PHYSICIAN COLLECTIVE BARGAINING: WHAT IMPACT WILL IT HAVE?

Jackson Walker is pleased to offer this Special Issue of HealthBrief. The 76th Texas Legislature produced new laws covering the spectrum of businesses and industries in Texas. As in recent years, the Health Care industry was in the spotlight of legislative reform. Managed care reform, physician contract rights, and public health initiatives— including the CHPs program—were the focus of efforts by my colleagues in the House and Senate. I hope this brief summary of legislation—with an in-depth look at a few significant bills—will help you in your business.

Rob Junell
Chairman, House Appropriations Committee
Of Counsel, Jackson Walker L.L.P.

On June 20, 1999, Governor George W. Bush signed into law S.B. 1468 which allows certain networks of competing, independent, and unintegrated physicians to collectively negotiate with health care plans having market power. The new Act has spawned much debate and attracted national attention, but what are its real implications for practicing Texas physicians?

S.B. 1468 is nothing short of groundbreaking in its departure from traditional antitrust legal analysis of collective physician negotiations. Under federal and state antitrust laws, a physician network (a group of two or more individual physicians or practices that align with each other for the purpose of, among other things, contracting with health plans) may not lawfully negotiate payer contracts unless the network, as a group, shares financial risk or clinically integrates their members’ individual practices. Exclusive networks of physicians, i.e., networks whose members do not contract outside of the network, face even stricter antitrust compliance burdens.

The immediate impact of S.B. 1468 is that it permits physicians, on a non-exclusive basis, to collectively deal with health plans without accepting financial risk and without clinically integrating their independent practices. Even so, S.B. 1468 should not be misconstrued as a general exemption from the antitrust laws; the hallmark antitrust prohibitions still apply to networks and are specifically referenced in the text of the Act — physician boycotts and work stoppages remain illegal, and physicians are prohibited from attempting to force health plans to accept all of their members or participation in all products offered by the plan.

S.B. 1468 provides that physicians may lawfully engage in joint negotiations with health plans relative to certain quality of care issues, such as:

(Please see “Physician Collective Bargaining” on p. 5)
BILLS ON ARBITRATION OF NURSING HOME MATTERS LIKELY TO CREATE CONFUSION

In the 1999 Session, the Texas Legislature passed two bills amending current laws relating to the arbitration of certain types of matters affecting nursing homes. The current law provides that the following matters may be submitted to binding arbitration:

- renewal of a license;
- suspension of a license;
- assessment of a civil penalty under 242.065;
- assessment of a monetary penalty (administrative) under 242.066; and
- assessment of a penalty under 32.021(k) of the Human Resources Code.

Only one of the foregoing matters, assessment of a civil penalty under 242.065, involves an original action in State district court. The other matters are actions that originate in an administrative proceeding before the Texas Department of Human Services. However, the statute is clear that arbitration may be elected for both contested case hearings and judicial proceedings relating to the assessment of a civil penalty.

CURRENT LAW

The current law has always been somewhat confusing as to when an election of arbitration must be filed in judicial proceedings relating to the assessment of a civil penalty. The statute at 242.252 currently requires that arbitration be elected “not later than the 10th day after a notice of hearing relating to any dispute” subject to arbitration. This language can be confusing in a court proceeding for the reason that hearings may be scheduled with regard to many types of pre-hearing matters such as discovery disputes, entry of scheduling orders, etc., which do not relate to the merits of the dispute which is being arbitrated, i.e., whether civil penalties should be imposed against the nursing home. Therefore, the question arises as to whether the election of arbitration had to be filed within 10 days of notice of any hearing in the lawsuit, or only within 10 days of the notice of a trial setting.

H.B. 3452

In an apparent attempt to address this issue, H.B. 3452, confuses matters even further. H.B. 3452 deletes the provision regarding election of arbitration not later than the 10th day after notice of hearing and substitutes the following language:

The election [of arbitration] must be filed not later than the 10th day after the date on which the answer is due or the date on which the answer is filed, whichever is sooner.

Therefore, the bill now clearly addresses when the election of arbitration must be filed in judicial proceedings, but ignores the issue in regard to administrative proceedings. In administrative proceedings regarding the renewal, suspension or revocation of licenses or the assessment of administrative monetary penalties, there are no “pleadings” filed as such. Rather, the nursing home receives an initial notice of the sanction or remedy and has the right to file an appeal. No formal pleadings or answer is filed by the administrative agency in response to a notice of appeal. Therefore, it appears that the language of the statute is now unclear as to when an election of arbitration must be filed in an administrative proceeding where arbitration is available.

Further, H.B. 3452 adds provisions limiting who may elect binding arbitration. The new provisions state that:

Arbitration may not be used to resolve a dispute related to an affected institution that has had an award levied against it in the previous five years. (Emphasis supplied.)

