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I. PATIENT PROTECTION ACT & REGULATIONS

THE LEGISLATION

In the 1995 legislative session, the Texas Legislature passed H.B. 2766, The Patient Protection Act, a bill designed to protect patients enrolled in managed care plans from suddenly losing their physician, as well as to protect those physicians from suddenly being terminated or “deselected” from participation in those plans. Supporters hailed the legislation as being consumer friendly because it mandated that individuals would have the right to see information about a managed care plan before they enrolled, including benefits and coverage, limitations and exclusions, out of pocket costs, and referral and preauthorization restrictions. The bill required coverage for emergency care given in non-network hospitals, required annual performance reports on managed care plans, and provided an appeals process for physicians “deselected” by a plan, or patients denied treatment deemed necessary by their physicians. The bill also prohibited financial incentives to physicians to limit medically necessary or appropriate care, a restriction long ago adopted by the federal Medicare program. The sponsors claimed the legislation would avoid some of the problems experienced by other states due to rapid and uncontrolled growth of managed care. After strong pressure from the insurance and HMO industry, Governor Bush surprised the bill’s proponents and vetoed the legislation. Calling the bill’s title a “misnomer”, Gov. Bush concluded the legislation imposed too much government regulation on the healthcare industry and “unfairly” impacted certain providers while exempting others. He agreed that certain protections for patients and physicians were necessary as health care moves into managed care, but stated that he believed such protections were better accomplished through regulation. He ordered Insurance Commissioner Elton Boemer to develop regulations to “ensure both patients and doctors are treated fairly as we move to managed care.”

THE REGULATIONS

In response to the Governor’s veto, the Texas Department of Insurance and the Texas Department of Health were directed to adopt rules that incorporate as much of the vetoed bill as current law allows. The Department of Insurance adopted two sets of PPA rules, “Patient Protection I” and “Patient Protection II”.

The TDI Rules

“Patient Protection I” & “Patient Protection II” rules provide as follows:

a. Disclosures. Requires that much more information be provided to prospective enrollees, including: complete provider network information, use of a drug formulary, description of benefits and any limitations, prior authorization and referral requirements, explanation of appeals process, and a toll-free phone number for additional information.

b. Emergency Care. The definition of emergency care includes the “expectation of a prudent layperson” standard and also includes circumstances requiring treatment for an acute medical condition in the case where a condition began several days earlier. Medical screening exams to determine if an emergency exists must be covered, and the HMOs must respond to the treating provider within one hour of the call to approve or deny coverage.
c. **Non-retaliation.** The HMO cannot retaliate against an enrollee or a physician or provider for filing a complaint against or appealing the decision of an HMO. d. **Transition of Care.** Reasonable notice must be given to an enrollee that his treating physician or provider is to be terminated from the plan. The physician or provider may request that under special circumstances an enrollee continue under his care for an additional 90 days following contract termination. The HMO must permit a terminated physician to continue caring for a patient who is beyond the 24th week of pregnancy at the time the contract is terminated, and contracts between an HMO and physicians shall provide dispute resolution procedures for such cases.

d. **Network Participation.** HMOs must make available to physicians and providers written application procedures and qualification requirements for contracting with the HMO. The HMO must provide written notice of reasons the initial application was denied, and must give physicians and providers written explanation of reasons for termination. Physicians and dentists are entitled to a peer review upon request prior to termination/HMO shall provide the physician or dentist a copy of the review panel recommendation and the HMO’s determination and economic profiles must be made available upon request to those profiled. Economic profiles must recognize the characteristics of the physician’s or provider’s practice that may account for variation from expected costs.

e. **Capitation Payment.** Enrollee must be able to select a primary care physician or provider, and must be allowed to change primary care physician or provider. HMO’s must pay capitation to a primary care physician or provider retroactively to the date of enrollment once the member selects a primary care physician or provider.

f. **Payments.** HMO may not use financial incentives which act as an inducement directly or indirectly to limit medically necessary services.

g. **Cancellation.** An employer or individual may cancel an HMO contract for a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees.

h. **Out-of-Network Services.** If medically necessary covered services are not available through network physicians or providers, the HMO must allow referral outside of the network. The HMO may not deny such a referral until the case has been reviewed by a specialist of the same or similar specialty as the referring physician.

i. **Advertising.** HMOs offering Medicare risk contracts to seniors must file all advertising with the TDI for review and compliance with regulations.

j. **Indemnification.** Contracts between HMOs and physicians and providers may not contain any clause purporting to indemnify the HMO for any tort liability resulting from acts or omissions of the HMO.
The TDH Rules

