REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF THE IMPACT OF LEGISLATIVE PROPOSALS ON MANAGED CARE COST CONTAINMENT/"POINT-OF-SERVICE" MANDATE PURSUANT TO HB 1393 AND HJR 231 OF 1996

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 79

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

JOINT COMMISSION ON HEALTH CARE

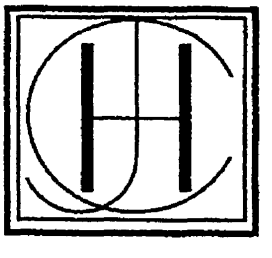
Chairman
The Honorable Stanley C. Walker

Vice Chairman
The Honorable Kenneth R. Melvin

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable George H. Heilig, Jr.
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Robert C. Metcalf

Director
Jane Norwood Kusiak



Preface

House Bill (HB) 1393, which was referred to as the "patient protection act," was passed by the 1996 Session of the General Assembly. As originally introduced, HB 1393 would have required carriers which offer health plans that limit enrollees' choices of providers to provide a "point-of-service" option for an enrollee to receive health care services from a provider who is not a member of the provider panel. However, this provision was stricken from the bill. The approved version of HB 1393 directed the Joint Commission on Health Care, in cooperation with the State Corporation Commission's Bureau of Insurance and the Division of Legislative Services, to study the need to require a point-of-service feature which would allow an enrollee the option to receive health care services outside the provider panel.

House Bill 1393 also directs the Joint Commission, in cooperation with the Bureau of Insurance, to study: (i) the extent to which provider panels, which may currently not be subject to state regulation, are forming in the Commonwealth; (ii) the impact that the formation of such provider panels has on the ability of enrollees to receive care from providers not in such panels; (iii) the extent to which these panels enhance or impede the ability of Virginians to access quality, affordable health care; and (iv) the need to extend the provisions of §38.2-3407.10 as added by HB 1393 or other relevant code sections to such provider panels.

House Joint Resolution (HJR) 231 of the 1996 Session of the General Assembly directed the Joint Commission, in cooperation with the Bureau of Insurance, to study the effects of certain legislative proposals on managed care cost containment strategies, including whether a point-of-service option or similar mechanisms should be mandated through legislation. This report is submitted in response to both HB 1393 and HJR 231.

Based on our research and analysis of the issues contained in HB 1393 and HJR 231, we concluded the following:

- The number of point-of-service (POS) plans being offered in the marketplace is increasing; POS is readily available in the marketplace for employers;

- There is no definitive information on the number of Virginia employers which offer only closed-panel HMO benefit plans to their employees;

- The threshold question to be addressed by this study is a public policy decision regarding whether the Commonwealth should enact legislation that requires POS plans to be offered at the employee level;

- If it is decided to require a POS feature, many important design issues would have to be addressed and resolved;

- Should a POS feature be required in Virginia, HMO regulations and relevant statutes would have to be reviewed and possibly revised;

- Few states have enacted POS legislation; New York is the only state which requires POS be offered to enrollees (individual market); and

- Other types of provider panels are forming in Virginia; however, to date, these panels are contracting with health plans similar to other providers. Provider panels which assume risk are required to be licensed as an insurer or HMO.

The following policy options were offered for consideration by the Joint Commission in deciding what actions, if any, to take regarding point-of-service health plans. Option III could be pursued along with either Option I or Option II.

Option I: Take No Legislative Action In 1997, And Monitor The Marketplace To Gain Greater Insight Into The Availability Of POS Plans At The Employee Level.

Option II: Introduce Legislation In The 1997 Session Stating That It Is The Policy Of The Commonwealth To Ensure That All Virginians Have Access To Health Plans Which Allow The Enrollee To Access Care From Their Provider Of Choice; And Direct The Bureau Of Insurance To Convene A Task Force Composed Of Actuarial Experts And Representatives Of The HMO/Insurance Industry, Providers, And Consumers To Develop POS Legislation That Would Ensure The Availability Of POS Plans At The Employee Level.

Option III: Introduce A Resolution Directing The Bureau Of Insurance To Review The Advisability Of Revising Current HMO/Insurer Licensing Laws To More Accurately Reflect The Changing Health Care Delivery System And Report Its Findings And Recommendations To The Joint Commission On Health Care And The General Assembly.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Due to the complexity of this study, we were not able to resolve a number of specific issues which required actuarial analysis. Accordingly, the Joint Commission introduced companion study resolutions (House Joint Resolution 631 and Senate Joint Resolution 297) in the 1997 General Assembly Session to establish a task force within the Joint Commission to address these outstanding actuarial issues. These resolutions were approved by the General Assembly.

Jane N. Kusiak

Jane N. Kusiak
Executive Director

February 25, 1997

TABLE OF CONTENTS

I.
Authority for Study

House Bill (HB) 1393, which was referred to as the "patient protection act," was passed by the 1996 Session of the General Assembly. This legislation requires insurers and health maintenance organizations (HMOs) to develop and administer managed care provider networks according to certain requirements and standards.

As originally introduced, HB 1393 also would have required carriers which offer health plans that limit enrollees' choices of providers to provide a "point-of-service" option for an enrollee to receive health care services from a provider who is not a member of the provider panel. However, this provision was stricken from the bill. The approved version of HB 1393 directs the Joint Commission on Health Care, in cooperation with the State Corporation Commission's Bureau of Insurance and the Division of Legislative Services, to study the need to require a point-of-service feature which would allow an enrollee the option to receive health care services outside the provider panel.

House Bill 1393 also directs the Joint Commission, in cooperation with the Bureau of Insurance, to study: (i) the extent to which provider panels, which may currently not be subject to state regulation, are forming in the Commonwealth; (ii) the impact that the formation of such provider panels has on the ability of enrollees to receive care from providers not in such panels; (iii) the extent to which these panels enhance or impede the ability of Virginians to access quality, affordable health care; and (iv) the need to extend the provisions of §38.2-3407.10 as added by HB 1393 or other relevant code sections to such provider panels.

House Joint Resolution (HJR) 231 of the 1996 Session of the General Assembly directs the Joint Commission, in cooperation with the Bureau of Insurance, to study the effects of certain legislative proposals on managed care cost containment strategies. Specifically, HJR 231 requests the Joint Commission to identify and examine the positive and negative effects of limiting a patient's ability to utilize providers outside of a managed care

plan's established network, including whether a point-of-service option or similar mechanisms should be mandated through legislation.

This issue brief is written in response to both HB 1393 and HJR 231. A copy of HB 1393 and HJR 231 is provided at Appendix A.

II.
Background

Managed Care Has Become The Dominant Health Insurance Delivery System In The Nation

The health care marketplace has undergone dramatic change in the past several years, and continues to evolve based on market forces. Perhaps more than any other change, the rapid expansion of managed care delivery systems is the most pervasive change in the health care marketplace today. Without question, managed care has become the dominant health care delivery system in the United States and has implications for providers, insurers, purchasers and consumers.

Before addressing the issues contained in HB 1393 and HJR 231, it is important to review the basic principles and types of managed care plans, including health maintenance organizations and "point-of-service" plans.

Managed care can be defined in many ways and can involve different levels of care management. In its simplest form, managed care may include pre-certification of hospital stays or utilization review to ensure services are medically necessary. However, more and more of the marketplace is moving to the more advanced form of managed care in which patients have limited choices of providers and access to care is coordinated and managed by a primary care provider.

Managed Indemnity Plans: Managed indemnity plans provide limited management of services, and typically include utilization review techniques such as hospital pre-certification and medical necessity determinations.

Preferred Provider Organizations (PPOs): In a PPO, enrollees receive the highest level of benefits if they receive care from providers who participate in the "preferred provider" network. Patients can receive care from providers who are not in the network; however, they receive a lower level of benefits when accessing care outside of the network. Providers in the network generally receive discounted reimbursement from the carrier in return for increased patient flow.

Health Maintenance Organizations (HMOs): HMOs provide the highest form of managed care. In an HMO, the plan provides health care services to the members (enrollees) in return for an annual fee. There are three distinct features of traditional HMOs:

(i) primary care providers (PCPs) are used to coordinate the enrollee's care;

(ii) enrollees must receive care from providers and facilities who are in the HMO's provider network, no benefits are provided for out-of-network services (except in special circumstances); and

(iii) a fixed fee structure (e.g. capitation) often is used to reimburse providers rather paying providers for each service rendered.