No definitions are provided for the terms “award” or “levied.” Obviously, the meaning of these terms will likely be in dispute because a broad interpretation will substantially limit the number of facilities eligible to elect arbitration. These new restrictions on those eligible to elect arbitration apply only to causes of action that accrue after the effective date of the Act, September 1, 1999. This last provision raises even further questions. For example, if a nursing home survey is conducted from August 1-3, 1999, and finds violations based on acts by the facility that occurred on July 4, 1999, but the Attorney General does not file a lawsuit for civil penalties until December 1, 1999, when

(Please see “Arbitration of Nursing Home Matters” on p. 11)
MANAGED CARE “TOP TEN”

The 76th Texas Legislature was a busy one for managed care. While the physician “collective bargaining” legislation undoubtedly consumed the most attention from health plans and physicians (see related article by Collin Hayes on p.1), a number of other significant bills passed relating to managed care. The following summarizes ten of the most noteworthy bills relating to managed care passed by the 76th Texas Legislature.

1. **Prompt Payment of Claims**

   H.B. 610 requires health plans to pay “clean claims” promptly. Specifically, an HMO or insurer has 45 days after it receives a claim from a physician or provider to (1) pay the total amount of the claim in accordance with its provider contract; (2) pay the undisputed portion of the claim and notify the claimant of the reason why the remaining portion of the claim will not be paid; or (3) notify the claimant in writing of the reason why the claim will not be paid. Prescription benefit claims that are adjudicated and paid electronically must be paid within 21 days after the treatment is authorized.

   If an HMO or insurer desires to audit a claim, it must pay the charges at 85% of the contracted rate within 45 days of receipt of the clean claim. Following completion of the audit, the HMO or insurer must make any additional payments within 30 days. Physicians or providers must make any refunds to the HMO or insurer within 30 days after the later of the date of receipt of notice of the audit results or the date on which the enrollee exhausts any appeal rights.

   HMOs and insurers who fail to meet the payment deadlines will be liable for the full amount of the charges submitted on the claim or a contracted penalty rate, less payments for amounts previously paid or charges for services which are not covered. In addition, the Texas Department of Insurance may impose a fine of up to $1,000 per day for each day a claim remains unpaid.

   H.B. 610 also requires that HMOs and insurers: (1) provide participating physicians and providers with copies of all applicable utilization review and claims processing policies and procedures and (2) give 60 days’ written notice to providers in advance of any changes to the data elements that must be submitted with a claim or any other changes in claims processing and payment procedures.

2. **Prohibition of Silent PPOs**

   S.B. 130 prohibits insurers and third party administrators from reimbursing a provider on a discounted fee basis for covered services provided to an insured unless:

   (1) the insurer or third party administrator has contracted with either the provider or a PPO that has contracted with the provider;

   (2) the provider has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

   (3) the insurer or third party administrator has agreed to provide coverage for those services under the health insurance policy.

   The bill also prohibits the parties to a preferred provider contract from selling, leasing or transferring the reimbursement terms of a contract without the express authority and prior adequate notification of other contracting parties.

3. **Expanded Health Coverage Options**

   H.B. 1498 requires, with certain exceptions, that HMOs offer to eligible employees of an employer’s health benefit plan an opportunity to obtain health benefit coverage through a non-network plan at the time of enrollment and at least annually if the only health benefit coverage under an employer’s health benefit plan is a network-based delivery system. HMOs offering coverage under an employer’s health benefit plan may, however, enter into an agreement designating one or more of them to offer the non-network plan.

   Non-network coverage may be provided through a point of service plan, a preferred provider benefit plan, or any other non-network coverage arrangement that permits access to services outside the HMOs delivery network. The premium for such coverage shall be based

   (Please see “Managed Care ‘Top Ten’” on p. 11)
PHYSICIANS HEAL THYSELVES

They’re angry, frustrated and alienated. They feel like the establishment is against them. And now they’re joining gangs. Your teenagers? No, your doctors.

For years, doctors have felt the walls closing in on them. Changes in the health care marketplace, government reimbursement and private insurance have chipped away at their financial and professional independence. Now they are doing something about it.

Doctors have become increasingly involved in politics over the last decade. There are now numerous physicians serving in our federal and state legislatures, and physicians continue to have some of the most effective lobbying organizations in the country. This increased political activity is evidenced by the successes doctors enjoyed during the most recent session of the Texas Legislature. A review of some of the most important of these achievements shows that while physicians are making progress toward their goals of renewed financial and professional independence, there is more work ahead.

The most prominent physician legislative initiative of this past session is the right of doctors to collectively bargain with managed care organizations. Basically, independent physicians are now allowed to negotiate collectively with managed care organizations on contract and reimbursement issues without fear of prosecution under federal antitrust law. However, there are a number of factors limiting the usefulness of this legislation, and all in all, this legislation is probably more of an interim stop rather than a final destination for physicians (see related article on p. 1).

Less well known, although potentially as significant, is legislation concerning the enforceability of covenants not to compete by physicians. A covenant not to compete is a contractual agreement by a physician not to compete for business with an employer or purchaser of his practice for a certain period of time within a specified geographical area. For example, Dr. Kildare sells his practice to a hospital-controlled organization. In his Contract of Sale, Dr. Kildare agrees that for a period of two years he will not compete for business against the hospital organization within a radius of twenty miles of his former office. In this manner, the hospital organization protects itself from having paid for a physician’s practice only to have the doctor reclaim it.

