SUBJECT: Regulating health care provider network contract arrangements

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Smithee, Eiland, G. Bonnen, Creighton, Morrison, Muñoz, C. Turner

1 nay — Taylor

1 absent — Sheets

WITNESSES: For — Dawn Buckingham, Texas Medical Association; John McCormick, Texas Optometric Association; Dan McCoy, Blue Cross and Blue Shield of Texas; Bill Reynolds; (*Registered, but did not testify:* Charles Bailey; Texas Hospital Association; Joel Ballew, Texas Health Resources; Christine Bryan, Clarity Child Guidance Center; Jaime Capelo, Texas Chapter American College of Cardiology, Texas Urological Society, Texas Academy of Physician Assistants; Tracy Casto; Audra Conwell, Alliance of Independent Pharmacists; Tony German, Texas Ambulatory Surgery Center Society; John Gill; Steven Hays; John Heal, PBA Health / Texas TrueCare Pharmacies; Greg Herzog, Texas Society of Gastroenterology and Endoscopy; Bobby Hillert, Texas Orthopaedic Association; Michelle Ho, Texas Medical Association; Harry Holmes, Harris County Healthcare Alliance; Chuck Hopson, Texas Pharmacy Business Council; Marshall Kenderdine, Texas Academy of Family Physicians; Phillip Korenman; John Lee Sang; David Marwitz, Texas Dermatological Society, Texas Pharmacy Association; Lorraine Powell; Michelle Rodriguez, Tri-County Medical Society; Robert Rogers; Alberto Santos; Will Schlotter, Texas Medical Group Management Association, Capitol Anesthesiology; Michael Wright, Texas Pharmacy Business Council; Sherif Zaafran, Texas Society of Anesthesiologists)

Against — David West, Texas Association of Benefit Administrators; (*Registered, but did not testify:* Lucinda Saxon, American Association of Preferred Provider Association)

On — David Gonzales, Texas Association of Health Plans; Kandice Sanaie, Texas Association of Business; (*Registered, but did not testify:* Debra Diaz Lara, Texas Department of Insurance)

BACKGROUND:

Many doctors, hospitals, and other health care providers access patients by participating in preferred provider organizations (PPO). PPOs and similar contracting entities, such as exclusive provider organizations (EPOs), form networks of health care providers who agree to offer their services at contractually discounted rates. The PPO sells access to these networks to insurance companies, health maintenance organizations (HMOs), employers, and other third parties seeking contractual discounts and decreased claims costs.

While the Texas Department of Insurance (TDI) has some authority over the health benefit plans that use PPO networks and financially regulates some aspects of companies that contract with PPOs, it does not have regulatory authority over the PPOs themselves. Insurance Code, sec. 1301.056 prohibits the sale, lease, or transfer of information regarding the reimbursement terms of health care provider network contracts without the prior notification and express authority of the other contracting parties. Administrative penalties are limited to insurers and third-party administrators.

DIGEST:

CSHB 620 would spell out the registration and responsibilities of "contracting entities," most commonly preferred provider organizations (PPOs). The bill would define a contracting entity as an individual or entity that contracted with health care providers for the delivery of services to individuals covered under a health benefit plan and that, in the ordinary course of business, established a provider network for access by another party.

Registration. Contracting entities that were neither HMOs nor insurers with a certificate of authority would have to register with the Texas Department of Insurance within the first 30 days of their operations and would have to disclose:

- all names used by the contracting entity;
- organizational charts and lists that show the entity's structure, including the relationships between the entity and any of its affiliates, as well as its internal management structure;
- the mailing address and main telephone number of the contracting entity's headquarters and primary contact for TDI; and
- any other information required by the commissioner by rule.

TDI would be authorized to collect a reasonable fee to administer the

registration process and the commissioner would adopt by rule the format for its submission.

Contracting entities that were HMOs or insurers holding a certificate of authority would file with the TDI commissioner an application for a registration exemption, which would include a list of the contracting entity's affiliates. This list would be public information and the contracting entity would update it annually. Affiliates would be exempt from registration if the commissioner determined that they did not have a basis to disclaim the affiliation, and that the relationships between the affiliates and the certified entity, including other networks, were disclosed and clearly defined.

Contract requirements. CSHB 620 would:

- prohibit a contracting entity such as a PPO from selling, leasing, or transferring information regarding the provider network contract's reimbursement terms without the adequate prior notification and express authority of the provider;
- require signatures for each separate line of business, including benefit plans for PPOs, EPOs, HMOs, Medicaid managed care, the state child health plan, Medicare Advantage or similar plans, and any additional lines of business the TDI commissioner added by rule;
- prohibit contracting entities from providing an individual or entity access to a provider network contract's services or discounts unless the contract specifically stated the person or entity had to comply with all applicable terms of the contract;
- require the contracting entity to provide by request information about whether a person or entity had authorized access to the provider's services and contractual discounts;
- make provider network contracts unenforceable against a provider unless they specified a fee schedule or payment methodology for each separate line of business; and
- require contracting entities to allow a provider reasonable access, including electronic access, during business hours to review the provider network contract.