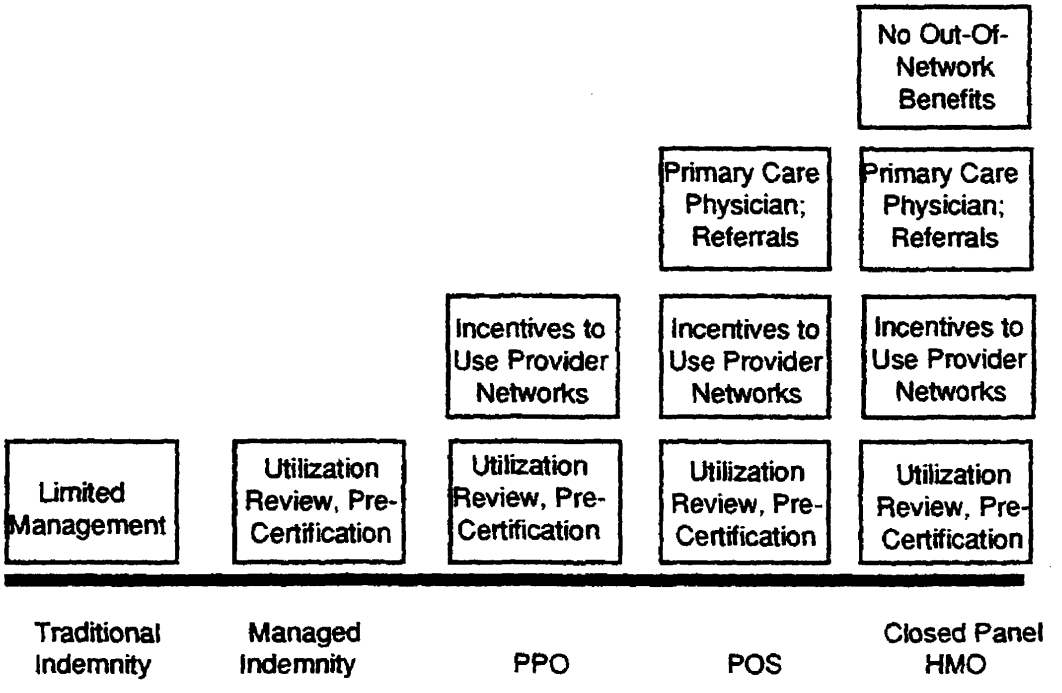
Point-of-Service (POS): POS plans have developed in recent years in response to the marketplace's demand for HMOs to provide enrollees with a greater choice of providers. In traditional "closed-panel" HMOs, enrollees receive no benefits if they receive care outside the HMO's provider network. An HMO benefit plan that includes a POS feature allows enrollees to receive services from providers and facilities outside the network for an increased cost. Typically, persons who utilize the POS feature pay either a higher premium, greater copayments or deductibles, or some combination of all three.

It is the POS benefit design that the Joint Commission has been directed to evaluate and recommend whether or not it should be required of all HMOs as a means of ensuring that all patients have a greater choice of providers.

Figure 1 illustrates the various components of each of the different types of managed care plans.

Figure 1

Key Components of Managed Care Plans



Note: The plan designs shown here are generalizations; there are variations among these different types of plans

Source: Joint Commission on Health Care Staff Analysis

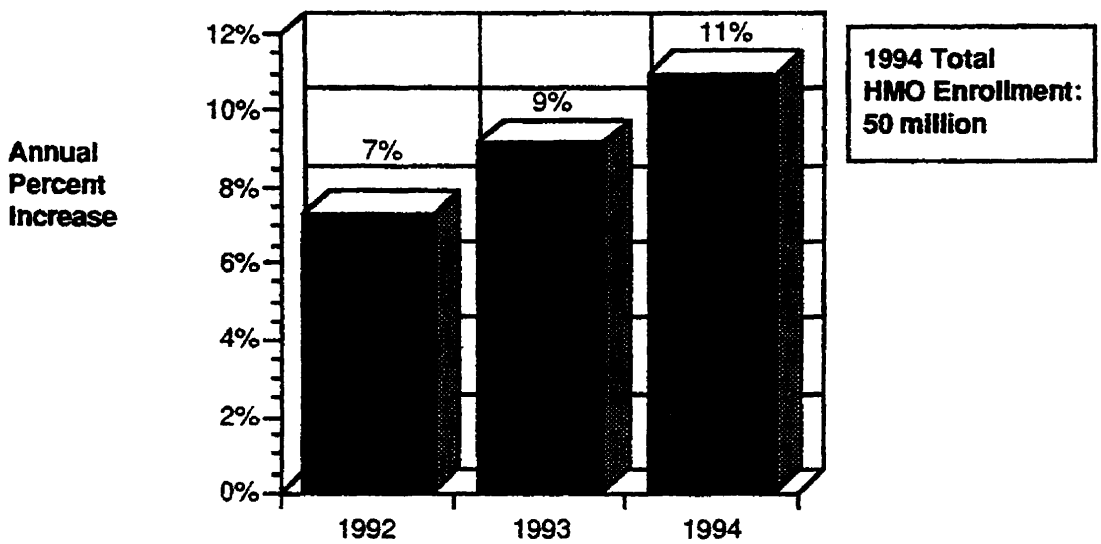
There Has Been Dramatic Growth In Managed Care Plans

Evidence of the move to managed care abounds and can be measured in numerous ways. In 1994, 65 percent of the nation's workers employed by large companies (200 or more employees) were enrolled in managed care plans, including HMOs, preferred provider organizations (PPOs), and point-of-service (POS) plans. In 1990, this percentage was less than 50 percent. According to the Group Health Association of America (GHAA), nationwide enrollment in HMOs increased by 5.3 million people (11%) in 1994, representing the single largest one year jump ever recorded by the industry trade group. The American Association of Health Plans

expects HMO membership to increase to about 70 million in 1996. Figure 2 illustrates the increases seen in nationwide HMO enrollments over the past few years.

Figure 2

Annual Increases in National HMO Enrollments 1992 - 1994

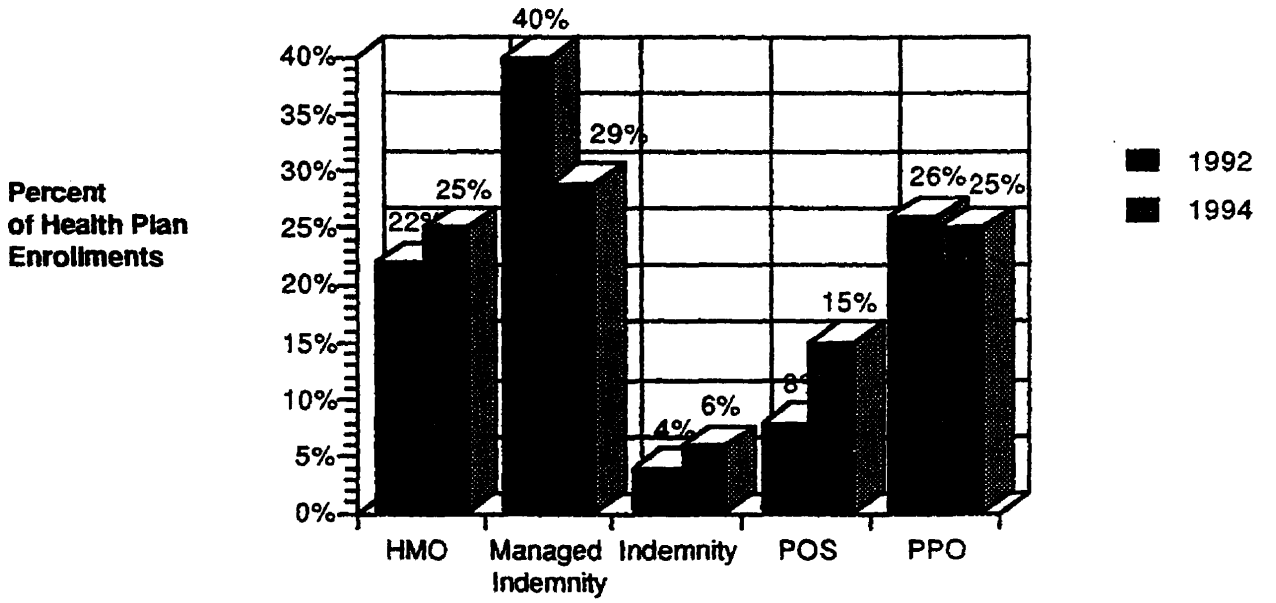


Source: Dimmit, Barbara; "Managed Care Organizations," The State of Health Care in America, Business and Health Magazine, 1995

The growth in managed care enrollment across the country has not been limited to HMOs. Point-of-service (POS) plans, which provide benefits to HMO enrollees who receive care outside the provider network, also have seen significant growth while most indemnity plans have seen declines in enrollments. Figure 3 illustrates these shifts in enrollment.

Figure 3

Trends In National Health Plan Enrollments 1992 - 1994



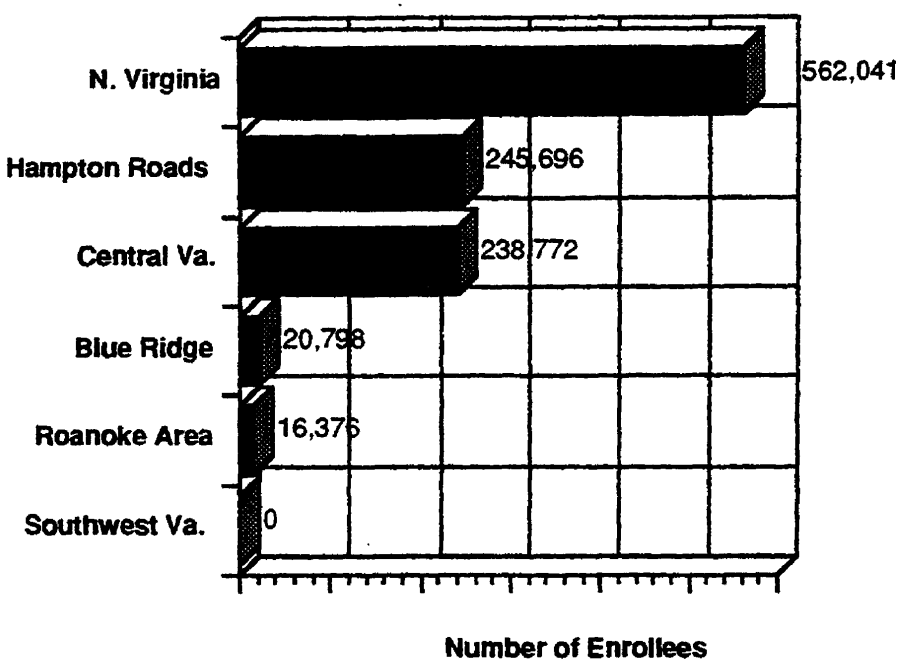
Source: KPMG, Peat Marwick, National Survey of Employer-Sponsored Health Plans, 1992, 1994.