Texas courts historically have been loath to enforce non-competes. However, under current law, covenants not to compete are enforced if they are reasonable in scope of time and geographic area. The courts will not allow the purchaser of a practice to bar a physician from practicing medicine anywhere in the world. Nor will they allow a covenant not to compete to be perpetual. They will afford protection for a reasonable length of time in a reasonable area.

For physician contracts entered into on or after September 1 (and, presumably, for contracts entered into before that date but that renew automatically afterwards), additional requirements have been added. In order to be enforceable, the covenant must not only be reasonable in terms of time and geographic scope, but must also (1) allow the physician access to a list of patients he has seen within the last year, (2) provide access to each consenting patient’s medical records, (3) provide for a buyout of the covenant by the physician at a reasonable price, and (4) provide that the physician will not be prohibited from providing continuing care and treatment to a particular patient during the course of an acute illness. Clearly, enforcing covenants not to compete has become increasingly problematic. In a state like Texas, where there is a strict prohibition on the employment of physicians by lay corporations, covenants not to compete amount to the only assurance for many purchasers of physician practices that they will receive the benefit of their contract. To the extent that courts interpret these new provisions strictly in favor of physicians, they could create a real hardship for entities attempting to work with doctors.

In addition to the collective bargaining statute, there are a number of other provisions addressing the balance (Please see “Physicians Heal Thyselves” on p. 9).
improving the delivery of preventive health care services, including childhood immunizations, prenatal care, mammograms, and other cancer screening tests;

- encouraging early detection of diseases and illnesses in children;

- improving the delivery of women’s medical care including menopause and osteoporosis;

- promoting patient education;

- preventing potentially fraudulent activities;

- effective, cost-efficient use of outpatient surgery;

- quality assurance programs;

- terms and conditions that are the subject of government regulation prohibiting or requiring the particular term or condition in question.

Notwithstanding its expansive appearance, the above list of authorized activities does not confer upon physicians any rights they did not already have under existing law. The antitrust laws have never prohibited physicians from jointly negotiating what are essentially quality of care issues. The primary significance of S.B. 1468 lies in its endorsement of physician conduct that has been summarily condemned as illegal price-fixing arrangements under existing law.

Negotiating Fees

The Act provides that certain physician networks may now engage, through a designated “physician representative,” in the collective negotiation of fees, conversion factors, discounts, or capitation payments. Not all physician networks, however, may take advantage of this new-found contracting freedom. Rather, only networks with 10% or fewer of the physicians within a defined service area are permitted to collectively negotiate with health plans. Notably, the designated “physician representative” negotiator may be a physician member of the group or network on whose behalf he or she is negotiating. This provision departs from traditional antitrust law and federal agency pronouncements which favored the use of a third-party “messenger” to facilitate such joint negotiations.

In practice, the Act will not significantly alter or add to the total mix of options that most physicians will face in dealing with health plans. As S.B. 1468 recognizes, physicians have historically been, and continue to be, at a marked disadvantage in their negotiations with payers of health care services. In most situations, for various reasons, that fact likely will not change. The reasons are several.

First, S.B. 1468 does not permit unbridled collective physician action by existing networks. Physician networks are limited to 10% of the available practicing physicians in any given service area. Thus, a good number of existing IPAs or other networks of physicians will not be able to take advantage of the Act because their membership already includes greater than 10% of available and practicing physicians in a given service area.

Second, the Act creates an administrative maze and mandates compliance before any joint negotiations may occur. Networks must submit a report to the AG identifying all member physicians and detailing, among other things, the reasons why they should be permitted to deal with the health plan on a collective basis. The AG must make a determination, based on information supplied by the physician network, as to whether the proposed contract’s “terms and conditions have already affected or threaten to adversely affect the quality and availability of patient care.” The AG is further empowered to collect market data directly from the health plans in issue to assist in the determination of whether joint negotiations should be authorized. Ultimately, the AG must pre-approve all requests to engage in joint negotiations. Conceivably, the time delay involved in the AG’s deliberative process could jeopardize a network’s ability to move forward.

(Please see “Physician Collective Bargaining” on p. 10)
GENERAL HEALTH CARE LEGISLATION

Other health care legislation didn’t make the front page of your local paper; but these bills will affect consumers and providers alike.

ADVANCE DIRECTIVES

S.B. 1260 consolidates various statutes on advance directives, including directives to physicians, durable power of attorney for health care, and out-of-hospital do not resuscitate orders. The legislation was intended to eliminate the confusion caused by the current laws regulating these directives which are found in three different statutes. The bill outlines the procedures to be followed by competent adults in preparing written advance directives and provides new forms for each advance directive. The bill further sets out the procedure to be followed for incompetent adults without a directive and for non-written directives. Directives are no longer required to be notarized and photocopies may be used for any purpose for which the original may be used. The bill also sets out the liability for a health care provider’s failure to follow an advance directive.

