By: Averitt S.B. No. 1257

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COMMITTEE SUBSTITUTE FOR S.B. No. 1257 By: Deuell

A BILL TO BE ENTITLED
AN ACT

relating to the regulation of certain market conduct activities of certain life, accident, and health insurers and health benefit plan issuers; providing civil liability and administrative and criminal penalties.

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

ARTICLE 1. RESCISSION OF HEALTH BENEFIT PLAN

SECTION 1.001. Subchapter B, Chapter 541, Insurance Code, is amended by adding Section 541.062 to read as follows:

Sec. 541.062. BAD FAITH RESCISSION. (a) For purposes of this section, "rescission" has the meaning assigned by Section 1202.101.

(b) It is an unfair method of competition or an unfair or deceptive act or practice for a health benefit plan issuer to:

(1) set rescission goals, quotas, or targets;

(2) pay compensation of any kind, including a bonus or award, that varies according to the number of rescissions;

(3) set, as a condition of employment, a number or volume of rescissions to be achieved; or

(4) set a performance standard, for employees or by contract with another entity, based on the number or volume of rescissions.

SECTION 1.002. Chapter 1202, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. INDEPENDENT REVIEW OF CERTAIN RESCISSION DECISIONS

Sec. 1202.101. DEFINITIONS. In this subchapter:

(1) "Affected individual" means an individual who is otherwise entitled to benefits under a health benefit plan that is subject to a decision to rescind.

(2) "Independent review organization" means an organization certified under Chapter 4202.

(3) "Rescission" means the termination of an insurance agreement, contract, evidence of coverage, insurance policy, or other similar coverage document in which the health benefit plan issuer refunds premium payments or, if applicable, demands the restitution of any benefit paid under the plan, on the ground that the issuer is entitled to restoration of the issuer's precontractual position.

(4) "Screening criteria" means the elements or factors used in a determination of whether to subject an issued health benefit plan to additional review for possible rescission, including any applicable dollar amount or number of claims submitted.

Sec. 1202.102. APPLICABILITY. (a) This subchapter applies only to a health benefit plan, including a small or large employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

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

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a Lloyd's plan operating under Chapter 941;

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

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

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan described by Subsection (a);

(6) a Medicaid managed care plan offered under Chapter 533, Government Code;

(7) any policy or contract of insurance with a state agency, department, or board providing health services to eligible individuals under Chapter 32, Human Resources Code; or

(8) a child health plan offered under Chapter 62, Health and Safety Code, or a health benefits plan offered under Chapter 63, Health and Safety Code.

Sec. 1202.103. RESCISSION FOR MISREPRESENTATION OR PREEXISTING CONDITION. Notwithstanding any other law, a health benefit plan issuer may not rescind a health benefit plan on the basis of a misrepresentation or a preexisting condition except as provided by this subchapter.

Sec. 1202.104. NOTICE OF INTENT TO RESCIND. (a) A health benefit plan issuer may not rescind a health benefit plan on the basis of a misrepresentation or a preexisting condition without first notifying an affected individual in writing of the issuer's intent to rescind the health benefit plan and the individual's entitlement to an independent review.

(b) The notice required under Subsection (a) must include, as applicable:

(1) the principal reasons for the decision to rescind the health benefit plan;

(2) the clinical basis for a determination that a preexisting condition exists;

(3) a description of any general screening criteria used to evaluate issued health benefit plans and determine eligibility for a decision to rescind;

(4) a statement that the individual is entitled to appeal a rescission decision to an independent review organization;

(5) a statement that the individual has at least 45 days in which to appeal the rescission decision to an independent

review organization, and a description of the consequences of failure to appeal within that time limit;

(6) a statement that there is no cost to the individual to appeal the rescission decision to an independent review organization; and

(7) a description of the independent review process under Chapters 4201 and 4202.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) An affected individual may appeal a health benefit plan issuer's rescission decision to an independent review organization not later than the 45th day after the date the individual receives notice under Section 1202.104.

(b) A health benefit plan issuer shall comply with all requests for information made by the independent review organization and with the independent review organization's determination regarding the appropriateness of the issuer's decision to rescind.