HMO Enrollments In Virginia Have More Than Doubled In The Past Six Years

The number of Virginians enrolled in HMOs has increased 140% since 1990. HMOs enrolled more than 1 million persons in 1995 providing coverage to one out of every six Virginians. As seen in Figure 4, much of Virginia's HMO enrollees live in Northern Virginia, the Hampton Roads area and Central Virginia. However, new managed care plans are developing in the Blue Ridge, Roanoke and Southwest Virginia areas which will increase further managed care's penetration in the Commonwealth.

Figure 4

HMO Enrollments in Virginia: 1995
Total Enrollment: 1,083,683



Note: Hampton Roads enrollment does not include 93,835 Medallion II enrollees.
Source: Virginia Association of HMOs

Between 1993 And 1994, The Percentage Increase in HMO Enrollments In Virginia Was One Of The Largest In The Nation

According to the 1995 HMO-PPO Digest published by Hoechst Marion Roussel, Inc., Virginia's enrollment in HMOs increased 82.4% between 1993 and 1994. This growth rate was greater than all but six of the other 49 states. Virginia's HMO penetration (i.e. percent of state population enrolled in HMOs) for 1994 was 14.1%, which ranked 28th among the 50 states. Virginia's HMO penetration rate in 1995 was approximately 17%.

III.
Current Health Insurance Marketplace in the Nation and Virginia

To evaluate whether the Commonwealth should enact legislation requiring HMOs to include a POS feature in their benefit offerings, it is essential to first assess the marketplace to determine the current availability of this type of managed care plan. The following paragraphs detail the degree to which POS plans are available in the marketplace, both across the nation and in Virginia.

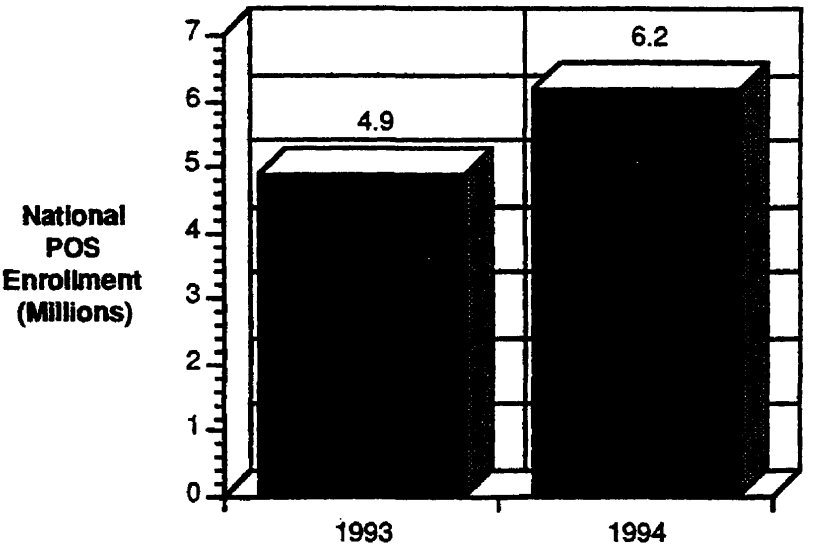
Nationally, The Number Of HMOs Offering POS Plans Has Grown Substantially In Recent Years

Point-of-service (POS) plans represent perhaps the fastest growing managed care plan design in the country. Nationwide, POS plans were offered by 266 of the 556 HMOs (55%) operating in 1994. This number represents a 44% increase from the number of HMOs (185) offering a POS feature in 1993. Of the 45% of HMOs that did not offer a POS feature in 1994, 35% planned to offer POS in 1995 (Hoechst Marion Roussel, Inc., 1995). The American Association of Health Plans reports that more than 80% of HMOs will offer a POS feature by the end of 1996.

The Increased Availability of POS Plans Is Reflected In Marked Increases In POS Enrollments Over The Past Several Years

The American Association of Health Plans indicates that from 1990 to 1995, enrollment in POS plans increased five-fold. As seen in Figure 5, the number of enrollments in POS plans across the nation increased 26% in one year (1993 -1994). Approximately 6.2 million persons were enrolled in POS plans in 1994.

Figure 5
National POS Enrollees: 1993 - 1994



Source: Hoechst Marion Roussel, Inc. HMO-PPO Digest, 1995

In Virginia, Nearly All HMOs Offer Employers A POS Feature In The Group Market

According to the Virginia Association of HMOs (VAHMO), virtually all of its 25 member HMOs offer a POS feature to employers. The results of a recently completed VAHMO survey indicate that of the 18 HMOs which responded, all offer a POS feature to their larger groups (i.e. over 25 employees). Seventeen of the 18 (94%) responding HMOs also reported that they offer the POS feature to small groups (i.e. 2-25 employees). The one HMO that does not offer POS to these small groups is in northern Virginia. Of those HMOs responding to the VAHMO survey, only four plans participate in the individual market; two of these HMOs offer individuals a POS feature.

It is important to note that, in the group market, the HMOs' offer of a POS benefit design is to the employer, and not the employee. The employer, in turn, selects the plan(s) it offers to its employees. Unless the

employer includes the POS plan in its offerings, the option is not available to the individuals in the group. As will be discussed later in this report, this is an important issue that must be addressed.

Employers' Ability To Offer More Than One HMO Benefit Plan Depends To Some Degree On The Size Of The Group

In the larger group market, it is clear that nearly all of the HMOs will allow the group to offer more than one plan to its employees. This enables the employer to offer a closed panel HMO (which in almost every case is the least costly alternative) and a PPO or POS plan for those employees who wish to pay a higher amount for the ability to receive care outside of the network.

It is less clear how many HMOs also will allow small groups (i.e. 2-25 employees) to offer more than one plan to their employees. Some HMOs allow small groups to offer more than one plan; some do not. A few small groups interviewed as part of this study noted that some HMOs offer more than one plan design (e.g. closed panel and POS) but require the small group to select only one plan to offer to its employees. When HMOs require a group to offer only one plan, small employers who are cost-driven often select the HMO closed panel plan due to the lower premium cost. When this happens, employees in these small groups are not able to select a plan with out-of-network benefits.

POS Plans Typically Include Higher Costs For Enrollees

As will be discussed later in this report, it is generally agreed that a POS plan is more costly than a traditional closed-panel HMO. For this reason, when an HMO includes a POS feature or a POS plan is offered as a separate plan selection, there typically are cost differentials required of POS enrollees. This cost differential is recovered through either higher premiums, or higher copays and deductibles.

Based on the results of a January, 1996 VAHMO survey of HMOs operating in Virginia, the standard *co-insurance* differentials for in-network

versus out-of-network services ranged from 20 to 30% (i.e. the enrollee's copayment for receiving care out-of-network was 20-30% higher than in-network). Premium differentials appear to be within a range of 10 - 30%, depending on the carrier and other benefit design factors.

Nationally, Employers Increasingly Are Including POS Plans In Their Employee Benefit Offerings

Seen as an "intermediate" step from indemnity coverage to managed care, POS plans increasingly are being offered by employers to their employees. Data regarding the health benefit plans that employers offer to their employees are limited somewhat to larger firms. Virtually none of the nation's major employers offered POS plans in 1990; however, 34% did so last year according to a Hewitt Associates study. KPMG Peat Marwick found that 40% of firms with at least 200 workers offered POS plans in 1995, compared to 23% in 1993.

While the number of large employers offering POS plans is increasing, the number of small employers offering POS plans is less clear. Because smaller groups are more cost-driven in the marketplace, and because some carriers limit these groups to only one plan offering, it is likely that the number of small groups offering POS plans is somewhat less than larger groups.

It Is Not Known How Many Employers In Virginia Currently Offer Only A Closed-Panel HMO To Their Employees

From the information provided above, it is clear that POS plans are widely available in the marketplace for employers. However, those who advocate requiring a POS feature feel that the critical issue to be addressed in this study is whether POS plans (or others that provide a broad choice of providers) are offered by employers to employees. In view of the fact that all other types of benefit plans (i.e. indemnity, managed indemnity, PPO, and POS) allow the enrollee to receive care outside of the provider network, albeit some at a higher cost, a threshold question of this study is: How

many Virginia employers limit their employees to only a closed-panel HMO?

Unfortunately, there currently are no data available to answer this question with any degree of certainty. The VAHMO's recent survey of Virginia HMOs specifically asked the respondents to identify the number of group contracts for which their standard (closed-panel) HMO plan was the only product offered by the group to its employees. The responding HMOs were unable to provide specific numbers of employers and employees because, in some cases, they were not certain of the other benefit plans offered to the employees. The only insight provided by the survey was that, in instances where the HMOs knew a traditional HMO was the only offering, the vast majority of these cases occurred in the small group market (2-25 employees). So, while the number of employers which only offer traditional HMOs is not known at this time, this does occur to some degree in the marketplace, and it appears to be primarily in the small group market.

