BILL ANALYSIS

Senate Research Center

H.B. 1772
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State Affairs
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Health insurers offering health plan coverage in Texas desire additional options to offer lower cost health plans to employers and individual consumers. Currently, Texas law does not allow for an exclusive provider organization, or EPO, plan. An EPO plan is a health plan offered by a health insurance company with a closed network. An EPO plan is similar to a health maintenance organization plan where only services provided by network providers are covered, with the exception of emergency services and out of network services provided when no network provider is available. H.B. 1772 amends the Insurance Code chapter on preferred provider benefit plans by adding an option for insurers to offer an EPO plan.

H.B. 1772 amends current law relating to the regulation of certain benefit plans.

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 Section 1273.001(4), Insurance Code, to redefine "point-of-service plan."

SECTION 2. Amends Section 1301.001, Insurance Code, by amending Subdivision (1) and adding Subdivision (1-a), to define "exclusive provider benefit plan" and to make a nonsubstantive change.

SECTION 3. Amends Section 1301.003, Insurance Code, as follows:

> Sec. 1301.003. New heading: PREFERRED PROVIDER BENEFIT PLANS AND EXCLUSIVE PROVIDER BENEFIT PLANS PERMITTED. Provides that a preferred provider benefit plan or an exclusive provider benefit plan that meets the requirements of this chapter, rather than a health insurance policy that provides different benefits from the basic level of coverage for the use of preferred providers and that meets the requirements of this chapter, is not:
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> > (1) unjust under Chapter 1701 (Policy Forms);
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> > (2) unfair discrimination under Subchapter A (General Prohibitions Against Discrimination by an Insurer or Health Maintenance Organization), or B (Other General Prohibitions Against Discrimination by Insurers), Chapter 544 (Prohibited Discrimination); or
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> > (3) a violation of Subchapter B (Designation of Practitioners Under Accident and Health Insurance Policy) or C (Selection of Practitioners), Chapter 1451 (Access to Certain Practitioners and Facilities).

SECTION 4. Amends Section 1301.0041, Insurance Code, as follows:

Sec. 1301.0041. APPLICABILITY. (a) Creates this subsection from existing text. Provides that, except as otherwise specifically provided by this chapter, this chapter applies to each preferred provider benefit plan, rather than any preferred provider benefit plan, in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider, rather than for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured uses a preferred provider. Makes a nonsubstantive change.

(b) Provides that, unless otherwise specified, an exclusive provider benefit plan is subject to this chapter in the same manner as a preferred provider benefit plan.

(c) Provides that this chapter does not apply to:

(1) the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 533 (Implementation of Medicaid managed Care Program), Government, Code.

SECTION 5. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.0042, as follows:

Sec. 1301.0042. APPLICABILITY OF INSURANCE LAW. (a) Provides that, except as provided by Subsection (b), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner of insurance (commissioner) determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

(b) Prohibits an exclusive provider benefit plan from providing dental care benefits.

SECTION 6. Amends Section 1301.0045, Insurance Code, as follows:

Sec. 1301.0045. CONSTRUCTION OF CHAPTER. (a) Creates this subsection from existing text. Prohibits this chapter, except as provided by Section 1301.0046, from being construed to limit the level of reimbursement or the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions, that are applicable to preferred providers or, for plans other than exclusive provider benefit plans, nonpreferred providers.

(b) Prohibits this chapter, except as provided by Sections 1301.0052 and 1301.155 (Emergency Care), from being construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

SECTION 7. Amends Section 1301.0046, Insurance Code, as follows:

Sec. 1301.0046. COINSURANCE REQUIREMENTS FOR SERVICES OF NONPREFERRED PROVIDERS. Prohibits the insured's coinsurance applicable to payment to nonpreferred providers from exceeding 50 percent of the total covered amount applicable to the medical or health care services. Provides that this section does not apply to an exclusive provider benefit plan.

SECTION 8. Amends Sections 1301.005(a) and (b), Insurance Code, as follows:

(a) Requires an insurer offering a preferred provider benefit plan to ensure that both preferred provider benefits and basic level benefits are reasonably available to all

insureds within a designated service area. Provides that this subsection does not apply to an exclusive provider benefit plan.