On March 12, 1996 the Department of Health weighed in with its proposed rules regarding HMO’s. Highlights of the proposed rules are as follows:

   a. TDH will conduct periodic quality of care examinations of HMOs.

   b. HMOs will be required to have a complaint process that includes all complaints or grievances and all denials, terminations or other limitations of covered health care services. Response time shall not exceed 30 days, and an appeal process is also required. Unresolved complaints will be sent to TDI, who will forward complaints concerning the quality, availability and accessibility of care to TDH.

   c. TDH may examine medical, hospital and health records of all enrollees and records of all physicians and providers providing service under independent contract with an HMO.

   d. HMO enrollees who live within the HMO’s service area shall not be required to travel more than 20 miles to reach a source of health care service. HMO enrollees who live outside the HMO’s service area shall not be required to travel more than 50 miles to reach a source of health care service. Exceptions are provided for services not available in the area or for “a higher level” of skill or specialty such as treatment of cancer, burns and cardiac diseases not available in the area.

   e. HMOs must have an ongoing Quality Improvement Program, including a peer review program that meets federal HCQIA standards.

   f. Contracts with physicians and others must have procedures for resolving disputes regarding the necessity for continued treatment.

   g. If an HMO performs Utilization Review, it must have an ongoing UR plan, for which the HMO governing body is ultimately responsible.

   h. Primary care physicians services must be available 24 hours per day, 7 days per week. After hours emergency and urgent care must be provided. Referral specialists must be available in the same manner as primary care.

   i. Emergency care will be paid for when rendered by non-network providers, and for any medical screening examination (and subsequent treatment and stabilization) required under EMTALA. HMOs must respond to inquiries from treating physicians in hospital emergency rooms within one hour.

The TDH rules have run into trouble, as there is a perception that TDH has not followed the Administrative Procedures Act in publishing the rules. Thus they may have to be repromulgated, and may change based on the substantive comments received.
II. 5.01(A) NON-PROFIT HEALTH CARE CORPORATIONS.

Somewhat like an armadillo, a 5.01(a) corporation is unique to Texas. A 5.01(a) organization is a nonprofit corporation “certified” by the Texas State Board of Medical Examiners (TSBME) under §5.01(a) of the Medical Practices Act. The entity is formed to provide healthcare services, has exclusively a physician board of directors, and must meet certain other TSBME requirements. Once approved, a 5.01(a) may practice medicine without concern of violating Texas’ corporate practice of medicine doctrine. That doctrine provides that a physician may not aid or abet, directly or indirectly, the practice of medicine by a person or partnership, association, or corporation not duly licensed to practice medicine by the TSBME. For example, the prohibition means that a physician may not employed by a lay person, receive funds from a lay person, and allow the lay person to make decisions about how medicine is practiced. It also means that HMOs and hospitals many not hire physicians – as employees – to provide medical care. Many hospitals have used such entities to create captive medical groups which the hospital essentially controls, but which does not violate the Medical Practice Act.

Section 5.01(a) allows the TSBME to “approve and certify” qualifying organizations, if those organizations are: a) non-profit corporations under the Texas Non-Profit Corporation Act; b) organized for purposes such as scientific research, research in the public interest in medical science, medical economics, public health, sociology and related areas, support of medical education through grants and scholarships, and the delivery of health care to the general public. The corporation must be organized and incorporated by licensed physicians, and its board of directors is composed only of licensed physicians actively engaged in the practice of medicine. Potential problems with 5.01(a)’s Since all Section 5.01(a) organizations are nonprofit corporations, the “Member”, including a nonphysician member, may reserve and exercise certain powers such as the power to adopt and amend the Articles of Incorporation, the setting of annual operating and capital budgets, the creation of subsidiaries and the approval of contracts with physicians or payors. These expressed and reserved powers have led to concerns over such matters as the authority of non-physician members to control the physician officers and directors and to remove them without cause. The way in which board members are selected and the definition of who may serve as a board member are critical in that physician board members represent the participating physicians, especially in matters that will affect the quality and appropriateness of care being provided to those serviced by the entity. When the corporate member has a large investment in the 5.01(a), it is unreasonable to believe that it will give up total control to a physician board.

