BILL ANALYSIS

Senate Research Center

S.B. 155
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Enrolled

AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

Many issuers of health benefit plans voluntarily undergo rigorous accreditation processes and are under continuous review by national accrediting organizations such as the Nation Commission on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC). These national organizations are in the business of reviewing health care benefit plan issuer processes and standards and currently accredit more than 300 health care entities. As a result, these organizations have the expertise to review certain health care plan issuer activities at least as effectively and efficiently, if not more so, than states conducting the review. Preparing for these reviews can cost a health care plan issuer hundreds of thousands or millions of dollars. These costs are in addition to the accreditation organization's fee which typically ranges from $40,000 to $100,000. Many of the systems and processes used by NCQA and URAC are also used by state agencies in conducting their accreditation reviews. This results in multiple and redundant reviews.

Similarly, health care plan issuers accredited by the Medicare Advantage coordinated care plans are subject to rules, standards, and monitoring by the Centers for Medicare and Medicaid Services (CMS).

S.B. 155 allows a health benefit plan issuer to be deemed in compliance with state statutory and regulatory requirements if the health benefit plan issuer has been accredited by a national accreditation organization and that organization's accreditation requirements are the same as or substantially similar to the state statutory or regulatory requirements.

This act would help reduce costs for state agencies overseeing licensing of health care entities, without reducing quality standards. The deeming provisions under this act would relieve state agencies from having to conduct potentially costly and lengthy review processes of health care benefit plan issuers. At a time when state budgets are financially challenged, the elimination of the state accreditation process for those health care benefit plan issuers that are nationally accredited would help the state reduce costs associated with accreditation processes. This would allow the applicable state agencies to focus on other issues such as developing programs to reduce the number of uninsured, while allow health care benefit plan issuers to put their own resources to better use.

S.B. 155 also allows coordination between state agencies that regulate and contract with Medicaid and Children's Health Insurance Program (CHIP) health care entities. The Texas Department of Insurance (TDI) and the Health and Human Service Commission (HHSC) often have similar requirements placed on the Medicaid and CHIP health care entities. Both TDI and HHSC review duplicative requirements for compliance and perform duplicative on-site reviews for compliance. This act allows the two agencies to enter into a memorandum of understanding to specify the responsibilities of each agency in this area.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 847.007) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle C, Title 6, Insurance Code, by adding Chapter 847, as follows:

CHAPTER 847. HEALTH CARE QUALITY ASSURANCE

Sec. 847.001. SHORT TITLE. Authorizes this chapter to be cited as the Health Care Quality Assurance Act.

Sec. 847.002. LEGISLATIVE FINDINGS; PURPOSES. Sets forth findings and purposes regarding the quality assurance accreditation process for certain entities that offer health benefit plans.

Sec. 847.003. DEFINITIONS. Defines "commission," "health benefit plan," and "national accreditation organization."

Sec. 847.004. APPLICABILITY OF CHAPTER. Provides that this chapter applies only to certain entities that offer health benefit plans.

Sec. 847.005. PRESUMED COMPLIANCE WITH CERTAIN STATUTORY AND REGULATORY REQUIREMENTS. (a) Provides that a health benefit plan issuer is presumed to be in compliance with state statutory and regulatory requirements if:

(1) the health benefit plan issuer has received nonconditional accreditation by a national accreditation organization; and

(2) the national accreditation organization's accreditation requirements are the same, substantially similar to, or more stringent than the department's statutory or regulatory accreditation requirements,.

(b) Provides that a health benefit plan issuer that offers a Medicare Advantage coordinated care plan under a contract with the federal Centers for Medicare and Medicaid Services is presumed to be in compliance with any state statutory and regulatory requirements that are the same, substantially similar to, or more stringent than the requirements for Medicare Advantage coordinated care plans, as determined by the commissioner of insurance (commissioner).