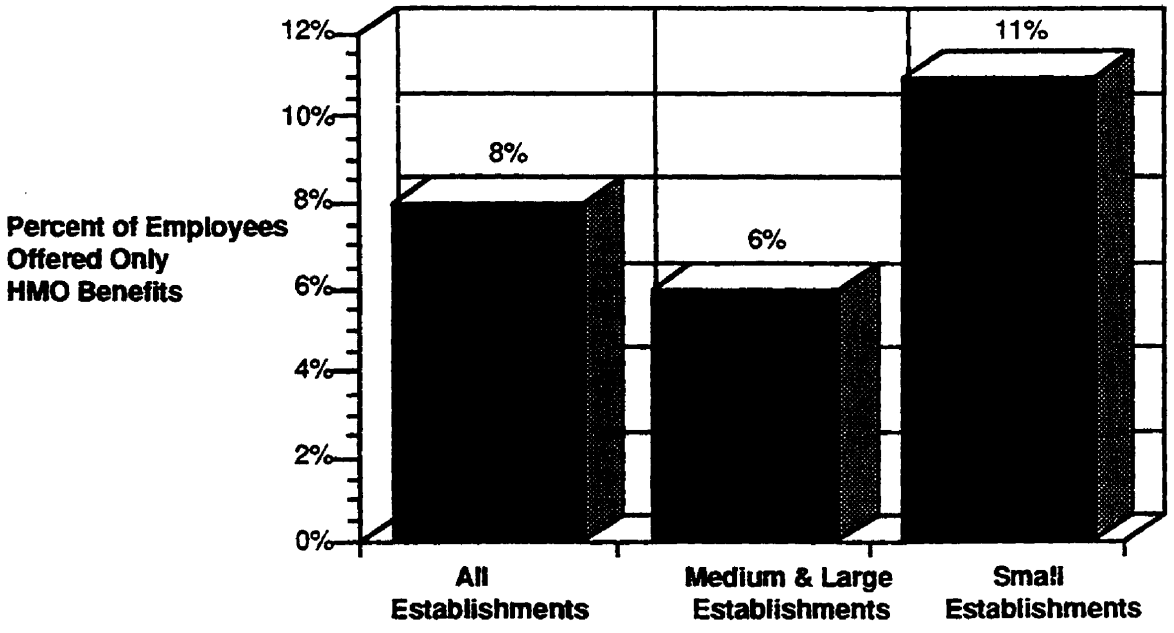
Some National Research Suggests The Number of Employees Offered Only An HMO Benefit Design Is Relatively Small

While not specific to Virginia, a 1995 Barents Group study conducted for the Alliance for Managed Care found that three percent of all employees offered health coverage during 1993-1994 were offered only an HMO.

In 1995, Bucci and Grant (Monthly Labor Review, October, 1995), analyzed national data on benefit choices available to employees during the years 1992 and 1993. While not specific to Virginia workers, as shown in Figure 6, they found that 8% of full-time employees in private establishments were offered only HMO benefits. The percentage of employees in small establishments (less than 100 employees) was 11%. This research did not analyze plan offerings for employees in smaller groups (i.e. fewer than 50 or 25 employees). However, given the price sensitivity of smaller groups, it is likely that the percentage of these employees being offered only an HMO benefit plan is somewhat greater than 11%.

Figure 6

Nationwide Percentage of Employees Offered Only HMO Benefits: 1992-1993



Note: Medium and large establishments are defined as 100 or more employees; Small establishments are defined as having fewer than 100 employees.
Source: Bucci and Grant, "Employer-Sponsored Health Insurance: What's Offered; What's Chosen"; Monthly Labor Review, October, 1995

A 1995 study commissioned by the Commonwealth Fund looked at this issue from a somewhat different perspective. In this study, managed care enrollees were surveyed on the types of plans available to them. Twenty-nine percent of the respondents reported they had no option to choose a POS plan.

IV.
Need For Point-Of-Service Legislation in Virginia

Any Legislation Requiring HMOs To Include POS Benefits Would Affect Only A Portion Of Virginia's Health Insurance Market

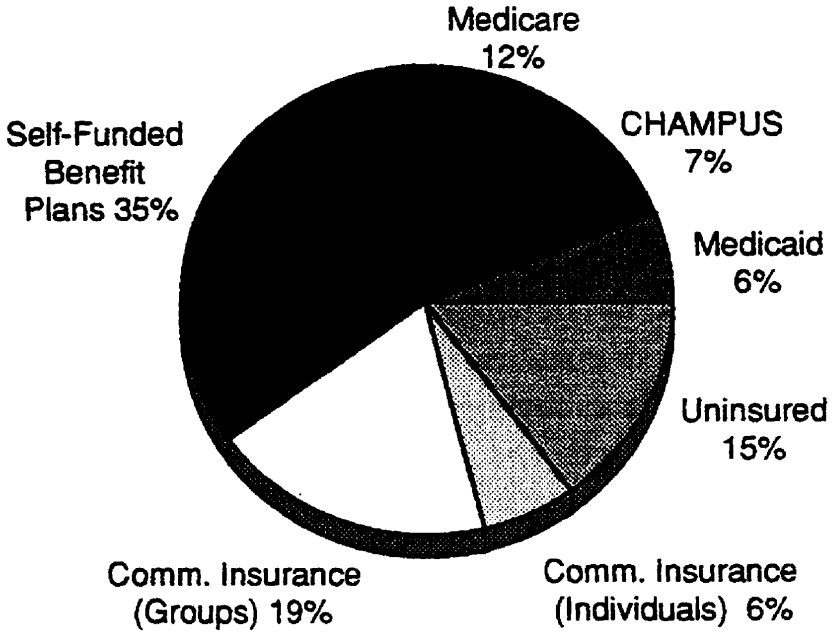
As has been noted in previous Joint Commission reports, legislative mandates that require insurance carriers and HMOs to provide certain benefits or comply with other mandates affect only the fully-insured commercial insurance market (approximately 25%). Other components of the market, including state and federal government benefit programs and self-insured groups would not be subject to the requirement. Figure 7 illustrates the health insurance status of Virginians in 1992 and the percentage of the marketplace (commercial insurance) which would be subject to any POS requirement.

POS Advocates Argue That All Patients Should Have Access To A Health Plan That Allows Enrollees To Choose Their Providers

Those who advocate requiring a POS feature argue that all patients should have access to a health plan which allows enrollees to choose their own providers. The Medical Society of Virginia and Virginians For Patient Choice believe that HMOs should be required to include a POS feature in their benefit designs, and that enrollees should be able to decide at initial enrollment and during annual enrollment periods thereafter whether to enroll in the closed panel HMO or the POS plan. A critical element of this position is that the availability of the POS option should be at the employee level, not just the employer level.

Figure 7

Health Insurance Status of Virginia's Population: 1992



Source: Virginia Commonwealth University, Survey Research Laboratory, U.S. Health Care Financing Administration, CHAMPUS Staff, Joint Commission on Health Care Staff

A POS Feature Could Be Required In One Of Two Different Ways: A Mandatory POS Or An Optional POS

Mandatory POS: A Mandatory POS requirement would require all HMO benefit plans to include a POS feature and essentially would eliminate the closed-panel HMO plan. Under this scenario, all patients would have out-of-network benefits because there would be no closed-panel HMO available.

The chief criticism of this approach is that it reduces plan choice in the marketplace by eliminating the closed panel HMO. Another criticism is that such an action would eliminate one of the most cost-effective types of insurance coverage from the market. The American Medical Association (AMA) recently defeated a proposal to require a mandatory POS provision. The Medical Society of Virginia agrees with the AMA

position, and does not advocate eliminating the traditional closed-panel HMO. There is a difference of opinion among the members of Virginians for Patient Choice on this issue.

Optional POS: In this scenario, HMOs could continue to market their traditional closed-panel HMO benefit plans, but also would have to offer a separate POS plan or arrange to have another carrier administer a POS plan. Both the AMA and the Medical Society of Virginia support the Optional POS approach. However, to meet the objectives of those advocating for greater provider choice, the offer of the POS feature must extend beyond the employer to the employee.

The difference between the Mandatory POS and Optional POS approach is somewhat akin to the current way in which the Commonwealth mandates that certain benefits be included in health insurance policies. In some instances, carriers must include the mandated benefit in their policies, and the purchaser has no choice but to purchase the policy with the benefits. This is similar to the Mandatory POS approach in that the only HMO benefits that purchasers could select would be one which included a POS feature.

The other approach to mandating insurance benefits is the mandate "to offer" the coverage, and allow the purchaser to decide if it wants to include the benefit in the policy. This is like the Optional POS approach where the purchaser can select the traditional closed-panel HMO or the HMO with a POS feature. There is, however, a key difference. The mandate to offer insurance benefits is made to the employer who decides whether or not to purchase the coverage. As previously noted, POS advocates insist that to truly provide choice to the enrollees, the "offer" must extend through the employer to the employees.

Proponents Believe POS Enrollees Should Pay Any Additional Costs Associated With The Out-Of-Network Benefits

Those advocating a POS requirement believe that any additional costs resulting from the POS benefits should be borne by those enrollees

who utilize the POS feature, rather than the plan or the employer. However, they believe that any such additional costs should be actuarially determined to reflect the true cost difference. They also believe that the benefits of the HMO and POS plans should be comparable. Lastly, advocates argue that there should be minimum reimbursement levels for services received from providers outside of the network.

