

A BILL TO BE ENTITLED

AN ACT

relating to the quality assurance accreditation process for certain entities that offer health benefit plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle C, Title 6, Insurance Code, is amended by adding Chapter 847 to read as follows:

CHAPTER 847. HEALTH CARE QUALITY ASSURANCE

Sec. 847.001. SHORT TITLE. This chapter may be cited as the Health Care Quality Assurance Act.

Sec. 847.002. LEGISLATIVE FINDINGS; PURPOSES. The legislature finds that to ensure enrollees high quality care, many health benefit plan issuers voluntarily undergo a rigorous accreditation process conducted by nationally recognized accreditation organizations. To maintain accreditation, these health benefit plan issuers are subject to continuing review of their processes and standards. The legislature recognizes that many of these processes and standards are also reviewed by state agencies, resulting in increased agency costs and increased health benefit plan administrative costs. The purpose of this chapter is to allow appropriate recognition of accreditation by nationally recognized accreditation organizations and to foster coordination among state agencies in order to:

(1) help make health benefit plan coverage more affordable for consumers; and

1           (2) eliminate duplication of effort by both health  
2 benefit plan issuers and state agencies.

3           Sec. 847.003. DEFINITIONS. In this chapter:

4           (1) "Commission" means the Health and Human Services  
5 Commission.

6           (2) "Health benefit plan" means an individual, group,  
7 blanket, or franchise insurance policy, a certificate issued under  
8 a group policy, a group hospital service contract, or an individual  
9 or group subscriber contract or evidence of coverage issued by a  
10 health maintenance organization that provides benefits for health  
11 care services. The term does not include:

12                   (A) accident-only or disability income insurance  
13 coverage or a combination of accident-only and disability income  
14 insurance coverage;

15                   (B) credit-only insurance coverage;

16                   (C) disability insurance coverage;

17                   (D) Medicare services under a federal contract;

18                   (E) Medicare supplement and Medicare Select  
19 benefit plans regulated in accordance with federal law;

20                   (F) long-term care coverage or benefits, nursing  
21 home care coverage or benefits, home health care coverage or  
22 benefits, community-based care coverage or benefits, or any  
23 combination of those coverages or benefits;

24                   (G) workers' compensation insurance coverage or  
25 similar insurance coverage;

26                   (H) coverage provided through a jointly managed  
27 trust authorized under 29 U.S.C. Section 141 et seq. that contains a

1 plan of benefits for employees that is negotiated in a collective  
2 bargaining agreement governing wages, hours, and working  
3 conditions of the employees that is authorized under 29 U.S.C.  
4 Section 157;

5 (I) hospital indemnity or other fixed indemnity  
6 insurance coverage;

7 (J) reinsurance contracts issued on a stop-loss,  
8 quota-share, or similar basis;

9 (K) short-term major medical contracts;

10 (L) liability insurance coverage, including  
11 general liability insurance coverage and automobile liability  
12 insurance coverage, and coverage issued as a supplement to  
13 liability insurance coverage, including automobile medical payment  
14 insurance coverage;

15 (M) coverage for on-site medical clinics;

16 (N) coverage that provides other limited  
17 benefits specified by federal regulations;

18 (O) coverage that provides limited scope dental  
19 or vision benefits; or

20 (P) other coverage that:

21 (i) is similar to the coverage described by  
22 this subdivision under which benefits for medical care are  
23 secondary or incidental to other coverage benefits; and

24 (ii) is specified by federal regulations.

25 (3) "National accreditation organization" means:

26 (A) the Accreditation Association for Ambulatory  
27 Health Care;

1           (B) the Joint Commission on Accreditation of  
2 Healthcare Organizations;

3           (C) the National Committee for Quality  
4 Assurance;

5           (D) the American Accreditation HealthCare  
6 Commission ("URAC"); or

7           (E) any other national accreditation entity  
8 recognized by rules jointly adopted by the commissioner of  
9 insurance and the executive commissioner of the commission.

