BILL ANALYSIS

C.S.H.B. 1772
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Health insurers offering health plan coverage in Texas desire additional options to offer lower cost health plans to employers and individual consumers in Texas. Currently, Texas law does not allow for a 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 an HMO 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. C.S.H.B. 1772 amends the insurance code chapter on preferred provider benefit plans ("PPO" plans) by adding an option for insurers to offer an exclusive provider benefit plan.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1772 amends the Insurance Code to require an insurer that offers an exclusive provider benefit plan, defined by the bill as a benefit plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services, provided by a physician or health care provider who is not a preferred provider, 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. The bill requires that such procedures include:

- mechanisms to ensure availability, accessibility, quality, and continuity of care;

- subject to quality assessment requirements, 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;

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

- subject to quality assessment requirements, a physician review panel to assist the insurer in reviewing medical guidelines or criteria;

- 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;

- a mechanism for making available to the commissioner of insurance the clinical records of insureds for examination and review by the commissioner on request of the commissioner; and

- a specific procedure for the periodic reporting of quality improvement program activities to the governing body and appropriate staff of the insurer and physicians and health care providers that provide health care services under the plan.

The bill requires that minutes of a formal proceeding of the quality improvement program be made available to the commissioner on the commissioner's request. The bill establishes that clinical records of insureds made available to the commissioner are confidential and privileged and are not subject to state public information law or to subpoena, except to the extent necessary for the commissioner to enforce provisions of law relating to preferred provider benefit plans.

C.S.H.B. 1772 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, in addition to the required information concerning preferred provider benefit plans, notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider.

C.S.H.B. 1772 specifies that a preferred provider benefit plan or an exclusive provider benefit plan, rather than a health insurance policy that provides different benefits from the basic level of coverage for the use of preferred providers, that meets applicable state law requirements is not unjust under provisions of law regarding certain policy forms, unfair discrimination by an insurer or health maintenance organization, or a violation of provisions of law relating to the selection or designation of a practitioner under certain policies. The bill makes provisions of law relating to preferred provider benefit plans applicable to each 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 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. The bill makes an exclusive provider benefit plan subject to provisions of law relating to preferred provider benefit plans in the same manner as a preferred provider benefit plan. The bill exempts from those provisions the child health plan program for certain low-income children or a Medicaid managed care program and prohibits provisions of law relating to preferred provider benefit plans from being construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured. The bill makes a provision of the Insurance Code or another state insurance law that applies to a preferred provider benefit plan applicable to an exclusive provider benefit plan to the extent that the commissioner of insurance determines the provision of law to be consistent with the function and purpose of an exclusive provider benefit plan.

C.S.H.B. 1772 exempts an exclusive provider benefit plan from coinsurance requirements for services of nonpreferred providers and from provisions of law requiring an insurer offering a preferred provider benefit plan to ensure both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. The bill defines "exclusive provider benefit plan." The bill redefines "point-of-service plan," for purposes of provisions of law relating to blended contracts offered by a health maintenance organization and an insurer, to include in the term an exclusive provider benefit plan. The bill provides for the meaning of "prospective insured" by reference. The bill makes its provisions applicable only to an exclusive provider benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. The bill makes conforming and nonsubstantive changes.

EFFECTIVE DATE

September 1, 2011.

COMPARISON OF ORIGINAL TO SUBSTITUTE

C.S.H.B. 1772 differs from the original by making provisions of law relating to preferred provider benefit plans apply to each preferred provider benefit plan in which an insurer provides for the payment of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider, whereas the original makes those provisions of law apply to each preferred provider benefit plan in which an insurer provides 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. The substitute contains a provision not included in the original exempting from provisions of law relating to preferred provider benefit plans the child health plan program for certain low-income children or a Medicaid managed care program. The substitute differs from the original by exempting an exclusive provider plan from the requirement that an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area, whereas the original exempts an exclusive provider plan from provisions of law governing the availability of preferred providers and including that same requirement.

C.S.H.B. 1772 contains provisions not included in the original requiring 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 and setting out the elements required to be included in such procedures. The substitute contains provisions not included in the original making insured clinical records made available to the commissioner of insurance under such procedures confidential, privileged, and not subject state open records law or subpoena, with certain exceptions, and requiring minutes of a formal proceeding of the quality improvement program to be made available to the commissioner on the commissioner's request. The substitute contains provisions not included in the original requiring 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 and providing for the meaning of "prospective insured."

C.S.H.B. 1772 differs from the original in nonsubstantive ways.