Effective Date: September 1, 1999, but some sections apply only to conduct that occurs after January 1, 2000

ASSISTED LIVING FACILITIES

S.B. 93 is comprehensive legislation regulating assisted living facilities. It adds standards relating to “controlling person” like that contained in nursing home statutes. The bill prohibits an unlicensed facility from using the term “assisted living” in referring to a facility and requires facilities to use a license number or state ID number in advertising and promotional materials. S.B. 93 requires managers of facilities of 17 beds or larger to meet certain educational or work requirements. It prohibits the admission of survey reports or other regulatory documents as evidence in civil courts but allows their use in enforcement actions. The bill allows residents to contract with a home health agency or other health care professional in order to meet individual needs in an assisted living facility rather than be forced to move when the resident is no longer appropriate for the assisted living facility.

Effective Date: August 30, 1999

DRUG TESTING POLICY

The purpose of HB 2914 is to inform potential consumers of home and community support services, licensed convalescent and nursing homes, and other related institutions of the employee drug testing policies of such organizations and to encourage health care employers to maintain a drug-free environment. H.B. 2914 requires agencies that provide home and community support services, licensed convalescent and nursing homes, and other related institutions to provide potential consumers with a statement regarding their employee drug testing policies.

Effective Date: September 1, 1999

NOTIFICATION REQUIREMENTS PRIOR TO PERFORMING AN ABORTION

Currently, Texas law does not require parents to receive notification that their minor child is seeking an abortion. S.B. 30 requires parental notification before an abortion can be performed on a minor, and provides exceptions in which parental notification is not in the child’s best interest. Specifically, physicians are prohibited from performing abortions on pregnant, unemancipated minors unless: (1) physicians give at least 48 hours notice to (a) a parent of the minor, or (b) a court-appointed managing conservator or guardian; (2) the minor obtains an order upon application with the court; or (3) the physician certifies that an immediate abortion is necessary to avoid death or serious bodily injury to the minor.

S.B. 30 authorizes minors to obtain an order for the abortion without providing notification to either of her parents, managing conservator or guardian. Denials of applications for an order allowing the abortion may be appealed to the court of appeals. A physician who intentionally performs an abortion in violation of these requirements commits an offense punishable by a fine of up to $10,000.

Effective Date: September 1, 1999

NURSING HOMES

Suits for Retaliation Against Employees

H.B. 1237 provides that a nursing home employee has a cause of action if the employee is terminated or otherwise disciplined or discriminated against for reporting to the employee’s supervisor, an administrator, a state regulatory agency, or a law enforcement agency a violation of law or any nursing home licensing regulations.

(Please see “General Health Care Legislation” on p. 7)
**General Health Care Legislation (cont’d from p. 6)**

In addition to actual and exemplary damages the employee may recover attorney’s fees, court costs, lost fringe benefits and be reinstated to the employee’s former position.

**Effective Date:** September 1, 1999

**Nursing Home Trust Fund**

H.B. 2909 increases the nursing home trust fund from $500,000 to $10 million over a 5-year period by increasing license fees by $12 per licensed bed.

**Effective Date:** August 30, 1999

**Civil Penalties Against Nursing Homes**

S.B. 18 clarifies that the Attorney General can bring suit to collect civil penalties pursuant to Section 242.065 of the Health & Safety Code, and that the Attorney General, on request of the Department of Human Services, may represent the department in arbitration proceedings under Section 242.253.

**Effective Date:** May 3, 1999

**Creating Employee Misconduct Registry**

S.B. 967 creates an Employee Misconduct Registry. The bill requires the Texas Department of Human Services to conduct an investigation of any employee that provides personal care in a facility licensed by the Texas Department of Human Services that may have abused, neglected, or exploited a resident. Nurse aides and other licensed health care professionals are not covered by this Act. If information is substantiated, information will be placed in the registry and will be available to the public. Providers will be required to check the registry in addition to the nurse aide registry before hiring new employees.

**Effective Date:** September 1, 1999

**Consequences of Appointment of Trustee**

S.B. 1197 excludes a person owning, controlling or operating a nursing or convalescent home, in which a trustee is appointed and emergency funds are used, from eligibility for a new or renewed license for a period of 2-10 years.

**Effective Date:** September 1, 1999

**Monitoring the Financial Condition of Nursing Facilities**

S.B. 1292 requires nursing homes to notify the Texas Department of Human Services of a significant change in the home’s financial position, cash flow, or results of operation that could adversely affect the nursing home’s delivery of essential services. The information provided to the Texas Department of Human Services under this act is confidential and not subject to disclosure under the Open Records Act.