(c) A health benefit plan issuer shall pay all otherwise valid medical claims under an individual's plan until the later of:

(1) the date on which an independent review organization determines that the decision to rescind is appropriate; or

(2) the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

Sec. 1202.106. RESCISSION AUTHORIZED; RECOVERY OF CLAIMS PAID. (a) A health benefit plan issuer may rescind a health benefit plan covering an affected individual on the later of:

(1) the date an independent review organization determines that rescission is appropriate; or

(2) the 45th day after the date an affected individual receives notice under Section 1202.104, if the individual has not initiated an appeal.

(b) An issuer that rescinds a health benefit plan under this section may seek to recover from an affected individual amounts paid for the individual's medical claims under the rescinded health benefit plan.

(c) An issuer that rescinds a health benefit plan under this section may not offset against or recoup or recover from a physician or health care provider amounts paid for medical claims under a rescinded health benefit plan. This subsection may not be waived, voided, or modified by contract.

Sec. 1202.107. RESCISSION RELATED TO PREEXISTING CONDITION; STANDARDS. (a) For purposes of this subchapter, a rescission for a preexisting condition is appropriate if, within the 18-month period immediately preceding the date on which an application for coverage under a health benefit plan is made, an affected individual received or was advised by a physician or health care provider to seek medical advice, diagnosis, care, or treatment for a physical or mental condition, regardless of the cause, and the individual's failure to disclose the condition:

(1) affects the risks assumed under the health benefit plan; and

(2) is undertaken with the intent to deceive the health benefit plan issuer.

(b) A health benefit plan issuer may not rescind a health benefit plan based on a preexisting condition of a newborn delivered after the application for coverage is made or as may otherwise be prohibited by law.

Sec. 1202.108. RESCISSION FOR MISREPRESENTATION; STANDARDS. For purposes of this subchapter, a rescission for a misrepresentation not related to a preexisting condition is inappropriate unless the misrepresentation:

(1) is of a material fact;

(2) affects the risks assumed under the health benefit plan; and

(3) is made with the intent to deceive the health benefit plan issuer.

Sec. 1202.109. REMEDIES NOT EXCLUSIVE. The remedies

provided by this subchapter are not exclusive and are in addition to any other remedy or procedure provided by law or at common law.

Sec. 1202.110. RULES. The commissioner shall adopt rules necessary to implement and administer this subchapter.

Sec. 1202.111. SANCTIONS AND PENALTIES. A health benefit plan issuer that violates this subchapter commits an unfair practice in violation of Chapter 541 and is subject to sanctions and penalties under Chapter 82.

Sec. 1202.112. CONFIDENTIALITY. (a) A record, report, or other information received or maintained by a health benefit plan issuer, including any material received or developed during a review of a rescission decision under this subchapter, is confidential.

(b) A health benefit plan issuer may not disclose the identity of an individual or a decision to rescind an individual's health benefit plan unless:

(1) an independent review organization determines the decision to rescind is appropriate; or

(2) the time to appeal has expired without an affected individual initiating an appeal.

SECTION 1.003. Section 4202.002, Insurance Code, is amended to read as follows:

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall adopt standards and rules for:

(1) the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201; and

(2) the suspension and revocation of the certification.

(b) The standards adopted under this section must ensure:

(1) the timely response of an independent review organization selected under this chapter;

(2) the confidentiality of medical records transmitted to an independent review organization for use in conducting an independent review;

(3) the qualifications and independence of each physician or other health care provider making a review determination for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making review determinations; [~~and~~]

(5) the timely notice to an enrollee of the results of an independent review, including the clinical basis for the review determination; and

(6) that review of a rescission decision based on a preexisting condition be conducted under the direction of a physician.

SECTION 1.004. Sections 4202.003, 4202.004, and 4202.006, Insurance Code, are amended to read as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of:

(A) the fifth day after the date the organization receives the information necessary to make the determination; or

(B) the eighth day after the date the organization receives the request that the determination be made; and

(2) for a condition other than a life-threatening condition or of the appropriateness of a rescission under Subchapter C, Chapter 1202, not later than the earlier of:

(A) the 15th day after the date the organization receives the information necessary to make the determination; or

(B) the 20th day after the date the organization receives the request that the determination be made.

