F I S C A L I M P A C T R E P O R T

SPONSOR: HBIC DATE TYPED: 3/5/03 HB 631/HBICS

SHORT TITLE: Rural Health Care Provider Access Act SB

ANALYST: Wilson

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY03	**FY04**	**FY03**	**FY04**		
		Indeterminate	See Narrative		

SOURCES OF INFORMATION

Responses Received From
Health Policy Commission (HPC)
Department of Health (DOH)

SUMMARY

Synopsis of Bill

The House Business & Industry Committee Substitute for House Bill 631 modifies the New Mexico Insurance Code to prohibit the exclusion of a health care provider from a provider service network. Any provider has the right to participate under a provider service network if the provider is willing to operate under the same terms and conditions as those offered to any other provider.

The provisions of the bill covers any person licensed as a physician, dentist, osteopathic physician and a certified nurse practitioner.

The bill applies only to rural areas. Bernalillo, Dona Ana, San Juan and Santa Fe counties are excluded as well as any area within 15 miles of Albuquerque.

A health care insurer may also refuse to contract if the provider network already has reasonable access for its members and the insurer is not acting unreasonably or arbitrarily to exclude the provider.

The bill states that if a provider believes that an insurer has refused to contract in violation of the Act, the provider may file a complaint with the Superintendent of Insurance. If the Superinten-

dent believes there is reasonable cause for a violation, then the Superintendent shall hold a hearing and enter an order as he deems necessary.

Significant Issues

HB 631/HBICS is referred to in the health care and health insurance business as Any Willing Provider (AWP) legislation. Consumer choice is a public policy objective served by AWP laws. Access to care is as well enhanced through AWP laws. Accountability, efficiency and health care cost containment are also public policy objectives. Consumer and provider choice must be balanced with accountability, efficiency and cost containment. Those are the fundamental issues behind an AWP law.

Providers advocating AWP legislation claim that a Managed Care Organization's (MCO) emphasis on the bottom line threatens quality care. Such laws will restore the emphasis in the practice of medicine to patient care and restore a true doctor-patient relationship without interference by a third party such as a clerk of an MCO telling the physician or other provider how to practice medicine.

The HB 631/HBICS could enhance choice for consumers because they will be permitted to choose their own providers who are practicing in an area, but not currently part of a health plan's or organization's provider net-work. In rural locations, this could improve access to care by not forcing patients to seek care out-of-town, where their insurance plan has a provider.

The HB 631/HBICS could help improve rural New Mexico's physician shortage areas by eliminating a possible barrier to a new physician beginning practice in a community and learning that the MCO provider panel will not contract with that physician. New physicians coming into New Mexico would not have a trade barrier that currently exists.

The bill could also improve access throughout New Mexico by reducing the amount of time patients have to wait to see their provider. When there are a limited number of plan-approved providers in an area, patients may have to choose between accepting a long waiting time to get an appointment, or seeking care from a non-plan provider and paying out of pocket. Accessing care in a more timely manner generally results in better health outcomes for patients, and avoids costly emergency care.

Opponents believe AWP laws undermine managed care's ability to control the cost and quality of clinical services provided to its members. Managed care organizations rely on utilization review and other quality assurance programs to ensure that patients receive high quality, cost-effective care. These programs could lose their effectiveness if managed care cannot selectively contract with providers who satisfy the plan's quality requirements and whose performance can be regularly monitored by the plan.

The HB 631/HBICS could result in increased costs to the health care system. Managed care plans achieve cost saving by selective contracting and minimizing administrative overhead by utilizing a selected network.

Estimates vary on how much AWP laws increase costs, according to the National Council of State Legislatures. Some studies have said the AWP statutes increase administrative costs by 34% to 52%. Others said the laws increase HMO costs by 5.8% to 18.4%."

HB 631/HBICS may be viewed as a precedent-setting intrusion into the affairs of a business organization, with legislation requiring an organization to do business with entities that they choose not to do business with.

TECHNICAL ISSUES

The HPC notes HB 631/HBICS may be excluding Los Lunas and northern Valencia County which has a significant shortage of physicians.

OTHER SUBSTANTIVE ISSUES

Fee-for-service medical care allows individuals to receive medical care from their provider of choice. Under this model, individuals chose their health care provider, receive care, and the provider bills an insurance plan on the basis of service provided.

The emergence of managed care organizations such as HMOs and PPOs narrowed and, in some cases, eliminated this ability to choose one's health care provider. MCOs entered the health care marketplace promising to reduce costs. MCOs maintain that the primary way to cut costs is by purchasing medical care in bulk by creating panels of selected providers who are promised patient volume in return for reduced prices.

MCOs manage costs by implementing cost-control mechanisms, such as utilization re-view. Central to the concept is a limited and highly managed provider panel, composed of selected high quality providers willing to accept reduced fees and utilization controls in return for a promised volume of patients.

At the same time, carefully developed and selected networks of providers have limited provider panels to promote accountability and efficiency. By limiting the number of providers in a network, managed care organizations such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are able to reduce administrative costs related to developing contracts, to monitor and better manage care with providers, to negotiate lower rates by offering a higher volume of patients, and to possibly enhance the quality of care through selective contracting of who is in their net-work.

Many employees, with some exceptions, are offered only one or two health plans by their employer. Employees usually have little or no input into selecting the plan. More economically fortunate workers do have options and tend to choose their health plan based on affordability and the ability to keep their own physician. Unfortunately for many people, the only real decision is whether to pay extra to receive the convenient, quality care of their choice or to have to change physicians to have insurance coverage.

The Robert Wood Johnson Foundation funded a study of the effect of AWP and freedom of choice laws on HMOs. The researchers found that AWP laws are typically enacted in states with little managed care activity, suggesting that states adopt them proactively as a tool to curb managed care growth. The results showed that AWP laws pertaining to physicians reduced HMO penetration. In addition, AWP laws pertaining to hospitals significantly increased HMO administrative costs. The laws, however, do not appear to have decreased the number or type of managed care plans offered by employers or increased the premiums.

Several other states have already passed AWP legislation including rural Western states such as Wyoming and Colorado, as well as Illinois, Indiana, Kentucky, Virginia and Arkansas.

AMENDMENTS

· The HBIC Substitute for HB631 narrowly defines health care providers. It does not mention hospitals, pharmacies, independent physical therapists, outpatient laboratories or radiology centers, ambulatory surgery centers, home health agencies, hospices, and others medical providers. If the intent of the bill is to improve access for rural consumers, the HBIC substitute for HB631 may not go far enough to provide comprehensive access. With the bill it is possible to have physicians, nurse practitioners and dentists in a rural community be part of a provider network, but the consumer may have to leave town for services beyond those provided by physicians, nurse practitioners and dentists.

· The HBIC Substitute for HB631 could define reasonable access in a manner similar to that which has previously been in place for the Salud MCO program for Medicaid. Those standards are as follows: 90 % of urban residents must travel no longer than 30 minutes to see a PCP (Primary Care Physician); 90 % of rural residents must travel no more than 445 minutes to see a physician; and 90% of frontier residents must travel no more than 60 minutes to see a physician. Urban counties are Bernalillo, Los Alamos, Santa Fe, and Dona Ana. Frontier counties are Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel, and Cibola. Rural counties are those that are not urban or frontier.

· The HBIC Substitute for HB631 could be re-worded to insure inclusion of northern Valencia County under the definition of “rural area.”

DW/prr