10           Sec. 847.004. APPLICABILITY OF CHAPTER. This chapter  
11 applies only to an entity that issues a health benefit plan and that  
12 holds a license or certificate of authority issued by the  
13 commissioner and provides benefits for medical or surgical expenses  
14 incurred as a result of a health condition, accident, or sickness,  
15 including:

16           (1) an insurance company;

17           (2) a group hospital service corporation operating  
18 under Chapter 842;

19           (3) a health maintenance organization operating under  
20 Chapter 843;

21           (4) an approved nonprofit health corporation that  
22 holds a certificate of authority issued by the commissioner under  
23 Chapter 844;

24           (5) a multiple employer welfare arrangement that holds  
25 a certificate of authority under Chapter 846;

26           (6) a stipulated premium company operating under  
27 Chapter 884;

1           (7) a fraternal benefit society operating under  
2 Chapter 885; or

3           (8) a reciprocal exchange operating under Chapter 942.  
4           Sec. 847.005. PRESUMED COMPLIANCE WITH CERTAIN STATUTORY  
5 AND REGULATORY REQUIREMENTS. (a) A health benefit plan issuer is  
6 presumed to be in compliance with state statutory and regulatory  
7 requirements if:

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

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

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

22           (c) A Medicaid managed care plan offered by a health benefit  
23 plan issuer under a contract with the commission is presumed to be  
24 in compliance with any contractual Medicaid managed care plan  
25 requirements that are the same, substantially similar to, or more  
26 stringent than any statutory and regulatory requirements, as  
27 determined by the commissioner.

1       (d) The commissioner may take appropriate action, including  
2 imposition of sanctions under Chapter 82, against a health benefit  
3 plan issuer who is presumed under Subsection (a), (b), or (c) to be  
4 in compliance with state statutory and regulatory requirements but  
5 does not maintain compliance with the same, substantially similar,  
6 or more stringent requirements applicable to the issuer under  
7 Subsection (a), (b), or (c).

8       (e) The department shall monitor and analyze periodically  
9 as prescribed by rule by the commissioner updates and amendments  
10 made to national accreditation standards as necessary to ensure  
11 that those standards remain the same, substantially similar to, or  
12 more stringent than the department's statutory or regulatory  
13 requirements.

14       Sec. 847.006. FILING OF ACCREDITATION REPORT;  
15 CONFIDENTIALITY REQUIREMENTS. (a) The commissioner may require a  
16 health benefit plan issuer to submit to the commissioner the  
17 accreditation report issued by the national accreditation  
18 organization.

19       (b) An accreditation report submitted under Subsection (a)  
20 is proprietary and confidential information under Chapter 552,  
21 Government Code, and is not subject to subpoena. The commissioner  
22 shall limit the disclosure of the accreditation report to those  
23 department employees who need the accreditation report to perform  
24 the duties of their job. A department employee may not further  
25 disclose the accreditation report.

26       (c) The national accreditation organization  
27 recommendations summary results are not proprietary information

1 and are subject to public disclosure under Chapter 552, Government  
2 Code.

3 Sec. 847.007. DUTIES OF COMMISSIONER OF INSURANCE. (a) In  
4 conducting an examination of a health benefit plan issuer, the  
5 commissioner:

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

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

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

20 (c) The commissioner may by rule determine the application  
21 of compliance with national accreditation requirements by a  
22 delegated entity, delegated third party, or utilization review  
23 agent to compliance by the health benefit plan issuer that  
24 contracts with the delegated entity, delegated third party, or  
25 agent.

26 Sec. 847.008. COMMISSION DUTIES. (a) The commission may  
27 require the commissioner to submit to the commission the documents

1 reviewed by the department that substantiate the compliance of the  
2 health benefit plan issuer with applicable state statutory and  
3 regulatory requirements.

4 (b) Documents submitted under Subsection (a) are  
5 proprietary and confidential information under Chapter 552,  
6 Government Code, and are not subject to subpoena. The commission  
7 shall limit disclosure of the documents to commission employees who  
8 need the documentation to perform the duties of their job. A  
9 commission employee may not further disclose the compliance  
10 documents.

11 Sec. 847.009. MEMORANDUM OF UNDERSTANDING. The  
12 commissioner and the commission must enter into a memorandum of  
13 understanding to specify the responsibilities of the department and  
14 the commission under this chapter.

15 Sec. 847.010. ENFORCEMENT. This chapter may not be  
16 construed to prohibit the commissioner or the commission from  
17 enforcing laws or rules relating to:

- 18 (1) the operation of a health benefit plan; or  
19 (2) violation of a contract.

20 SECTION 2. This Act takes effect June 1, 2005, if it  
21 receives a vote of two-thirds of all the members elected to each  
22 house, as provided by Section 39, Article III, Texas Constitution.  
23 If this Act does not receive the vote necessary for effect on that  
24 date, this Act takes effect September 1, 2005.