Sec. 4202.004. CERTIFICATION. To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G);

(5) the percentage of the applicant's revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of the areas of expertise of the physicians or other health care providers making review determinations for the applicant; and

(7) the procedures to be used by the applicant in making independent review determinations under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201.

Sec. 4202.006. PAYORS FEES. (a) The commissioner shall charge payors fees in accordance with this chapter as necessary to fund the operations of independent review organizations.

(b) A health benefit plan issuer shall pay for an independent review of a rescission decision under Subchapter C, Chapter 1202.

SECTION 1.005. Section 4202.009, Insurance Code, is amended to read as follows:

Sec. 4202.009. CONFIDENTIAL INFORMATION. (a) Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential.

(b) A record, report, or other information received or maintained by an independent review organization, including any material received or developed during a review of a rescission decision under Subchapter C, Chapter 1202, is confidential.

(c) An independent review organization may not disclose the identity of an affected individual or an issuer's decision to rescind a health benefit plan under Subchapter C, Chapter 1202, unless:

(1) an independent review organization determines the decision to rescind is appropriate; or

(2) the time to appeal a rescission under that subchapter has expired without an affected individual initiating an appeal.

SECTION 1.006. Subsection (a), Section 4202.010, Insurance Code, is amended to read as follows:

(a) An independent review organization conducting an independent review under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201, is not liable for damages arising from the review determination made by the organization.

SECTION 1.007. The change in law made by this article applies only to an insurance policy that is delivered, issued for delivery, or renewed on or after the effective date of this Act. An insurance policy that is delivered, issued for delivery, or renewed

before the effective date of this Act is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 2. MEDICAL LOSS RATIOS

SECTION 2.001. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.010 to read as follows:

Sec. 1301.010. MEDICAL LOSS RATIO. (a) In this section, "medical loss ratio" means direct losses incurred and direct losses paid for all preferred provider benefit plans issued by an insurer, divided by direct premiums earned for all preferred provider benefit plans issued by that insurer. This amount may not include home office and overhead costs, advertising costs, network development costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(b) An insurer shall report the insurer's medical loss ratio annually or more often as required by the commissioner by rule or order.

(c) A medical loss ratio reported under this section is public information.

(d) The department shall include information on the medical loss ratio on the department's Internet website.

(e) An insurer shall report to the master policyholder or sponsor:

(1) the total dollar amount for health care claims paid under the preferred provider benefit plan for the nine months following the policy effective date or renewal date; and

(2) the total dollar amount of premiums paid by the master policyholder or the sponsor and insureds.

(f) The commissioner shall adopt rules as necessary to implement this section, including rules regarding:

(1) a specific, uniform definition of "medical loss ratio" for reporting and disclosure purposes;

(2) the frequency and form of reporting medical loss ratios;

(3) standardizing and regulating the frequency and form of reporting cost-containment expenses separate from the medical loss ratio; and

(4) any disclaimers or explanations that an insurer may include in the report required by Subsection (e).

SECTION 2.002. (a) Not later than January 1, 2010, the commissioner of insurance shall adopt all rules necessary to implement Section 1301.010, Insurance Code, as added by this article. The first reporting period under Subsection (b), Section 1301.010, Insurance Code, may not cover any period that begins before January 1, 2010.

(b) Subsection (e), Section 1301.010, Insurance Code, as added by this article, applies only to a preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after January 1, 2010. A policy delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 3. PREMIUM RATE INCREASES FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

SECTION 3.001. Subchapter D, Chapter 501, Insurance Code, is amended by amending Sections 501.151 and 501.153 and adding Section 501.160 to read as follows:

Sec. 501.151. POWERS AND DUTIES OF OFFICE. (a) The office:

(1) may assess the impact of insurance rates, rules, and forms on insurance consumers in this state; [~~and~~]

(2) shall advocate in the office's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers; and

(3) shall accept from a small employer, an eligible employee, or an eligible employee's dependent and, if appropriate, refer to the commissioner, a complaint described by Section 501.160.

(b) The decision to refer a complaint to the commissioner under Subsection (a) is at the public counsel's sole discretion.

