BILL ANALYSIS

Senate Research Center
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S.B. 155
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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).

As proposed, S.B. 155 would allow 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 would also allow 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 would allow the two agencies to enter into a memorandum of understanding to specify the responsibilities of each agency in this area.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

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. DEEMED COMPLIANCE WITH CERTAIN STATUTORY AND REGULATORY REQUIREMENTS. (a) Provides that, notwithstanding any provision of this code, the Health and Safety Code, or any other law, a health benefit plan issuer is deemed to be in compliance with state statutory and regulatory requirements if:

(1) the health benefit plan issuer has been accredited at any level by a national accreditation organization; and

(2) the national accreditation organization's accreditation requirements are the same or substantially similar to the department's statutory or regulatory accreditation requirements, as determined by the commissioner.

(b) Provides that, notwithstanding any provision of this code, the Health and Safety code, or any other law, 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 deemed to be in compliance with any state statutory and regulatory requirements that are the same or substantially similar to the requirements for Medicare Advantage coordinated care plans, as determined by the commissioner of insurance (commissioner).

(c) Provides that, notwithstanding Sections 533.005 (REQUIRED CONTRACT PROVISIONS) and 533.007 (CONTRACT COMPLIANCE), Government Code, or any other law, a Medicaid managed care plan offered by a health benefit plan issuer under a contract with the Health and Human Services Commission (HHSC) is deemed to be in compliance with any contractual Medicaid managed care plan requirements that are the same or substantially similar to any statutory and regulatory requirements, as determined by the commissioner.

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 and is not subject to subpoena. Requires the commissioner to limit the disclosure of the accreditation report to certain department employees. Prohibits a Texas Department of Insurance (TDI) employee from further disclosing the accreditation report.

Sec. 847.007. COMMISSIONER DUTIES. (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 demonstrating 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.

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

(b) Provides that documents submitted under Subsection (a) are proprietary and confidential and are not subject to subpoena. Requires the HHSC to limit disclosure of the documents to certain HHSC employees.

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

SECTION 2. Effective date: upon passage or September 1, 2005.