(b) Requires an insurer, if services are not available through a preferred provider within a designated service area under a preferred provider benefit plan or an exclusive provider benefit plan, to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

SECTION 9. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.0051, 1301.0052, 1301.0053, and 1301.0056, as follows:

Sec. 1301.0051. EXCLUSIVE PROVIDER BENEFIT PLANS: QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT. (a) Requires an insurer that offers an exclusive provider benefit plan to establish procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice. Requires that the procedures include:

(1) mechanisms to ensure availability, accessibility, quality, and continuity of care;

(2) subject to Section 1301.059 (Quality Assessment), a continuing quality improvement program to monitor and evaluate services provided under the plan, including primary and specialist physician services and ancillary and preventive health care services, provided in institutional or noninstitutional settings;

(3) a method of recording formal proceedings of quality improvement program activities and maintaining quality improvement program documentation in a confidential manner;

(4) subject to Section 1301.059, a physician review panel to assist the insurer in reviewing medical guidelines or criteria;

(5) a patient record system that facilitates documentation and retrieval of clinical information for the insurer's evaluation of continuity and coordination of services and assessment of the quality of services provided to insureds under the plan;

(6) a mechanism for making available to the commissioner the clinical records of insureds for examination and review by the commissioner on request of the commissioner; and

(7) a specific procedure for the periodic reporting of quality improvement program activities to:

(A) the governing body and appropriate staff of the insurer; and

(B) physicians and health care providers that provide health care services under the plan.

(b) Requires that minutes of a formal proceeding of the quality improvement program established under Subsection (a) be made available to the commissioner on request of the commissioner.

(c) Provides that insured records made available to the commissioner under Subsection (a)(6) are confidential and privileged, and are not subject to Chapter 552 (Public Information), Government Code, or to subpoena, except to the extent necessary for the commissioner to enforce this chapter.

Sec. 1301.0052. EXCLUSIVE PROVIDER BENEFIT PLANS: REFERRALS FOR MEDICALLY NECESSARY SERVICES. (a) Requires the issuer of an exclusive provider benefit plan, if a covered service is medically necessary and is not available through a preferred provider, on the request of a preferred provider, to:

(1) approve the referral of an insured to a nonpreferred provider within a reasonable period; and

(2) fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider.

(b) Requires that an exclusive provider benefit plan provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under Subsection (a) before the issuer of the plan may deny the referral.

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. Requires the issuer of an exclusive provider benefit plan to reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services if a nonpreferred provider provides emergency care as defined by Section 1301.155 to an enrollee in the plan.

Sec. 1301.0056. EXAMINATIONS AND FEES. (a) Authorizes the commissioner to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer under this chapter. Provides that an insurer is subject to a qualifying examination of the insurer's exclusive provider benefit plans and subsequent quality of care examinations by the commissioner at least once every five years. Provides that documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) Requires an insurer examined under this section to pay the cost of the examination in an amount determined by the commissioner.

(c) Requires the Texas Department of Insurance (TDI) to collect an assessment in an amount determined by the commissioner from the insurer at the time of the examination to cover all expenses attributable directly to the examination, including the salaries and expenses of TDI employees and all reasonable expenses of TDI necessary for the administration of this chapter.

(d) Requires TDI to deposit an assessment collected under this section to the credit of the Texas Department of Insurance operating account. Requires that money deposited under this subsection be used to pay the salaries and expenses of examiners and all other expenses relating to the examination of insurers under this section.

SECTION 10. Amends Subchapter D, Chapter 1301, Insurance Code, by adding Section 1301.1581, as follows:

Sec. 1301.1581. INFORMATION CONCERNING EXCLUSIVE PROVIDER BENEFIT PLANS. (a) Defines, in this section, "prospective insured."

(b) Requires an insurer that offers an exclusive provider benefit plan to provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider, in addition to the information required to be provided under Section 1301.158 (Information Concerning Preferred Provider Benefit Plans).

(c) Requires that an identification card or similar document issued by an insurer to an insured in an exclusive provider benefit plan display:

(1) the first date on which the insured became insured under the plan;

(2) a toll-free number that a physician or health care provider may use to obtain the date on which the insured became insured under the plan; and

(3) the acronym "EPO" or the phrase "Exclusive Provider Organization" on the card in a location of the insurer's choice.

SECTION 11. Provides that the change in law made by this Act applies only to an exclusive provider benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. Provides that an exclusive provider benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 12. Effective date: September 1, 2011.