Opponents Of A POS Requirement Believe The Marketplace Already Provides This Option To Patients, And That Requiring A POS Feature Be Offered To Employees Is A Mandate On Employers

The HMO industry and several business organizations, including the Virginia Chamber of Commerce, the Virginia Manufacturers Association and the Commonwealth Coalitions on Health are among those who have voiced opposition to such a requirement. (The Virginia Chapter of the National Federation of Independent Businesses has not taken a formal position on the POS issue; but, in the past, has supported other measures to enhance patient choice of providers (e.g. the any willing provider law).) Those who oppose requiring HMOs to offer a POS feature argue that the marketplace already provides this option. Moreover, they contend that requiring a POS plan to be offered to employees is, in effect, a mandate on employers.

Opponents Believe Assigning All Additional Costs Of An Optional POS On POS Enrollees Is Unrealistic; Adverse Selection Costs Eventually Will Price The POS Plan Out Of The Reach Of Most Employees Or Will Require Subsidy From The HMO Plan

Opponents argue that a requirement to offer a POS feature will have a significant cost impact that, in the long run, cannot be borne entirely by POS enrollees. They point to actuarial studies which indicate plans (e.g. POS plans) that offer a broader choice of providers and out-of-network benefits generally attract a higher percentage of enrollees with costly medical conditions. This is referred to as "adverse selection." Because these enrollees incur higher medical costs than those enrolled in more tightly managed plans (i.e. closed panel HMOs), the plan in which they enroll must be priced higher and the premium increased at a greater rate.

Opponents generally agree that POS enrollees should bear any additional costs associated with a POS feature, should it be required. However, they also contend that even if the cost differential for the POS plan is actuarially sound and the benefits are comparable with the HMO plan, adverse selection costs eventually will require it to be priced so high that it is, in effect, no longer an option. To prevent this from occurring, the HMO product would have to be priced to subsidize the POS plan which would increase the premium for HMO enrollees. They assert that the ultimate effect is higher costs for all enrollees.

The Impact Of A POS Requirement On The Cost Of Health Insurance Depends On The Type Of Legislative Requirement And Assumptions Made In Estimating Costs

Most of the studies that have been conducted on the cost of requiring a POS feature have focused on the cost of a mandatory POS where closed-panel HMOs, in effect, would be eliminated. It should be noted that the findings of each study are based on varying assumptions that have a significant impact on the findings. Also, all of the studies appear to have been commissioned by either proponents or opponents of POS requirements. As one might expect, the methodology and the findings in each study have been criticized by those with opposing views. Nonetheless, the following paragraphs provide a brief summary of several studies which attempted to estimate the additional cost of mandating a POS plan.

Barents Study: The Barents Group, LLC of KPMG Peat Marwick prepared a report for the Virginia Chamber of Commerce and the Virginians For Health Care Solutions. This report was issued during the 1996 General Assembly Session and estimated the cost of certain provisions of House Bill 1393, including the POS provisions of the bill.

Barents concluded that mandatory POS legislation would reduce HMO savings by 13%. Barents also estimated that a less strict provision (i.e. an Optional POS approach where closed panels would be offered in

addition to a POS) would reduce HMO savings by 7% for small employers and 4% for larger employers. Barents identified three key reasons for the projected increase in costs:

(i) mandatory POS reduces the ability of managed care plans to achieve savings through utilization management;
(ii) price discounts with providers are more difficult to achieve, and quality and utilization guidelines are more difficult to enforce with network providers; and
(iii) plans would incur greater administrative costs associated with the increasing number of providers serving plan members.

Shiels, et al.: In a 1995 study, Shiels concluded that nationwide mandatory POS requirements would increase HMO claims costs by 11% and claims processing costs by 4%.

Coopers & Lybrand: A 1994 analysis by Coopers & Lybrand concluded that mandatory POS would increase costs for traditional HMOs by as much as 17%.

Milliman & Robertson: In 1995, the Patient Access to Specialty Care Coalition retained Milliman & Robertson (M&R) to study the cost effect of requiring HMOs to provide out-of-network coverage for the commercial, non-Medicare, non-Medicaid population. M&R concluded that a mandatory POS requirement can either increase or decrease claims costs. The impact depends upon the HMO's selection of benefit designs that encourage or discourage use of the POS option by covered members and by factors that increase or decrease payments to service providers within and outside the HMO's network. Under several "reasonable scenarios," M&R found that the combined effect of these factors did not result in an increase or decrease of more than 10%.

Lewin-VHI, Inc.: A 1995 study by Lewin-VHI, Inc. concluded that a mandatory POS would downgrade the cost effectiveness of HMOs in reducing costs to levels consistent with PPOs and POS plans resulting in an increase in costs for HMO enrollees of 11%.

VAHMO Survey of Virginia HMOs Indicated The Cost Differential Between HMO and POS Plans Ranges From No Additional Cost to 20% More For POS Benefits

Virginia HMOs which responded to a January, 1996 VAHMO survey reported that the *relative cost differential* (i.e. overall cost/premium difference between a stand-alone HMO and an HMO/POS plan) ranged from no cost differential to 20% higher for POS benefits. Of the 14 plans that responded to the survey; two plans indicated that the difference was between 0 and 5%; seven plans indicated the differential ranged from 6-10%; three plans said it ranged from 11-15%; and two plans estimated the differential to be 16-20%.

Advocates Of POS Benefit Plans Assert That POS Benefits Can Lower The Indirect Costs Often Associated With Enrollees Having To Travel Longer Distances To Network Providers

In addition to any direct cost impact of POS plans, advocates for requiring POS benefits assert that POS benefits, in fact, may lower some indirect costs to employers and employees. The argument here is that in those instances where employees have to travel longer distances to network providers, more time is lost from work which is costly to the employer and the employee. POS plans which allow enrollees to see other providers who may be closer to the work site can reduce time away from work.

The Impact Of A POS Requirement On The Quality Of Health Care Services Is Unknown

There are many different definitions of exactly what "quality" health care is. Defining quality is difficult enough; agreeing on the best way to measure quality is even more problematic. There are studies which have concluded that managed care plans provide lower quality health care than indemnity plans; there are also studies which conclude managed care provides equal or better quality. As with most issues dealing with health care, there are those who agree and those who disagree with these studies'

findings. In sum, when it comes to research on managed care quality and consumer satisfaction, much depends on the eye of the beholder. Survey findings appear to offer conflicting assessments; in many cases, the same data, depending upon interpretation, can reveal serious concerns regarding managed care or virtually no difference between managed care and indemnity plans. (The Changing Health Care Marketplace, 1996).

Enrollees Value The Choice Of Providers Available Through POS Plans; Many Feel This Results In Higher Quality

Measuring the impact of POS benefit plans on the quality of health care falls into the same dilemma as other aspects of measuring quality of care. Proponents and opponents likely can point to various studies to support their respective views. However, research consistently has shown that being able to choose one's own provider of care, which is the chief selling point of POS plans, is one of the most important concerns of patients when selecting a health plan. Being able to continue a course of treatment or maintain a long-time relationship with a particular provider is extremely important to many patients. In fact, many patients equate the quality of their care with the provider from whom they receive the care. If the provider is their choice, the quality is good; if not, the quality is suspect. Thus, the broader choice of providers available in POS plans leads many patients to believe that these plans provide better quality of care.

POS Legislation Likely Would Require Changes In Current Statutes And Regulations Regarding The Operation And Financial Solvency Requirements Of HMOs

Legislation that requires an HMO to include or provide a POS feature would require the plan to recognize and pay non-negotiated fees for unanticipated services rendered by previously unidentified providers, and likely would reduce the plan's ability to manage its risk and costs. The Bureau of Insurance has indicated that, to the degree the plan's ability to manage risk is lessened, it may be necessary to require higher financial reserves, net worth, and deposits to offset the increased variability. The

Bureau also has indicated that the increased risk may require new or revised mechanisms for protecting consumers.

Another regulatory matter that would have to be addressed should a POS feature be required of HMOs is the current requirement in §38.2-4300 that at least 90% of the total costs of an HMO be derived from the "arrangement of services" with network providers as opposed to indemnification of services received from other providers. If an HMO is required to provide benefits for services received outside of its panel, this law would have to be revised to recognize the increase in out-of-network costs. A related matter is the requirement in the HMO regulations (14 VAC 5-210-70 C) which limits the maximum copayment that can be required of HMO enrollees to 200% of the total annual premium. Because a POS requirement likely would involve greater copays by POS enrollees, this regulation would need to be reviewed and possibly revised.

Should a POS feature be required, a complete review of current HMO regulations and relevant statutes would need to be completed as part of the process of drafting legislation.

V.
Point-of-Service Legislation In Other States

Four States Have Enacted "Optional POS" Legislation

According to the Intergovernmental Health Policy Project at George Washington University, six states considered POS legislation in 1995; three of these states (Maryland, New York, and Oregon) enacted "Optional POS" laws. In 1996, 17 states considered POS legislation; one state (Georgia) passed an "Optional POS" law. The following paragraphs summarize the key provisions of each state's legislation.

Maryland: Maryland passed its POS legislation in 1995. This law states that if an employer, association, or other private group arrangement offers only an HMO to its employees, the HMO must offer, or contract with another carrier to offer, a POS option to the employer. The employer decides whether to include the POS option in the benefits made available to its employees. If the employer decides to decline the POS option, the employees' only benefit plan is the HMO. If the employer accepts the POS option, it must be made available to all employees.

HMOs are not permitted to require a minimum participation level in the POS option. However, the employer may require the employee to pay a premium over the amount charged for the HMO. Additionally, the HMO may impose different cost-sharing provisions for the POS option.