TSBME Regulations

Because of the proliferation of 5.01(a)’s, and the concerns for abuse, the TSBME (after more than a year of study) adopted regulations effective January 12, 1996. The final 5.01(a) rules provide:

a. The 5.01(a) bylaws shall reserve the sole authority to engage in the practice of medicine to its physicians. The 5.01(a) Board of Directors shall have the sole authority to direct the medical, professional, and ethical aspects of the practice of medicine.
b. Directors are to individually disclose to TSBME the identity of all financial relationships with any supplier or affiliate of the 5.01(a), and provide an explanation of the nature of each such financial relationship.

c. The termination of physicians from a 5.01(a) may be accomplished only by the Board of Directors, subject to due process procedures adopted by the Board of Directors or provided by the contract between the 5.01(a) and the physician.

d. If the 5.01(a) Member is a non-physician or an organization not wholly owned and controlled by physicians, then all credentialling, quality assurance, utilization review and peer review policies shall be made exclusively by the physician Board of Directors.

e. Without the approval of at least a majority of the Board of Directors, the non-physician member may not unilaterally amend the bylaws of the 5.01(a) unless required to obtain or maintain tax exemption.

f. Biennial compliance reports are required.

g. 5.01(a) Directors shall report to TSBME any action or event which such they reasonably and in good faith believes constitutes a violation or attempted violation of the Medical Practice Act or Rules.

h. There is an initial fee of $2,500 and a biennial fee of $500. 5.01(a)’s continue to flourish in Texas and are at the enter of another ongoing regulatory controversy.

III. DIRECT CONTRACTING ISSUES

An ongoing issue in Texas and other states has been whether physician groups, IPA’s, PHO’s, and other healthcare providers may contract directly with employers and other self funded payors to provide healthcare services on a risk sharing/capitated basis, without contracting through an HMO, or being licensed as an HMO. State Insurance boards traditionally do not want entities assuming large financial risks without some sort of regulatory oversight. Proponents of such provider networks believe that, when providers control the entire risk pool, they will be able to manage care in the most cost and care effective manner. Managed care groups on the other hand view this as a “reverse patient protection” issue, arguing that medical groups are attempting to avoid the stringent regulation of insurance companies for competitive gain.

In 1995, the Texas Legislature passed two bills that affect this issue. The bills concern the ability of 5.01(a) organizations to provide health care services, and further regulate the manner in which healthcare providers may contract to provide services on a risk or capitated basis. HB 3111 amended the Texas Insurance Code to clarify the range of services that various healthcare providers could provide on a capitated basis, so long as they provided such care through a contract with an HMO. Physicians can provide or arrange for “medical care”, and certain services ancillary to the practice of medicine, while providers (hospitals, nursing homes and the like) may provide or arrange for health care services for which they are licensed. Physicians may not provide or arrange for healthcare services, and providers may not provide or arrange for medical care. To further define expand the authority of 5.01(a)’s, SB 1407 provided a mechanism for “certifying” 5.01(a) organizations to essentially make them an HMO lookalike.
This certification process is tantamount to certification as an HMO, but it would allow the 5.01(a) to provide all healthcare services (not just physicians services) on a capitated basis, and to contract directly with employers.

**Regulations**

Because these statutes are somewhat contradictory, the Texas Department of Insurance in March published rules to reconcile the provisions. These rules can be summarized as follows:

(i) A 5.01(a) that needs a TDI certificate of authority must basically follow the requirements for an HMO, and must demonstrate either NCQA or JCAHO accreditation.

(ii) The 5.01(a) must continue to comply with all appropriate HMO law requirements, and will be considered to be an HMO.

(iii) A 5.01(a) that contracts to arrange, or contracts to provide, medical care only is not required to meet HMO requirements or obtain a certificate of authority.

(iv) A “primary HMO” that contracts with either a 5.01(a) or a “provider HMO” in which either a 5.01(a) agrees to arrange for or provide health care services other than medical care, or the provider HMO agrees to arrange for or provide health care on a risk sharing or capitated basis, must 1) submit a Monitoring plan to TDI, 2) file its written agreements with the 5.01(a) or provider HMO, 3) conduct onsite audits of the 5.01(a) or provider HMO, and 4) promptly correct any deficiencies found.

**Possible New Department of Insurance Regulations**

The Texas Department of Insurance reportedly is considering publishing new regulations, or a new “interpretation” of existing regulations, which would allow physician groups, §5.01(a) organizations, hospitals, and other providers, to contract directly with employers or other self-funded groups to provide health care services on a capitated basis, without the certification process required by SB 1407. That is to say, those providers could accept risk to provide healthcare services without contracting through a licensed HMO. Nothing has yet been set forth in writing, but this development, if true, represents a significant departure from existing Department of Insurance policy as well as current Texas law. The new Insurance Department regulations effectively would eviscerate SB 1407. It would not be necessary for a 5.01(a) to become certified as an HMO lookalike, because it would be able to provide physicians’ services and other healthcare services, by contracting directly with employers on a capitated basis. By forming a three party contract between the 5.01(a), a hospital or hospitals, and the employer, the 5.01(a) could essentially provide almost all healthcare services on a risk sharing basis without contracting through an HMO.

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