S.B. No. 155

AN ACT

relating to the quality assurance accreditation process for certain entities that offer health benefit plans and the provisional credentialing process for 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

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

Sec. 847.003. DEFINITIONS. In this chapter:

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

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

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

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) Medicare services under a federal contract;

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

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

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

(H) coverage provided through a jointly managed

1 trust authorized under 29 U.S.C. Section 141 et seq. that contains a
2 plan of benefits for employees that is negotiated in a collective
3 bargaining agreement governing wages, hours, and working
4 conditions of the employees that is authorized under 29 U.S.C.
5 Section 157;
6 (I) hospital indemnity or other fixed indemnity
7 insurance coverage;
8 (J) reinsurance contracts issued on a stop-loss,
9 quota-share, or similar basis;
10 (K) short-term major medical contracts;
11 (L) liability insurance coverage, including
12 general liability insurance coverage and automobile liability
13 insurance coverage, and coverage issued as a supplement to
14 liability insurance coverage, including automobile medical payment
15 insurance coverage;
16 (M) coverage for on-site medical clinics;
17 (N) coverage that provides other limited
18 benefits specified by federal regulations;
19 (O) coverage that provides limited scope dental
20 or vision benefits; or
21 (P) other coverage that:
22 (i) is similar to the coverage described by
23 this subdivision under which benefits for medical care are
24 secondary or incidental to other coverage benefits; and
25 (ii) is specified by federal regulations.
26 (3) "National accreditation organization" means:
27 (A) the Accreditation Association for Ambulatory

1 Health Care;
2 (B) the Joint Commission on Accreditation of
3 Healthcare Organizations;
4 (C) the National Committee for Quality
5 Assurance;
6 (D) the American Accreditation HealthCare
7 Commission ("URAC"); or
8 (E) any other national accreditation entity
9 recognized by rules jointly adopted by the commissioner of
10 insurance and the executive commissioner of the commission.
11 Sec. 847.004. APPLICABILITY OF CHAPTER. This chapter
12 applies only to an entity that issues a health benefit plan and that
13 holds a license or certificate of authority issued by the
14 commissioner and provides benefits for medical or surgical expenses
15 incurred as a result of a health condition, accident, or sickness,
16 including:
17 (1) an insurance company;
18 (2) a group hospital service corporation operating
19 under Chapter 842;
20 (3) a health maintenance organization operating under
21 Chapter 843;
22 (4) an approved nonprofit health corporation that
23 holds a certificate of authority issued by the commissioner under
24 Chapter 844;
25 (5) a multiple employer welfare arrangement that holds
26 a certificate of authority under Chapter 846;
27 (6) a stipulated premium company operating under

1 Chapter 884;
2 (7) a fraternal benefit society operating under
3 Chapter 885; or
4 (8) a reciprocal exchange operating under Chapter 942.
5 Sec. 847.005. PRESUMED COMPLIANCE WITH CERTAIN STATUTORY
6 AND REGULATORY REQUIREMENTS. (a) A health benefit plan issuer is
7 presumed to be in compliance with state statutory and regulatory
8 requirements if:
9 (1) the health benefit plan issuer has received
10 nonconditional accreditation by a national accreditation
11 organization; and
12 (2) the national accreditation organization's
13 accreditation requirements are the same, substantially similar to,
14 or more stringent than the department's statutory or regulatory
15 requirements.
16 (b) A health benefit plan issuer that offers a Medicare
17 Advantage coordinated care plan under a contract with the federal
18 Centers for Medicare and Medicaid Services is presumed to be in
19 compliance with any state statutory and regulatory requirements
20 that are the same, substantially similar to, or more stringent than
21 the requirements for Medicare Advantage coordinated care plans, as
22 determined by the commissioner.
23 (c) If the department determines that a health benefit plan
24 issuer is in compliance with a state statutory or regulatory
25 requirement, the commission may presume that a Medicaid or state
26 child health plan program managed care plan offered by a health
27 benefit plan issuer under contract with the commission is in

1 compliance with any contractual Medicaid or state child health plan
2 program managed care plan requirement that is the same as,
3 substantially similar to, or more stringent than the state
4 statutory or regulatory requirement, as determined by the
5 commission.

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

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

19 Sec. 847.006. FILING OF ACCREDITATION REPORT;
20 CONFIDENTIALITY REQUIREMENTS. (a) The commissioner may require a
21 health benefit plan issuer to submit to the commissioner the
22 accreditation report issued by the national accreditation
23 organization.