The Maryland law has raised some questions as to whether it represents a mandate on employers and thus violates the provisions of the Employee Retirement Income Security Act (ERISA). However, Maryland's Attorney General has opined that the law's mandate applies to the HMOs and not employers, and that the law does not pose any constitutional problems.

New York: The POS legislation enacted in New York applies only to the individual market. This law requires HMOs to offer a POS option to individuals with benefits similar to those available through their HMO

products. The POS provisions were part of a larger individual health insurance reform bill.

Oregon: The POS legislation enacted in Oregon was part of a Patient Protection Act that was passed in 1995. The Oregon law mandates that insurers offer group plan purchasers (with more than 25 employees) a POS plan covering the services of a "provider on a discounted fee-for-service basis with reasonable access to a broad array of licensed providers..." This statute also requires that "[A]ny higher premium for the POS benefit may not exceed the true actuarial cost, including administrative costs, to the insurer." (Advocates of a POS requirement in Virginia believe this provision is a critical component of any legislation that may be passed in the Commonwealth.)

Georgia: Georgia passed its POS legislation as part of a "Patient Protection Act" that was enacted in 1996. Essentially, the legislation is the same as that passed in Maryland. The Georgia statute provides that if the only type of insurance that an employer offers to eligible employees or individuals is health benefit plan coverage through an HMO, the HMO must offer or make arrangements for the offering of a POS option to the employer. The employer then can elect to offer the POS option to its employees. Employers may require an employee who accepts the POS option to pay a higher premium, and the HMO may impose different cost-sharing provisions. Lastly, the employer can charge an employee a reasonable administrative fee for costs associated with the employer's reasonable administration of the POS option.

The Impact Of POS Legislation Passed In Other States Is Unknown

The POS legislation passed in other states has been so recent, there is very little or no information available on the impact these laws have had in the marketplace.

VI.
Application Of Certain Insurance Laws To Other Types Of Provider Panels In Virginia

House Bill 1393 directs the Joint Commission to study: (i) the extent to which provider panels, which may currently not be subject to state regulation, are forming in the Commonwealth; (ii) the impact that the formation of such provider panels has on the ability of enrollees to receive care from providers not in such panels; (iii) the extent to which these panels enhance or impede the ability of Virginians to access quality, affordable health care; and (iv) the need to extend the provisions of §38.2-3407.10 as added by HB 1393 or other relevant code sections to such provider panels.

This language was added to HB 1393 out of concern that there may be some provider panels forming in Virginia which are limiting patients' access to providers outside of the panel but are not being required to comply with certain provisions of the insurance code.

Other Types Of Provider Panels Are Forming In Virginia; Currently, These Panels Are Contracting With Health Plans To Provide Services To Plan Enrollees

A number of provider panels have formed in Virginia, many of which are groups of physicians which have formed for the purposes of sharing administrative systems, improving their negotiating positions with health plans, and garnering a greater market share of patients. These provider panels are contracting with health plans to participate in the plans' provider networks. However, to date, there is little, if any, evidence that these panels are contracting directly with employer or other groups to provide health insurance or benefits administration or otherwise functioning as a health insurer or HMO.

The panels which are contracting with and providing health care services through health plans are subject to the same requirements as other providers who contract with health plans. Moreover, patients' access to

providers outside of the panel is governed by the health plan with which the panel has contracted. As such, these provider panels do not appear to be having any negative impact on patients' access to providers outside of the panel, or access to affordable, quality health care coverage.

The Bureau Of Insurance Has Issued An Administrative Letter Requiring Any Insurer, HMO, Third Party Administrator Or Health Care Provider That Enters Into A Capitated Administrative Services Only (ASO) Agreement Be Subject To The Provisions Of The Insurance Code

In 1995, concerns were brought to the Bureau of Insurance that certain entities, including health care providers, were entering into capitated Administrative Services Only (ASO) agreements with employer groups in which the entity was assuming all or a portion of the risk. In response to these concerns, the Bureau issued Administrative Letter 1995-10 which states that these capitated ASO arrangements constitute a contract of insurance under Virginia law; and, therefore, are subject to the provisions of Title 38.2 (insurance laws) of the Code of Virginia. This ruling assures that any provider panel that is functioning as an insurer (i.e. assuming risk) will be subject to the same insurance laws as HMOs, insurers, etc.

As The Marketplace Continues To Evolve, Virginia May Want To Consider Revising Its Licensing Laws For Entities Assuming Risk

As the health care marketplace continues to evolve, new types of health plans, provider panels and other entities are forming which do not exactly fit the traditional definitions of insurance carrier, health services plan or HMO. As a result, current insurer licensing laws may not be keeping in step with these changes. In recognition of these market changes, the National Association of Insurance Commissioners (NAIC) has begun looking at a model Consolidated Licensure for Entities Assuming Risk (CLEAR) statute that would recognize the wide array of entities now in the marketplace and ensure that entities that perform the same or similar functions are subject to a level regulatory playing field.

Some states also are looking at adopting revised licensing laws, including Iowa and Ohio. However, in contrast to the direction being taken by the NAIC, the Illinois Department of Insurance recently announced that it will not regulate health care provider groups that engage in direct contracting and full risk assumption with self-insured employers that retain the risk for their employees.

The Joint Commission may want to consider requesting the Bureau of Insurance to study this issue and advise the Commission as to whether any changes are needed in the Commonwealth's current insurer licensing laws.

VII.
Conclusions

The Number Of Point-of-Service (POS) Plans Being Offered In The Marketplace Is Increasing; POS Is Readily Available In The Marketplace For Employers

National and Virginia-specific information on the current health care marketplace indicate that POS plans are increasing perhaps faster than any other type of health insurance benefit plan. Accordingly, this type of health care coverage is available to nearly all employers. While POS plans are more readily available to larger employers, smaller employers also can offer this product to their employees.

There Is No Definitive Information On The Number Of Virginia Employers Which Offer Only Closed-Panel HMO Benefit Plans To Their Employees

The critical issue for those who advocate for a POS requirement is that all employees should be able to select a health plan which offers a broader choice of providers than available through closed-panel HMOs. The fact that POS plans are available to employers does not fully address this concern. Currently, there is no information available that definitively answers the question: How many employees are limited to only a closed-panel HMO which does not provide benefits for care received outside the HMO's panel of providers? Information that is available suggests that, for larger employers, the number is probably rather small. For smaller employers, the number is somewhat greater; how much greater is unknown.

The Threshold Question To Be Addressed By This Study Is A Public Policy Decision Regarding Whether The Commonwealth Should Enact Legislation That Requires POS Plans To Be Offered At The Employee Level

As previously stated, POS plans are readily available to employers in Virginia. Enacting legislation that requires HMOs to offer a POS feature

to employers seems unnecessary given the current availability in the marketplace. Accordingly, the "bottom line" to the POS issue is whether the Commonwealth should enact legislation that requires POS plans to be offered at the employee level. This is a public policy decision that, even if further descriptive and actuarial information could have been included in this report, would still be a difficult one.

Advocates argue that a patient's choice of providers is one of the most important aspects of a health insurance plan. And, to ensure patients have the ability to receive care from their choice of providers, employees should not be limited to only a closed-panel HMO. To accomplish this, advocates believe that a POS feature should be available at the employee level. Advocates propose that any additional costs should be borne by those patients who enroll in the POS plan. They believe that this approach would enhance consumer satisfaction and quality of care. Those who oppose this approach argue that choice is already available in the marketplace; that legislation which would require a POS feature at the employee level would increase costs; and that such a law would represent government intrusion into a marketplace that is already responding to purchasers' demand for a broader choice of providers.

If It Is Decided To Require A POS Feature, Many Important Design Issues Would Have To Be Addressed And Resolved

If it is decided to require a POS feature, a number of important issues would have to be analyzed and resolved prior to enacting the legislation. For such a requirement to be effective, issues such as limits on POS premiums, cost-sharing differentials, benefits comparability, provider reimbursement, and other matters would have to be resolved. Given the complexity of these issues, no attempt is made here to suggest a certain plan design. Addressing these issues in a comprehensive manner would require the expertise and involvement of actuaries, the Bureau of insurance, insurance/HMO representatives and those advocating for a POS feature.

Should A POS Feature Be Required In Virginia, HMO Regulations and Relevant Statutes Would Have To Be Reviewed And Possibly Revised

The Bureau of Insurance has identified some current HMO statutes and regulations that would need to be reviewed and possibly revised if a POS feature is required of HMOs. Should legislation be drafted to enact such a requirement, a complete review of relevant HMO Code and regulatory provisions should be included in the drafting process.

Few States Have Enacted POS Legislation; New York Is The Only State Which Requires POS Be Offered To Enrollees (Individual Market)

To date, four states have enacted POS legislation. Three states require HMOs to offer POS plans to employers. In these states, the employers can decide whether to offer the POS plan to their employees. Only New York has passed legislation which requires HMOs to offer POS directly to enrollees. However, the New York POS requirement applies only to the individual market.

Other Types Of Provider Panels Are Forming In Virginia; However, To Date, These Panels Are Contracting With Health Plans Similar To Other Providers. Provider Panels Which Assume Risk Are Required To Be Licensed As An Insurer Or HMO.

A number of provider panels have formed in Virginia, and are contracting with health plans to participate in the plans' provider networks. However, to date, there is little, if any, evidence that these panels are contracting directly with employers or other groups to provide health insurance or benefits administration, or otherwise functioning as a health insurer or HMO. The Bureau of Insurance has opined that provider panels (and other entities) which assume risk must be appropriately licensed as an insurer or HMO.