**Effective Date:** September 1, 1999

**HOME HEALTH AGENCIES**

**Regulating Home Health Services**

S.B. 94 provides that the Texas Department of Health shall adopt rules relating to quality of care and quality of life for individuals receiving care from home and community support agencies and provides for the imposition of prompt and effective remedies for the violation of said rules. The statute adopts the same language as applicable to nursing homes with regard to controlling persons and provides that the Department may require documentation relating to any controlling person’s compliance with any applicable licensing standard in this or other states. The Department is required to maintain records or documents relating to complaints by consumers of home health, hospice, or personal assistance services and make such information available to the public. S.B. 94 contains language limiting the admissibility of survey documents in civil actions. It provides that a physician may not refer a patient to a home and community support services agency if the referral violates the federal law that prohibits physician referrals to entities in which they have financial interests, with certain specified exceptions.

**Effective Date:** September 1, 1999

**Transferring Licensing, Certification, and Regulation of Home Health and Community Support Services Agencies**

(No statutory change)

S.B. 96 transfers authority over licensing, certification and regulation of home health and community support services agencies and home health medication aides under Chapter 142, Health and Safety Code, from the Texas Department of Health to the Texas Department of Human Services effective September 1, 2001, or an earlier date provided in an interagency agreement.

**Effective Date:** August 30, 1999

**ICF-MR FACILITIES**

**Administrative Penalties**

Currently there is an established system for regulating

*(Please see “General Health Care Legislation” on p. 8)*
**GENERAL HEALTH CARE LEGISLATION (cont’d from p. 7)**

Intermediate care facilities for the mentally retarded (ICF-MR) which addresses ICF-MR regulation, governance, and use of administrative penalties. SB 196 sets forth procedural and due process provisions concerning the survey and enforcement of ICF-MRs, the imposition of administrative penalties for acts of violation, and the appeal of administrative penalties. This section provides for the assessment of administrative penalties between $100 and $5,000 per violation, with the total amount of the penalties for acts continuing or repeated violation capped at either $5,000 or $25,000 depending on the size of the facility. SB 196 further requires that the facility be informed of the acts of violation and the penalty amounts, and that the facility is entitled to a reasonable period of time (not less than 45 days) in which to correct violations that did not result in, or pose a serious threat of harm or death to residents.

Effective Date: September 1, 1999

**HOSPITALS**

**Indigent Health Care**

In 1985, the Texas Legislature enacted the Indigent Health Care and Treatment Act to address the problem of medical indigence in Texas and to define the basic indigent health care responsibilities of the counties, public hospitals, and hospital districts. H.B. 1398 authorizes the Texas Department of Health to administer and enforce the Indigent Health Care and Treatment Act, widens the scope of mandatory and optional indigent health care services, renames mandatory services as “basic,” modifies state financial assistance to counties, and establishes reporting requirements. The bill raises the eligibility standards for assistance under this program over a 3 year period. Effective September 1, 2000, minimum eligibility is raised to 17% of the federal poverty level; effective September 1, 2001, it increases to 21%; and September 1, 2002, it moves to 25%. However, coverage of eligible residents up to 50% of the federal poverty level may be credited toward a county’s eligibility for state assistance. The threshold for receiving state assistance is reduced from 10% of general tax levy to 8%.

Effective Date: September 1, 1999

**Tertiary Medical Services**

H.B. 2573 provides that the Board of Health may adopt rules to implement a system that encourages hospitals to provide tertiary medical services and stabilization services. The statute creates a Tertiary Care Account in the State Treasury for the purpose of reimbursement of unpaid tertiary medical services and stabilization services provided as a result of extraordinary emergencies occurring during the year. Eighteen million dollars was appropriated for this.

Effective Date: September 1, 1999

**HEALTH CARE PROFESSIONALS**

**Authority of Physicians and Optometrists to Form Jointly Owned Entities**

H.B. 2453 authorizes physicians and optometrists or therapeutic optometrists to organize, jointly own and manage partnerships, limited liability companies and other legal entities for certain specified purposes. Under prior law, only those individuals licensed to perform the same type of professional services could form a legal entity together.

Effective Date: September 1, 1999

**Authority of Physicians and Podiatrists to Form Jointly Owned Entities**

H.B. 1572 authorizes physicians and podiatrists to organize and co-own limited liability companies, non-profit corporations, and partnerships for the purpose of providing professional health care services that fall within the scope of practice of those practitioners.

Effective Date: August 30, 1999

**Advanced Practice Nurses and Physician Assistants**

S.B. 1131 makes five major changes. First, it authorizes, but does not require, hospitals to establish policies concerning granting clinical privileges to advanced practice nurses and physician assistants. If the hospital has adopted a policy granting clinical privileges to APNs and PAs, it must specify a reasonable time period for considering the application and providing written notice of any final action taken. Privileges may not be denied or revoked without providing certain procedural rights to provide fairness of process. Second, the bill also adds APNs and PAs to Article 21.52, Insurance Code. This requires insurance companies to pay for covered services provided an enrollee if the APN or PA is legally authorized.

*(please see “General Health Care Legislation” on p. 9)*
General Health Care Legislation (cont’d from p. 8)

rized to provide the service. Third, S.B. 1131 authorizes physicians who delegate prescriptive authority to APNs or PAs to designate a person who may call prescriptions to the pharmacy for the APN or PA. The designated agent must have an education equivalent to or greater than a LVN. Fourth, the bill authorizes APNs to conduct the physical necessary for a cosmetologist to obtain or renew a license. Fifth, the statute is amended to clarify that if an APN or PA is legally authorized to provide a service, the documentation and signature of the APN or PA satisfies any documentation requirements, i.e. a physician’s co-signature is not necessary.

