providers. Additional communications requirements would be needed, such as requiring the insurer to inform prospective and current insureds of their network's adequacy to provide services within a reasonable distance from an insured's home, offering benefit cards that clearly identify the coverage as EPO coverage, and annual consumer report cards on quality.

NOTES:

The major changes in the committee substitute from the filed bill include the addition of provisions that specified that EPO regulations would not apply to CHIP or Medicaid health plans and established requirements concerning quality improvement and utilization management standards and mechanisms as well as communications to prospective insureds.

The author plans to offer a floor amendment that would make several changes to the committee substitute, including:

- clarifying the application of PPO and other insurance law and that EPOs cannot provide dental benefits;
- requiring EPOs to approve the referral of an insured to a nonpreferred provider for medically necessary care that is not available from a preferred provider and to fully reimburse the nonpreferred provider;
- requiring EPOs to fully reimburse nonpreferred providers for emergency care;
- requiring TDI examination of EPO network adequacy and quality of care;
- authorizing EPO examination fees and assessments; and
- requiring EPOs to issue a benefit card containing specified plan information to each insured.