In the future, as provider panels and other entities form in the marketplace that do not exactly fit the traditional definitions of insurance carrier, health services plan or HMO, there may be a need to revise current licensing laws to reflect these market changes.

VIII.
Policy Options

The following policy options are offered for consideration by the Joint Commission in deciding what actions, if any, to take regarding point-of-service health plans. Option III could be pursued along with either Option I or Option II.

Option I: **Take No Legislative Action In 1997, And Monitor The Marketplace To Gain Greater Insight Into The Availability Of POS Plans At The Employee Level.**

Option II: **Introduce Legislation In The 1997 Session Stating That It Is The Policy Of The Commonwealth To Ensure That All Virginians Have Access To Health Plans Which Allow The Enrollee To Access Care From Their Provider Of Choice; And Direct The Bureau Of Insurance To Convene A Task Force Composed Of Actuarial Experts And Representatives Of The HMO/Insurance Industry, Providers, And Consumers To Develop POS Legislation That Would Ensure The Availability Of POS Plans At The Employee Level.**

Under Option II, the Bureau of Insurance would convene a task force to develop legislation that addresses the key issues discussed earlier, including benefits comparability, premium and cost-sharing differentials, necessary regulatory changes, and other related matters.

Option III: **Introduce A Resolution Directing The Bureau Of Insurance To Review The Advisability Of Revising Current HMO/Insurer Licensing Laws To More Accurately Reflect The Changing Health Care Delivery System And Report Its Findings And Recommendations To The Joint Commission On Health Care And The General Assembly.**

APPENDIX A

VIRGINIA ACTS OF ASSEMBLY -- 1996 SESSION

CHAPTER 776

An Act to amend and reenact §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.10, relating to accident and sickness insurance; health care provider panels.

[H 1393]

Approved April 6, 1996

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214, 38.2-4319 and 38.2-4509 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.10 as follows:

§ 38.2-3407.10. Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

2. Any corporation providing individual or group accident and sickness subscription contracts;

3. Any health maintenance organization providing health care plans for health care services;

4. Any corporation offering prepaid dental or optometric services plans; or

5. Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

"Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

B. Any such carrier which offers a provider panel shall establish and use it in accordance with the following requirements:

1. Notice of the development of a provider panel in the Commonwealth or local service area shall be filed with the Department of Health Professions.

2. Carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

C. A carrier that uses a provider panel shall establish procedures for:

1. Notifying an enrollee of:

a. The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

b. The right of an enrollee upon request to continue to receive health care services for a period of up to sixty days from the date of the primary care provider's notice of termination from a carrier's provider panel, except when a provider is terminated for cause.

2. Notifying a provider at least sixty days prior to the date of the termination of the provider, except when a provider is terminated for cause.

3. Providing reasonable notice to primary care providers in the carrier's provider panel of the termination of a specialty referral services provider.

4. Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the health benefit plan of:

a. A description of all types of payment arrangements that the carrier uses to compensate providers for health care services rendered to enrollees, including, but not limited to, withholds, bonus payments, capitation and fee-for-service discounts; and

b. The terms of the plan in clear and understandable language which reasonably informs the purchaser of the practical application of such terms in the operation of the plan.

D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such termination to his patients who are enrollees under such plan.

E. A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, religion or national origin.

F. 1. For a period of at least sixty days from the date of the notice of a provider's termination from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:

a. Were in an active course of treatment from the provider prior to the notice of termination; and

b. Request to continue receiving health care services from the provider.

2. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with the providers.

G. 1. A carrier shall provide to a purchaser prior to enrollment and to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients.

2. The information provided under subdivision 1 shall be updated at least once a year.

H. No contract between a carrier and a provider may require that the provider indemnify the carrier for the carrier's negligence, willful misconduct, or breach of contract, if any.

I. No contract between a carrier and a provider shall require a provider, as a condition of participation on the panel, to waive any right to seek legal redress against the carrier.

J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider.

K. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

L. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

M. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996, or at any time after the effective date hereof when any term of any such policy, contract, or plan is changed or any premium adjustment is made. In addition, the requirements of this section shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1996.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, *38.2-3407.10*, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, *38.2-3407.10*, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500,

38.2-3514.1, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, *38.2-3407.10*, 38.2-3415, 38.2-3541, and 38.2-3600 through 38.2-3603 shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

2. That the Joint Commission on Health Care, in cooperation with the State Corporation Commission's Bureau of Insurance and the Division of Legislative Services, shall study the need to require a point-of-service feature which would allow an enrollee the option to receive health care services outside the provider panel. The Joint Commission, in cooperation with the Bureau of Insurance, shall also study (i) the extent to which provider panels, which may currently not be subject to state regulation, are forming in the Commonwealth, (ii) the impact that the formation of such provider panels has on the ability of enrollees to receive care from providers not in such panels, (iii) the extent to which these panels enhance or impede the ability of Virginians to access quality, affordable health care and (iv) the need to extend the provisions of § 38.2-3407.10 as added by this act or other relevant code sections to apply to such provider panels. The Joint Commission shall report its findings and recommendations to the Governor and the 1997 Session of the General Assembly by December 1, 1996.

HOUSE JOINT RESOLUTION NO. 231

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance of the State Corporation Commission, to study the effects of certain legislative proposals on managed care cost-containment strategies.

Agreed to by the House of Delegates, February 13, 1996
Agreed to by the Senate, February 29, 1996

WHEREAS, the rising cost of health care in the United States and in the Commonwealth is of concern to the General Assembly of Virginia and to all citizens of the Commonwealth; and

WHEREAS, the health care industry is undergoing sweeping change in an effort to decrease health care costs; and

WHEREAS, the marketplace is determined to maximize cost-saving efficiencies and quality through various forms of managed care; and

WHEREAS, ensuring affordable and quality health care choices is critical for Virginia's employers, taxpayers, and consumers; and

WHEREAS, in response to both private and public purchasers of health care, Virginia's managed health care organizations are developing a wide variety of managed care options, including preferred provider organizations, health maintenance organizations and point-of-service plans; and

WHEREAS, physicians and other health care professionals are participating in a variety of options; and

WHEREAS, these preferred provider plans, health maintenance organizations and point-of-service options utilize limited provider networks as one mechanism to achieve the goals of affordable and quality care; and

WHEREAS, the use of these limited provider panels or networks limit the enrollee's ability to utilize or self-refer to providers that are not participating in the networks; and

WHEREAS, the restriction of the patient's ability to choose his own health care provider increases the control of the insurer over the provider and the treatment plan which results in reduced health care costs; and

WHEREAS, limitations on the patient's ability to choose his own health care provider reduces his ability to manage his own treatment by preventing him from changing providers in the event of an unsatisfactory relationship or when dissatisfied with the course of treatment or with the quality and availability of health care services; and

WHEREAS, insurers, employers, providers, employees and patients are all interested in a quality cost-efficient health care delivery system which promotes the best possible treatment outcomes and use of resources; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance of the State Corporation Commission, be directed to study the effects of certain legislative proposals on managed care cost-containment strategies. The Commission shall (i) determine whether, and the extent to which, there exists a need to intervene through legislation, including selected legislation before the 1996 General Assembly of Virginia, to ensure that managed health care preserves the health care purchasers' and consumers' ability to choose, while ensuring accountability for the costs and the quality of health care; (ii) examine the impact of legislating restrictions on selective contracting between managed care entities and health care providers; (iii) identify and examine the positive and negative effects of limiting a patient's ability to utilize providers outside of a managed care plan's established network, including whether a point-of-service option, or any other similar mechanism should be mandated through legislation; and (iv) determine the necessity of parameters to ensure the availability of such means, mechanism, or insurance product to all enrollees of managed care health insurance plans at a reasonable cost.

The Division of Legislative Services shall provide technical assistance for the study. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

The Joint Commission on Health Care shall complete its work by October 1, 1996, and shall submit its findings and recommendations to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 7: Study of the Impact of Legislative Proposals on Managed Care Cost Containment/"Point-of-Service" Mandate

Comments regarding the Study of the Impact of Legislative Proposals on Managed Care Cost Containment/"Point-of -Service" Mandate Brief were received from the following 22 interested parties:

12 Provider and Provider/Consumer Groups

Brookside Health Care
Medical Society of Virginia
Roberts Home Medical
Virginia Association for Home Care
Virginia Association of Durable Medical Equipment Companies
Virginia Association of Nonprofit Homes for the Aging
Virginia Home Medical
Virginia Hospital & Healthcare Association
Virginia Occupational Therapy Association
Virginia Pharmacists Association
Visiting Nurse Association
Virginians for Patient Choice

Five Insurance Organizations, Companies and HMOs

Alliance for Managed Care
Prudential HealthCare
Sentara Health System
Trigon BlueCross BlueShield
Virginia Association of Health Maintenance Organizations

Two Business Organizations

Virginia Chamber of Commerce
Virginia Manufacturers Association

One Consumer Advocacy Group

AARP

One State Agency

Department of Medical Assistance Services

One Individual Citizen

Lori A. Edmonds

Policy Options Presented in Issue Brief

The following policy options were offered for consideration by the Joint Commission in deciding what actions, if any, to take regarding point-of-service health plans. Option III could be pursued along with either Option I or Option II.