Effective Date: September 1, 1999

Regulation of Anesthesia in Certain Outpatient Settings

S.B. 1340 requires the Board of Medical Examiners to establish minimum standards for the provision of anesthesia services in outpatient settings by physicians licensed by the Board. The Board of Nurse Examiners is required to establish minimum standards for the provision of anesthesia services in outpatient settings by nurse anesthetists. Beginning on September 1, 2000, physicians and nurse anesthetists will be required to register with their respective licensing boards if the physician or nurse anesthetist administers anesthesia in an outpatient setting or, in the case of the physicians, performs a surgical procedure for which anesthesia is provided in an outpatient setting. Outpatient settings are defined to not include licensed hospitals or licensed ambulatory surgical centers.

Effective Date: September 1, 1999

Regulation of Dentists and Dental Hygienists

S.B. 964 modifies the licensure requirements for dentists and dental hygienists. It makes dental records confidential. Records can be disclosed only with releases from persons specified in statute. This act provides that the State Board of Dental Examiners may adopt rules prohibiting a dentist from engaging in contracts that allow a person who is not a dentist to influence or interfere with the exercise of a dentist’s independent professional judgment. Rules adopted by the Board may not preclude a dentist’s right to contract with a management service organization.

Effective Date: September 1, 1999

Physicians Heal Thyselves (cont’d from p. 4)

of power between physicians and their great nemesis, managed care. Of these, two seem most noteworthy. One requires managed care companies to pay all “clean claims” submitted by physicians within 45 days of receipt. The Texas Department of Insurance is charged with defining “clean claims.” Failure of a managed care company to meet these deadlines can result in the imposition of penalties by the Texas Department of Insurance of $1000 for each day a claim remains unpaid. The other requires health maintenance organizations to offer out-of-network options to their enrollees. Right now, an enrollee must choose a doctor from the health maintenance organization’s network of physicians. This statute allows enrollees to use non-network physicians if the enrollee is willing to pay the extra cost associated with such physicians.

While it was an active and successful legislative session for physicians, much remains uncertain. Will the right to collectively bargain really make an impact? How will the courts interpret the new provisions concerning covenants not to compete? Can doctors prevent the shift of power from themselves to managed care? Obviously, the battle has just begun.
Physician Collective Bargaining (cont’d from p. 5)

quickly on a contract or contract renewal in order to avoid patient displacement.

Third, physician networks can never be completely sure whether their membership comprises 10% or fewer of available physicians in a service area. This is because the Act appears to defer the determination of the relevant “service area” to the health plan, e.g., physicians may jointly negotiate “within the service area of a health benefit plan.” While seemingly innocuous, this provision allows the health plan, for antitrust purposes, to define the relevant market, i.e., its service area. In practice, a health plan may narrowly define its service area and communicate this information to the AG, with the result that the physician network may exceed 10% of the health plan’s conception of the number of available practicing physicians. While nothing prohibits physicians from challenging the health plan’s formulation of its service area, the Act appears to give deference, in the first instance, to the plan’s definition of the relevant market.

Supporting this conclusion is the fact that the Act requires the AG to collect health plan market share data from the health plans themselves.

Fourth, the Act does not permit joint physician negotiations with every health plan. Physicians may jointly negotiate and contract only with group health plans that provide benefits for medical or surgical expenses. Self-insured employers, plans that provide coverage for “ carve-out” procedures or illnesses, Medicare supplement plans, workers’ compensation plans, motor vehicle coverage plans, or plans covering long-term illnesses are exempted under the Act.

Perhaps the most substantive restriction contained in the Act is that joint physician negotiations may take place only with those plans having “substantial market power.” The Act does not define substantial market power, and with good reason. Such a determination necessarily involves numerous fact-specific considerations, not the least of which is the number of alternative (substitute) health plans in the area. The Act appears to place the determination of “market power” in the AG’s hands by conferring upon that office the authority to collect and investigate market share data.

WHAT DOES THE FUTURE HOLD?

The future carries many uncertainties but, in the coming years, Texas physician communities likely will observe one or more of the following evolutions in the delivery of physician services:

Larger networks or independent practice associations (IPAs) may disband, split off into smaller networks, or form less inclusive contracting sub-units that can avail themselves of the 10% market share limitation.

Networks in rural areas, even those exceeding 10% of available physicians, will likely remain largely unaffected by the Act. They will continue to enjoy greater latitude in jointly negotiating with payers, chiefly because health plans desire more inclusive panels in rural areas to ensure adequate coverage and marketability of the plan to local, predominantly rural employers.