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. The public counsel:

(1) may appear or intervene, as a party or otherwise, as a matter of right before the commissioner or department on behalf of insurance consumers, as a class, in matters involving:

(A) rates, rules, and forms affecting:

(i) property and casualty insurance;

(ii) title insurance;

(iii) credit life insurance;

(iv) credit accident and health insurance; or

(v) any other line of insurance for which the commissioner or department promulgates, sets, adopts, or approves rates, rules, or forms;

(B) rules affecting life, health, or accident insurance; or

(C) withdrawal of approval of policy forms:

(i) in proceedings initiated by the department under Sections 1701.055 and 1701.057; or

(ii) if the public counsel presents persuasive evidence to the department that the forms do not comply with this code, a rule adopted under this code, or any other law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising from an action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this chapter;

(3) may appear or intervene, as a party or otherwise, as a matter of right on behalf of insurance consumers as a class in any proceeding in which the public counsel determines that insurance consumers are in need of representation, except that the public counsel may not intervene in an enforcement or parens patriae proceeding brought by the attorney general; [~~and~~]

(4) may appear or intervene before the commissioner or department as a party or otherwise on behalf of small commercial insurance consumers, as a class, in a matter involving rates, rules, or forms affecting commercial insurance consumers, as a class, in any proceeding in which the public counsel determines that small commercial consumers are in need of representation; and

(5) may appear before the commissioner on behalf of a small employer, eligible employee, or eligible employee's dependent in a complaint the office refers to the commissioner under Section 501.160.

Sec. 501.160. COMPLAINT RESOLUTION FOR CERTAIN PREMIUM RATE INCREASES. (a) A small employer, an eligible employee, or an eligible employee's dependent may file a complaint with the office alleging that a rate is excessive for the risks to which the rate applies, if the percentage increase in the premium rate charged to a small employer under Subchapter E, Chapter 1501, for a new rating period exceeds 15 percent.

(b) The office shall refer a complaint received under Subsection (a) to the commissioner if the office determines that the complaint substantially attests to a rate charged that is excessive for the risks to which the rate applies.

(c) With respect to a complaint filed under Subsection (a), the office may issue a subpoena applicable throughout the state that requires the production of records.

(d) On application of the office in the case of disobedience of a subpoena, a district court may issue an order requiring any individual or person, including a small employer health benefit plan issuer described by Section 1501.002, that is subpoenaed to obey the subpoena and produce records, if the individual or person has refused to do so. An application under this subsection must be made in a district court in Travis County.

SECTION 3.002. Section 1501.205, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) On the request of a small employer, a small employer

health benefit plan issuer shall disclose the percentage change in the risk load assessed to a small employer group to the group, along with the percentage change attributable exclusively to any change in case characteristics.

SECTION 3.003. Subchapter E, Chapter 1501, Insurance Code, is amended by adding Section 1501.2131 and amending Section 1501.214 to read as follows:

Sec. 1501.2131. COMPLAINT FACILITATION FOR PREMIUM RATE ADJUSTMENTS. If the percentage increase in the premium rate charged to a small employer for a new rating period exceeds 15 percent, the small employer, an eligible employee, or an eligible employee's dependent may file a complaint with the office of public insurance counsel as provided by Section 501.160.

Sec. 1501.214. ENFORCEMENT. (a) Subject to Subsection (b), if [~~If~~] the commissioner determines that a small employer health benefit plan issuer subject to this chapter exceeds the applicable premium rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Chapter 82.

(b) The commissioner shall enter an order under this section if the commissioner makes the finding described by Section 1501.653.

SECTION 3.004. Chapter 1501, Insurance Code, is amended by adding Subchapter N to read as follows:

SUBCHAPTER N. RESOLUTION OF CERTAIN COMPLAINTS AGAINST SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUERS

Sec. 1501.651. DEFINITIONS. In this subchapter:

(1) "Honesty-in-premium account" means the account established under Section 1501.656.

(2) "Office" means the office of public insurance counsel.

Sec. 1501.652. COMPLAINT RESOLUTION PROCEDURE. (a) On the receipt of a referral of a complaint from the office of public insurance counsel under Section 501.160, the commissioner shall request written memoranda from the office and the small employer health benefit plan issuer that is the subject of the complaint.

(b) After receiving the initial memoranda described by Subsection (a), the commissioner may request one rebuttal memorandum from the office.

(c) The commissioner may by rule limit the number of exhibits submitted with or the time frame allowed for the submittal of the memoranda described by Subsection (a) or (b).