Option I: **Take No Legislative Action In 1997, And Monitor The Marketplace To Gain Greater Insight Into The Availability Of POS Plans At The Employee Level.**

Option II: **Introduce Legislation In The 1997 Session Stating That It Is The Policy Of The Commonwealth To Ensure That All Virginians Have Access To Health Plans Which Allow The Enrollee To Access Care From Their Provider Of Choice; And Direct The Bureau Of Insurance To Convene A Task Force Composed Of Actuarial Experts And Representatives Of The HMO/Insurance Industry, Providers, And Consumers To Develop POS Legislation That Would Ensure The Availability Of POS Plans At The Employee Level.**

Under Option II, the Bureau of Insurance would convene a task force to develop legislation that addresses the key issues discussed earlier, including benefits comparability, premium and cost-sharing differentials, necessary regulatory changes, and other related matters.

Option III: **Introduce A Resolution Directing The Bureau Of Insurance To Review The Advisability Of Revising Current HMO/Insurer Licensing Laws To More Accurately Reflect The Changing Health Care Delivery System And Report Its Findings And Recommendations To The Joint Commission On Health Care And The General Assembly.**

Summary of Comments

Eight commenters, primarily insurance and business entities, commented in support of Option I. They noted that Virginia's health care marketplace is already moving toward offering POS plans. They also commented that a mandatory POS is not necessary and would have a detrimental effect on the market by increasing costs, particularly for small businesses. The Department of Medical Assistance Services supported Option I, and commented that if a POS feature is required of the Medicaid program, it likely would increase costs.

Twelve commenters, primarily provider and consumer groups, commented in support of Option II. They stressed the importance of allowing enrollees to choose their providers, and stated that adequate choice currently does not exist in closed panel HMOs. These groups also noted that requiring a POS option at the enrollee level will provide continuity of care for patients. Virginians for Patient Choice included a draft bill in their comments to implement Option II.

Three commenters supported Option III, citing a changing marketplace which may require a different regulatory approach.

Summary of Individual Public Comments

Brookside Health Care

Sandra Brown commented that the Joint Commission should introduce legislation in 1997 that ensures that patients can choose their own health care providers. She also stated that if this is not possible for 1997, Option II should be pursued as a compromise if it included a deadline for action by the Bureau of Insurance.

Medical Society of Virginia

Madeline I. Wade commented in support of Option II and III. Specifically, she expressed that the Medical Society supports Option II; however, the Medical Society does not believe the study and analysis contemplated in Option II should delay the adoption of responsible POS legislation. Additionally, Ms. Wade stated that the Medical Society supports Option III and that they believe that all competing managed care plans which assume insurance risk should, where possible, be subject to essentially the same

level of governmental regulation in order to adequately protect consumers and to permit the plans to compete on a level playing field.

Roberts Home Medical

Bob Evans expressed strong support for Option II and recommended that a deadline be set for the Bureau of Insurance to address this issue.

Virginia Association for Home Care

Martha B. Pulley suggested that legislation be introduced in the 1997 Session of the General Assembly to ensure that employees have the option of choosing a health care plan that allows them to select their own providers. She stated that if the provider of choice is not part of the managed care plan's panel of providers and if additional costs are incurred by the selection, those added costs, which are actuarially determined, should be paid by the employee. She recommended that if Option II is adopted, it should either require the Bureau of Insurance to develop regulations in the very near future to guarantee the availability (to employees) of plans that allow patient choice of providers, or require any such legislation to be prepared for the 1998 legislature.

Virginia Association of Durable Medical Equipment Companies

H. Douglas Ellis, Sam Clay and Cindy Warriner expressed support for Option II and stated that their members would prefer to have legislation introduced in 1997 that ensures patients the ability to choose their own health care providers. Additionally, they recommended that, if Option II is adopted, a deadline be set with the Bureau of Insurance in order that this issue would not be delayed, but addressed in the 1998 session.

Virginia Association of Nonprofit Homes for the Aging

Marcia A. Melton commented in support of Option II and expressed strong support for this concept as it applies to the elderly living in all types of long-term care retirement communities and facilities.

Virginia Home Medical

Tom Inman suggested that the Joint Commission review the provisions of HB 840 (1994) applying to ancillary service providers, which were repealed in 1995, as a starting point to help protect the consumer. He stated that the major feature in HB 840 was that it allowed the consumer to have the last

say in how their healthcare dollars would be spent, if they were dissatisfied with the "plan" provider. Further, Mr. Inman concluded that if this is not possible, he would support the Joint Commission focusing on Option II and that the Bureau of Insurance should be given a deadline to act upon the issue due to the critical nature of this problem and the length of time consumers have already been without this kind of statutory protection.

Virginia Hospital & Healthcare Association

Katharine M. Webb did not express support for a specific option. Ms. Webb stated that the market has already moved to offer POS options for large and small employers and any mandate to offer POS options to small employers requires restructuring of the small employer market to avoid increasing the number of working uninsured. She also stated that it is essential to look for ways to expand coverage for the uninsured rather than tinkering with the existing commercial market, where essential health care needs are being met. Finally, Ms. Webb felt that one must recognize consumer "choice" means meaningful choice of health benefit plans for small employers and their employees -- not just choice of providers; and that care must be taken not to sacrifice one for the other.

Virginia Occupational Therapy Association

Margaret M. Antoine commented in support of Option II. She also recommended that legislation, which mandates choice for Virginians in choosing health care providers, be introduced and passed in the 1997 General Assembly Session.

Virginia Pharmacists Association

Rebecca Snead expressed support for Option II and also suggested that the Bureau of Insurance develop regulations that would ensure patients the opportunity to participate in plans that allow patient choice.

Visiting Nurse Association

Emilie M. Deady urged the Joint Commission to emphasize patient choice which she indicated was not addressed in the report. She stated that she would recommend Option II in combination with Option III; however, she indicated that this delays resolution of the issue regarding patient choice. She concluded by stating that the Commonwealth needs to take a strong position that individuals have a right to choose their providers of care.

Without these choices, a monopoly could exist; and, therefore, quality care could be compromised.

Virginians for Patient Choice

Mark E. Rubin commented that, ideally, legislation would be introduced during the 1997 General Assembly Session that would assure employees have a health care plan option that allows them to choose their own providers. He also noted that Option II may be a workable compromise and suggested that the Bureau of Insurance develop regulations to ensure the availability of plans that allow patient choice of provider at the employee level. Additionally, Mr. Rubin submitted draft legislation to implement Option II.

Alliance for Managed Care

James W. Hazel expressed support for Option I and stated that the AMC believes it would be imprudent for the Commonwealth to enact legislation that requires POS plans to be offered at the employee level.

Sentara Health System

Patti Forrester suggested that the Joint Commission take no further action on this issue. She indicated that further study on the availability of POS plans is not necessary and stated that a "Point-of-Service" mandate would be inconsistent with the original mission of the Joint Commission.

Trigon BlueCross BlueShield

Wilda M. Ferguson expressed support for the first part of Option I (i.e., taking no legislative action in the 1997 session). She further stated that Trigon would support a careful evaluation of the marketplace changes that will occur as a result of the passage of the federal Kennedy/Kassebaum legislation.

Virginia Association of Health Maintenance Organizations

Mark C. Pratt stated that VAHMO supports the role of the Joint Commission and General Assembly to examine and monitor the marketplace as described in Options I, II and III, and pledges its cooperation and assistance in such endeavors. However, VAHMO respectfully and strongly opposes any movement toward a mandatory point-of-service law, including the introduction of legislation in the 1997

session. Mr. Pratt stated the VAHMO believes that requiring employers to provide their employees with a benefit for services rendered by providers outside of HMO networks in the name of "choice" would be bad public policy.

Prudential HealthCare

W. Bradford Wells stated that Prudential HealthCare concurs with the position of the Virginia Association of Health Maintenance Organizations .

Virginia Chamber of Commerce

Sandra D. Bowen respectfully suggested that the Joint Commission consider the following alternatives: (1) continue to monitor the marketplace which is responding to the popularity of POS plans by making them increasingly available to purchasers; (2) continue to address the viability of the small group and individual market to determine if there is any role for government in stimulating competition in that market; (3) await further action by the Congress which will affect the commercial health care marketplace; (4) continue the study to determine how significant actuarial and structural problems might be overcome so that POS plans might be made available to enrollees in small group plans without resulting in the loss of viable HMO options; and (5) address the problem of the uninsured in Virginia.

Virginia Manufacturers Association

Robert P. Kyle indicated that the paramount objective of public policy for the Commonwealth should be to reduce the proportion of the citizenry without any health insurance. He commented that VMA has no objection to Option I, and predicted that the marketplace evolution toward greater employee involvement in health care financing decisions will be evident. Mr. Kyle specifically expressed opposition to Option II.

AARP

Mary H. Madge commented in support of Option II and III. Ms. Madge recommended two changes to Option II: (1) do not limit the Option to POS, but also include Preferred Provider Organizations as types of managed care plans that would allow choice of providers; and (2) the language in Option II should be amended to include the individual insurance market.

Department of Medical Assistance Services

Joseph M. Teefey expressed support for Option I. He stated that if a POS option is mandated and the mandate applies to Virginia Medicaid recipients who are enrolled in HMOs or who become eligible to be enrolled in HMOs, it would likely increase costs to the Virginia Medicaid program.

Lori A. Edmonds

Ms. Edmonds expressed support for Option II and urged the Joint Commission to set a deadline for the Bureau of Insurance to address this legislation promptly in the 1998 General Assembly Session.

JOINT COMMISSION ON HEALTH CARE

Director

Jane Norwood Kusiak

Senior Health Policy Analyst

Patrick W. Finnerty

Office Manager

Mamie V. White