(c) Authorizes the Health and Human Services Commission (HHSC), if the Texas Department of Insurance (TDI) determines that a health benefit plan issuer is in compliance with a state statutory or regulatory requirement, to presume that a Medicaid or state child health plan program managed care plan offered by a health benefit plan issuer under contract with HHSC is in compliance with any contractual Medicaid or state child health plan program managed care plan requirement that is the same as, substantially similar to, or more stringent than the state statutory or regulatory requirement, as determined by HHSC.

(d) Authorizes the commissioner to take action, including imposing sanctions under Chapter 82, against a health benefit plan issuer who is presumed under Subsection (a), (b), or (c) to be in compliance but does not maintain compliance.

(e) Requires TDI to monitor and analyze periodically, as prescribed by rule by the commissioner, updates and amendmentments to national accreditation standards as necessary to ensure that those standards remain the same, substantially similar to, or more stringent than the department's statutory or regulatory requirements.

Sec. 847.006. FILING OF ACCREDITATION REPORT; CONFIDENTIALITY REQUIREMENTS. (a) Authorizes the commissioner to require a health benefit plan issuer to submit to the commissioner the accreditation report issued by the national accreditation organization.

(b) Provides that an accreditation report submitted under Subsection (a) is proprietary and confidential under Chapter 552, Government Code and is not subject to subpoena. Requires the commissioner to limit the disclosure of the accreditation report to certain department employees. Prohibits a TDI employee from further disclosing the accreditation report.

(c) Provides that the national accreditation organization recommendations summary results are not proprietary information and are subject to public disclosure under Chapter 552, Government Code.

Sec. 847.007. DUTIES OF COMMISSIONER OF INSURANCE. (a) Provides that in conducting an examination of a health benefit plan, the commissioner:

(1) shall accept the accreditation report submitted by the health benefit plan issuer as a prima facie demonstration of the issuer's compliance with the processes and standards for which the issuer has received accreditation; and

(2) may adopt relevant findings in a health benefit plan issuer's accreditation report in the examination report if the accreditation report complies with applicable state and federal requirements regarding the nondisclosure of proprietary and confidential information and personal health information.

(b) Provides that Subsection (a) does not apply to any process or standard of a health benefit plan issuer that is not covered as part of the issuer's accreditation. Provides that this section does not set minimum quality standards but operates only as a replacement of duplicate requirements.

(c) Authorizes the commissioner, by rule, to determine the application of compliance with national accreditation requirements by a delegated entity, delegated third party, or utilization review agent to compliance by the health benefit plan issuer that contracts with the delegated entity, delegated third party, or agent.

Sec. 847.008. COMMISSION DUTIES. (a) Authorizes HHSC to require the commissioner to submit certain documents to HHSC.

(b) Provides that documents submitted under Subsection (a) are proprietary and confidential information under Chapter 522, Government Code, and are not subject to subpoena. Requires HHSC to limit disclosure of the documents to certain HHSC employees. Prohibits an HHSC employee from further disclosing the compliance documents.

Sec. 847.009. MEMORANDUM OF UNDERSTANDING. Requires the commissioner and HHSC to enter into a memorandum of understanding to specify the responsibilities of TDI and HHSC under this chapter.

Sec. 847.010. ENFORCEMENT. Prohibits this chapter from being construed to prohibit the commissioner or HHSC from enforcing law relating to the operation of a health benefit plan or violation of a contract.

SECTION 2. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1457, as follows:

CHAPTER 1457. PROVISIONAL CREDENTIALING STATUS

Sec. 1457.001. DEFINITIONS. Defines "enrollee," "physician," and "provider network."

Sec. 1457.002. PROVISIONAL CREDENTIALING STATUS. (a) Requires a health benefit plan to have a process for provisional credentialing status in compliance with the requirements of the National Committee for Quality Assurance.

(b) Authorizes a health benefit plan to grant provisional credentialing status to a physician who meets certain criteria.

(c) Requires a health benefit plan to complete the credentialing process within 60 calendar days of the date a physician is granted provisional status. Requires a physician, in the event the physician does not meet the health plan's credentialing standards, to be provided the same appeal process as any other physician applying for participation with the health benefit plan.

SECTION 3. Effective date: June 1, 2005 or September 1, 2005.