Sec. 1501.653. ORDER; FINDINGS. The commissioner shall issue an order under Section 1501.214(b) if the commissioner determines that the rate complained of is excessive for the risks to which the rate applies.

Sec. 1501.654. COSTS. The office may request, and the commissioner may award to the office, reasonable costs and fees associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

Sec. 1501.655. ASSESSMENT. (a) The commissioner may make an assessment against each small employer health benefit plan issuer in an amount that is sufficient to cover the costs of investigating and resolving a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) The commissioner shall deposit assessments collected under this section to the credit of the honesty-in-premium account.

Sec. 1501.656. HONESTY-IN-PREMIUM ACCOUNT. (a) The honesty-in-premium account is an account in the general revenue fund that may be appropriated only to cover the cost associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) Interest earned on the honesty-in-premium account shall be credited to the account. The account is exempt from the application of Section 403.095, Government Code.

Sec. 1501.657. RATE CHANGE NOT PROHIBITED. Nothing in this subchapter prohibits a small employer health benefit plan issuer from, at any time, offering a different rate to the group whose rate

is the subject of a complaint.

SECTION 3.005. The change in law made by Chapter 1501, Insurance Code, as amended by this article, applies only to a small employer health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2010. A small employer health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2010, is covered by the law in effect at the time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

ARTICLE 4. PHYSICIAN RANKING BY HEALTH BENEFIT PLAN ISSUERS

SECTION 4.001. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1460 to read as follows:

CHAPTER 1460. STANDARDS REQUIRED REGARDING CERTAIN PHYSICIAN RANKINGS BY HEALTH BENEFIT PLANS

Sec. 1460.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(2) "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

Sec. 1460.002. EXEMPTION. This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 533, Government Code;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicare supplement benefit plan, as defined by Chapter 1652.

Sec. 1460.003. PHYSICIAN RANKING REQUIREMENTS. (a) A health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless:

(1) the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005;

(2) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer; and

(3) each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that includes due process protections that conform to protections described by 42 U.S.C. Section 11112.

(b) This section does not apply to the publication of a list of network physicians and providers if ratings or comparisons are not made.

Sec. 1460.004. DUTIES OF PHYSICIANS. A physician may not require or request that a patient of the physician enter into an agreement under which the patient agrees not to:

(1) rank or otherwise evaluate the physician;

(2) participate in surveys regarding the physician; or

(3) in any way comment on the patient's opinion of the physician.

Sec. 1460.005. RULES; STANDARDS. (a) The commissioner shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement this chapter.

(b) The commissioner shall adopt rules as necessary to ensure that a health benefit plan issuer that uses a physician ranking system complies with the standards and guidelines described by Subsection (c).

(c) In adopting rules under this section, the commissioner shall consider the standards and guidelines prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care, including the National Quality Forum and the AQA Alliance. If neither the National Quality Forum nor the AQA Alliance has established standards or guidelines regarding an issue, the commissioner shall consider the standards and guidelines prescribed by the National Committee for Quality Assurance and other similar national organizations.

Sec. 1460.006. DUTIES OF HEALTH BENEFIT PLAN ISSUER. A health benefit plan issuer shall ensure that:

(1) physicians being measured are actively involved in the development of the standards used under this chapter; and

(2) the measures and methodology used in the comparison programs described by Section 1460.003 are transparent and valid.

Sec. 1460.007. SANCTIONS; DISCIPLINARY ACTIONS. (a) A health benefit plan issuer that violates this chapter or a rule adopted under this chapter is subject to sanctions and disciplinary actions under Chapters 82 and 84.

(b) A violation of this chapter by a physician constitutes grounds for disciplinary action by the Texas Medical Board, including imposition of an administrative penalty.

SECTION 4.002. (a) A health benefit plan issuer shall comply with Chapter 1460, Insurance Code, as added by this article, not later than December 31, 2009.

(b) A health benefit plan issuer is not subject to sanctions or disciplinary actions under Section 1460.007, Insurance Code, as added by this article, before January 1, 2010.

ARTICLE 5. EFFECTIVE DATE

SECTION 5.001. Except as otherwise provided by this Act, this Act takes effect immediately 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 immediate effect, this Act takes effect September 1, 2009.

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