24 (b) An accreditation report submitted under Subsection (a)
25 is proprietary and confidential information under Chapter 552,
26 Government Code, and is not subject to subpoena. The commissioner
27 shall limit the disclosure of the accreditation report to those

1 department employees who need the accreditation report to perform
2 the duties of their job. A department employee may not further
3 disclose the accreditation report.
4 (c) The national accreditation organization
5 recommendations summary results are not proprietary information
6 and are subject to public disclosure under Chapter 552, Government
7 Code.
8 Sec. 847.007. DUTIES OF COMMISSIONER OF INSURANCE. (a) In
9 conducting an examination of a health benefit plan issuer, the
10 commissioner:
11 (1) shall accept the accreditation report submitted by
12 the health benefit plan issuer as a prima facie demonstration of the
13 issuer's compliance with the processes and standards for which the
14 issuer has received accreditation; and
15 (2) may adopt relevant findings in a health benefit
16 plan issuer's accreditation report in the examination report if the
17 accreditation report complies with applicable state and federal
18 requirements regarding the nondisclosure of proprietary and
19 confidential information and personal health information.
20 (b) Subsection (a) does not apply to any process or standard
21 of a health benefit plan issuer that is not covered as part of the
22 issuer's accreditation. This section does not set minimum quality
23 standards but operates only as a replacement of duplicate
24 requirements.
25 (c) The commissioner may by rule determine the application
26 of compliance with national accreditation requirements by a
27 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) The commission may require the commissioner to submit to the commission the documents reviewed by the department that substantiate the compliance of the health benefit plan issuer with applicable state statutory and regulatory requirements.

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

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

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

(1) the operation of a health benefit plan; or

(2) violation of a contract.

SECTION 2. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1457 to read as follows:

1 CHAPTER 1457. PROVISIONAL CREDENTIALING STATUS
2 Sec. 1457.001. DEFINITIONS. In this chapter:
3 (1) "Enrollee" means an individual who is eligible to
4 receive health care services through a health benefit plan.
5 (2) "Physician" means an individual licensed to
6 practice medicine in this state under the authority of Subtitle B,
7 Title 3, Occupations Code.
8 (3) "Provider network" means a health benefit plan
9 under which health care services are provided to enrollees through
10 contracts with physicians and that requires those enrollees to use
11 physicians participating in the plan and procedures covered by the
12 plan. The term includes a network operated by:
13 (A) a health maintenance organization;
14 (B) a preferred provider organization; or
15 (C) another entity that issues a health benefit
16 plan, including an insurance company.
17 Sec. 1457.002. PROVISIONAL CREDENTIALING STATUS. (a) A
18 health benefit plan shall have a process for provisional
19 credentialing status in compliance with the requirements of the
20 National Committee for Quality Assurance.
21 (b) A health benefit plan may grant provisional
22 credentialing status to a physician who:
23 (1) submits a completed standard credentialing
24 application to the health benefit plan;
25 (2) meets the health plan's requirements for
26 provisional credentialing; and
27 (3) joins as a partner, shareholder, or employee of

1 another physician who is contracted with a health benefit plan to
2 provide medical or health care services to enrollees.
3 (c) A health benefit plan must complete the credentialing
4 process within 60 calendar days of the date a physician is granted
5 provisional status. In the event the physician does not meet the
6 health plan's credentialing standards, the physician must be
7 provided the same appeal process as any other physician applying
8 for participation with the health benefit plan.
9 SECTION 3. This Act takes effect June 1, 2005, if it
10 receives a vote of two-thirds of all the members elected to each
11 house, as provided by Section 39, Article III, Texas Constitution.
12 If this Act does not receive the vote necessary for effect on that
13 date, this Act takes effect September 1, 2005.

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President of the Senate Speaker of the House

I hereby certify that S.B. No. 155 passed the Senate on March 30, 2005, by the following vote: Yeas 30, Nays 0; and that the Senate concurred in House amendments on May 27, 2005, by the following vote: Yeas 29, Nays 0.

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Secretary of the Senate

I hereby certify that S.B. No. 155 passed the House, with amendments, on May 25, 2005, by the following vote: Yeas 145, Nays 0, two present not voting.

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Chief Clerk of the House

Approved:

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Date

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Governor