Specialty IPAs or networks in urban to semi-urban areas may proliferate. Under a strict reading of S.B. 1468, the 10% market share restriction is not limited on a per specialty basis. While the Act requires the AG to consider the competitive effects of physician distribution by specialty practice area, it does not on its face preclude the formation of all-inclusive single or multi-specialty networks whose members nonetheless comprise less than 10% of all physicians in the area. Thus, it is conceivable, for example, that all of the urologists in a rural area could offer a contracting panel to payers, yet still comprise fewer than 10% of available area physicians.

One thing is certain. Texas’ enactment of S.B. 1468 places it at the forefront of change in the continuing national debate over whether the antitrust laws are properly applied in the context of health care. While acknowledging general antitrust principles, the Act attempts to strike a competitive balance on a playing field that many providers argue has been un-level for too long.

Prior to joining Jackson Walker L.L.P., Mr. Hayes was a health care antitrust attorney in the Health Care Division of the Federal Trade Commission, Washington, D.C.
Arbitration of Nursing Home Matters (cont’d from p. 2)

did the cause of action accrue? Presumably, this will be an issue that courts will have to resolve in applying the new law.

H.B. 3451

Adding to the confusion regarding arbitration is H.B. 3451. That bill provides that a court having jurisdiction over “a judicial review” with regard to a dispute involving the denial, suspension, or revocation of a license, an emergency suspension or closing order, the appointment of a trustee, or the suspension of admissions may not order such matters into binding arbitration. Further, a court having jurisdiction over a “judicial review” of such matters, may not order binding arbitration to resolve a dispute concerning the conduct with respect to which the denial, suspension, or revocation of a license, and emergency suspension or closing order, the appointment of a trustee, or the suspension of admissions was based. H.B. 3451 is effective September 1, 1999 and applies only to a suit commenced on or after the effective date.

H.B. 3451 is confusing in that the term “judicial review” is a term of art in administrative practice meaning the judicial review that is provided in an appeal of an agency ruling in a contested case matter. Therefore, judicial reviews may be conducted regarding any action that originates as an administrative action such as the denial, suspension or revocation of a license, an emergency suspension or closing order or the suspension of admissions. However, the appointment of a trustee is an original action in district court. Therefore, there would be no “judicial review” of an appointment of a trustee.

The most confusing aspects of the Bill are its provisions prohibiting a court with jurisdiction from ordering binding arbitration to resolve a dispute as to the conduct upon which license suspension, revocation, emergency closing order or suspension of admissions is based. Presumably, this prohibition is limited only to judicial reviews of appeals from agency actions and would not apply to cases in which a district court has original jurisdiction over civil penalties. However, given the lack of clarity as to the law’s applicability, it can be anticipated that a broader application of the arbitration prohibition will be sought in civil penalty litigation.

Managed Care “Top Ten” (cont’d from p. 3)

on its actuarial value and may be different from the premium for the HMO coverage. In addition, the bill allows the imposition of different cost sharing requirements on the enrollee for a point-of-service contract and provides that any additional costs for the selection of a non-network plan may be imposed on the employee who selected such non-network coverage.

H.B. 1498 also establishes the concept of “blended contracts” that provide for a combination of indemnity and HMO benefits under a point-of-service plan. Insurance carriers may contract with HMOs to provide benefits under a point-of-service plan, including optional coverage for out-of-area and out-of-network health care services. In addition, HMOs may offer point-of-service riders without becoming licensed as insurance companies if the expenses incurred under the point-of-service rider do not exceed 10% of the total medical and hospital expenses incurred for all health plans sold.

4. Delegated Network Functions

S.B. 890 requires that an HMO entering into an agreement with a network obtain a written agreement with the delegated network. The agreement must include certain provisions, including: (1) a financial monitoring plan; (2) termination without cause; (3) enrollee hold harmless; and (4) that the network is licensed as a UR agent or third party administrator if the network is performing those functions. A delegated network is an entity other than an HMO or insurer that provides or arranges for medical care to an enrollee on a prepaid basis and to which an HMO transfers the re-

(Please see “Managed Care Top Ten” on p. 12)
Managed Care “Top Ten” (cont’d from p. II)

sponsibility for the performance of certain functions such as claims payment or utilization review. The delegation agreement must be filed with the department of insurance within 30 days of execution.

In the event that an HMO receives information that the delegated entity is not complying with the delegation agreement or if it is operating in a condition that renders its continuance hazardous to enrollees, the TDI can impose sanctions against the delegated entity. SB 890 also requires that the HMO provide to the delegated network a litany of information on a timely basis so that the delegated entity can assess its financial risk.

5. Drug Formularies

S.B. 1030 requires that health benefit plans that offer prescription drugs continue to make an approved or covered drug available to each enrollee at the contracted benefit level until the enrollee’s contract with the health benefit plan expires regardless of whether the prescribed drug has been removed from the health benefit plan’s formulary. This bill excludes certain limited plans, small employer health benefit plans, and Medicare supplemental policies. If a health benefit plan refuses to provide coverage for a non-formulary drug which the enrollee’s physician has determined to be medically necessary, such denial shall constitute an adverse determination which may be appealed by the enrollee using an independent review process. SB 1030 also requires that health benefit plans that provide prescription drug benefits provide certain notice and disclosure to enrollees concerning drug formularies.