Enforcement and penalties. The bill would allow the TDI commissioner to adopt rules to implement its provisions and impose administrative penalties on a contracting entity that violated the bill's provisions or

implementing rules.

Effective date. A provider's express authority would be presumed if, on the first renewal after the effective date of CSHB 620, the provider did not object within 60 days after receiving a mailed notice from the contracting entity that included:

- the fee schedules for each line of business in the contract;
- separate signature lines for each line of business; and
- notice that lack of a timely response would serve as agreement to the renewal.

The bill would take effect September 1, 2013, and would apply only to contracts entered into or renewed on or after that date.

SUPPORTERS SAY:

CSHB 620 would clarify the regulatory environment for contracting entities and give TDI the authority to protect health care providers and consumers.

The bill would increase contracting entities' accountability for provider reimbursement. Currently providers face costly and time-consuming administrative burdens attempting to verify the accuracy of payments they receive for their services. The complex interaction among contracting entities, payers, third-party administrators, and their affiliates is made even less clear as contracts signed with PPOs are often resold, rented, and leased to other parties without the providers' knowledge. CSHB 620 would increase transparency by requiring providers know of and approve any such transactions, giving providers control over what they are paid and by whom.

The bill would protect consumers. Because PPOs and other contracting entities are largely unregulated, TDI does not know how many are operating in Texas or the degree of consumer harm. PPOs' ability to sell, rent, and lease provider contracts without approval can create uncertainty for patients regarding their coverage options and may lead to higher health care costs if a provider is not in-network as expected. Consumers also have little recourse should they seek to file a complaint against a PPO. CSHB 620 would not only decrease uncertainty about health care coverage, it would require each contracting entity be registered and would give TDI the authority to sanction PPOs for violating state law.

The registration requirements for contracting entities are not onerous, and

the fees necessary to administer the program would be reasonable and would not impose a financial burden on the state.

Despite critics' claims otherwise, sec. 1458.102 would not conflict with the federal Employee Retirement Income Security Act of 1974 (ERISA) and not lead to an ERISA preemption challenge. The bill would contain no mandate that an entity, including a self-funded employee benefit plan, accept any particular provider network contract. While network contract purchasers would be held to all applicable terms and conditions of the contract, they would be under no obligation to accept the services offered by the contracting entity. The bill would only place limits on the contracting entity, which would be clearly defined as an entity that established a provider network or networks for access by another party in the ordinary course of business. The bill would not place limits on potential purchasers and would therefore regulate only sellers. Since the provider network is not an ERISA benefit plan, the terms of ERISA would not be implicated.

OPPONENTS SAY:

CSHB 620 would limit employers' ability to reduce health care costs in self-funded plans by requiring that they comply with all applicable provider network contract terms. This would prohibit employers from including what few legally available cost-control mechanisms still exist to them, such as language allowing only "medically necessary" services and employer-specific rate schedules. Where such plan provisions already exist, legal issues would arise over which contract controls.

The bill would create difficulties for claims administrators by prohibiting access to the network provider agreements, which are signed with confidentiality provisions. Without access to the contract terms, claims administrators would have a difficult time ensuring claims were properly adjudicated.

CSHB 620's section 1458.102 would not survive a federal preemption challenge under ERISA. An ERISA-governed health benefit plan accessing or wanting to access a PPO network would be forced to alter the terms of its plan without it having been negotiated or agreed to. This would interfere with the congressional intent expressed through ERISA for a national, uniform administration of employee benefit plans. It would also create conflicts between the terms of the PPO contract and the design of an ERISA plan.

NOTES:

The companion bill, SB 822 by Schwertner, was passed by the Senate on April 17 and referred to the House Insurance Committee on April 22.

Among other provisions, the committee substitute differs from the original in that it would:

- regulate only contracting entities rather than third parties to prohibit the sale, lease, and rental of provider network contracts;
- extend to advanced practice nurses, optometrists, and therapeutic optometrists;
- extend to Medicaid, Medicare, and the state child health plan;
- define the separate lines of business that require a provider’s express authority;
- grant the commissioner rulemaking authority to implement the bill's provisions, including to add lines of business requiring a provider's express authority, and;
- change the bill’s contract implementation date from January 1, 2014 to September 1, 2013 and provide procedures for presuming a provider's express authority when initially renewing an existing contract.