By: Shapiro, Janek S.B. No. 155

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

(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 trust authorized under 29 U.S.C. Section 141 et seq. that contains a

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

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

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

(K) short-term major medical contracts;

(L) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

(M) coverage for on-site medical clinics;

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

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

(P) other coverage that:

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

(ii) is specified by federal regulations.

(3) "National accreditation organization" means:

(A) the Accreditation Association for Ambulatory Health Care;

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

(C) the National Committee for Quality Assurance;

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

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

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

(1) an insurance company;

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

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

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

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

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

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

(8) a reciprocal exchange operating under Chapter 942.

Sec. 847.005. PRESUMED COMPLIANCE WITH CERTAIN STATUTORY AND REGULATORY REQUIREMENTS. (a) 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 requirements.

(b) 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.

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

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

(e) The department shall monitor and analyze periodically as prescribed by rule by the commissioner updates and amendments made 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) The commissioner may require a health benefit plan issuer to submit to the commissioner the accreditation report issued by the national accreditation organization.

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

(c) 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) In conducting an examination of a health benefit plan issuer, 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) 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. This section does not set minimum quality standards but operates only as a replacement of duplicate requirements.

(c) The commissioner may by rule 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) 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. This Act takes effect June 1, 2005, if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for effect on that date, this Act takes effect September 1, 2005.