6. Mandatory Benefit Review

H.B. 1919 requires appointment of a joint interim committee to study health care benefits mandated by law to be provided by health benefit plans. The committee shall study: (1) the extent that mandated health care benefits have increased premium costs as well as the effect of any increased premium costs on the affordability and accessibility of health benefit coverage; (2) the effect of mandated health benefits on improving and maintaining the health of Texas residents; (3) the number and percentage of residents who have made a claim for such mandated benefits; and (4) whether alternatives to each mandated benefit are feasible.

The committee is to develop recommendations on methods which will allow the Legislature to accurately and timely assess the costs and benefits of proposed mandated benefits. The committee’s report and recommendations must be completed by January 1, 2001 and the committee will be abolished on June 1, 2001.

7. HMO Solvency Requirements

H.B. 3023 amends the Insurance Code to set forth minimum net worth requirements for HMOs as follows: (1) HMOs authorized to provide basic health care services are required to maintain a minimum net worth of $1.5 million; (2) HMOs authorized to provide limited health care services are required to maintain a minimum net worth of $1.0 million; and (3) HMOs authorized to provide only a single health care service plan are required to maintain a minimum net worth of $500,000. There is a phase-in period for HMOs licensed before September 1, 1999. Net worth is defined as the excess of total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Article 1.39 of the Insurance Code.

The bill also authorizes the Insurance Commissioner to adopt rules or guidelines requiring any HMO to maintain a specified net worth based on certain criteria including, the nature and types of risks underwritten, the premium volume of risks underwritten, the composition, quality, duration, or liquidity of the HMO’s investment portfolio, the adequacy of HMO reserves, the number of enrollees, and other business risks.

8. Moratorium on Medicaid Managed Care

H.B. 2896 places a moratorium on future implementation of Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, and Medicaid Star+Plus pilot programs, until the Texas Health and Human Services Commission (THHSC) has completed a comprehensive study of the pilot programs currently underway. The commission is to submit its report to the Governor and the Legislature no later than November 1, 2000. The moratorium does not apply to the currently planned programs in El Paso or Dallas.

This bill also contains a number of new requirements

(Please see “Managed Care ‘Top Ten’” on p. 13)
related to the Medicaid program, including: (1) requiring an annual independent external financial and performance audit of all Medicaid contractors; (2) provisions requiring the THHSC to consider the ability of organizations to process Medicaid claims electronically; and (3) a provision limiting the number of mandatory contracts to be offered to managed care organizations in a region to one contract per region.

9. Children’s Health Insurance Program

S.B. 445 establishes an insurance program for uninsured children under the age of 19 who are not eligible for Medicaid. Eligibility is set at 200 percent of the federal poverty level.

awarding contracts to managed care organizations; and

“S.B. 445 establishes an insurance program for uninsured children under the age of 19 who are not eligible for Medicaid. Eligibility is set at 200 percent of the federal poverty level.”

10. Physician Credentialing

H.B. 3216, in an effort to eliminate duplication of physician credentialing efforts, creates a system where physicians provide core credentialing data elements to the Texas State Board of Medical Examiners (TSBME). Such core data elements include name and other demographic data, professional education and training, licensure, and certification of foreign medical graduates. The TSBME is required to develop standardized forms and guidelines for the administration of the collection, verification, correction, updating, modification, maintenance and storage of information relating to physician credentials and for releasing it to health care entities or other credentials verification organizations who have been authorized by the physician to receive that information. Prior to the releasing of a physician’s credentials data for the first time, the TSBME must provide the physician with 15 days to review the data and request reconsideration or resolution of errors in or omissions from the data. The TSBME is also required to provide a physician with notice of any change in the physician’s information when a change is made by a person other than the physician. Physicians are required to provide the TSBME with any correction or modification to their data no later than 30 days after the date the file is no longer accurate.

Health care entities, including hospitals and health plans, are required to use the board verification system to obtain core credentialing data. In turn, the TSBME must provide the data no later than 15 days after their receipt of a request for the same. This bill does not affect or restrict the authority of a health care entity to approve or deny an application for hospital staff membership, clinical privileges, or managed care network participation. Health care entities are not required to use the TSBME data until September 1, 2001, and not until the TSBME is accepted as a primary source by national accreditation organizations.
HealthBriefTM is published periodically by the law firm of Jackson Walker L.L.P. to inform readers of recent developments in health law and related areas. It is not intended nor should it be used as a substitute for legal advice or opinions, which can be rendered only when related to specific fact situations.

This publication is not intended to create an attorney-client relationship or to indicate that such a relationship exists between Jackson Walker L.L.P. and the recipient of this publication, but is offered merely as a courtesy to inform the recipient about developments in the law.

This and other issues of HealthBriefTM may be found in the publications section of the firm’s webpage at http://www.jw.com.

For more information, please contact Jed Morrison at 210-978-7700 or jmorrison@jw.com.

© 1999 Jackson Walker L.L.P.