AN ACT

relating to the regulation of certain benefit plans.

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

SECTION 1. Section 1273.001(4), Insurance Code, is amended to read as follows:

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee chooses to obtain benefits or services through:

(i) a health maintenance organization delivery network, including a limited provider network; or

(ii) a non-network delivery system outside the health maintenance organization delivery network, including an exclusive provider benefit plan under Chapter 1301 or a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of health care services are provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization.

SECTION 2. Section 1301.001, Insurance Code, is amended by amending Subdivision (1) and adding Subdivision (1-a) to read as follows:

(1) "Exclusive provider benefit plan" means a benefit

plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under Section 1301.155, provided by a physician or health care provider who is not a preferred provider.

(1-a) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term does not include a physician.

SECTION 3. Section 1301.003, Insurance Code, is amended to read as follows:

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS AND EXCLUSIVE PROVIDER BENEFIT PLANS PERMITTED. A preferred provider benefit plan or an exclusive provider benefit plan [~~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:

(1) unjust under Chapter 1701;

(2) unfair discrimination under Subchapter A or B, Chapter 544; or

(3) a violation of Subchapter B or C, Chapter 1451.

SECTION 4. Section 1301.0041, Insurance Code, is amended to read as follows:

Sec. 1301.0041. APPLICABILITY. (a) Except as otherwise specifically provided by this chapter, this [~~This~~] chapter applies to each [~~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 [~~from the basic level of coverage provided by the health insurance policy if the~~] insured uses a preferred provider or a nonpreferred provider.

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

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 533, Government Code.

SECTION 5. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.0042 to read follows:

Sec. 1301.0042. APPLICABILITY OF INSURANCE LAW. (a) 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 determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

(b) An exclusive provider benefit plan may not provide dental care benefits.

SECTION 6. Section 1301.0045, Insurance Code, is amended to read as follows:

Sec. 1301.0045. CONSTRUCTION OF CHAPTER. (a) Except as provided by Section 1301.0046, this chapter may not be 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) Except as provided by Sections 1301.0052 and 1301.155, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

SECTION 7. Section 1301.0046, Insurance Code, is amended to read as follows:

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

SECTION 8. Sections 1301.005(a) and (b), Insurance Code, are amended to read as follows:

(a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. This subsection does not apply to an exclusive provider benefit plan.

(b) If services are not available through a preferred provider within a designated [~~the~~] service area under a preferred provider benefit plan or an exclusive provider benefit plan, an

insurer shall 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. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Sections 1301.0051, 1301.0052, 1301.0053, and 1301.0056 to read as follows:

Sec. 1301.0051. EXCLUSIVE PROVIDER BENEFIT PLANS: QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT. (a) An insurer that offers an exclusive provider benefit plan shall 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 procedures must include:

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

(2) subject to Section 1301.059, 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) Minutes of a formal proceeding of the quality improvement program established under Subsection (a) shall be made available to the commissioner on request of the commissioner.

(c) Insured records made available to the commissioner under Subsection (a)(6) are confidential and privileged, and are not subject to Chapter 552, 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) If a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider, shall:

(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) An exclusive provider benefit plan must 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. If a nonpreferred provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall 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.

Sec. 1301.0056. EXAMINATIONS AND FEES. (a) The commissioner may 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. 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. 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) An insurer examined under this section shall pay the cost of the examination in an amount determined by the commissioner.

(c) The department shall 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 department employees and all reasonable expenses of the department necessary for the administration of this chapter.

(d) The department shall deposit an assessment collected under this section to the credit of the Texas Department of Insurance operating account. Money deposited under this subsection shall 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. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.1581 to read as follows:

Sec. 1301.1581. INFORMATION CONCERNING EXCLUSIVE PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" has the meaning assigned by Section 1301.158.

(b) In addition to the information required to be provided under Section 1301.158, an insurer that offers an exclusive provider benefit plan shall 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.

(c) An identification card or similar document issued by an insurer to an insured in an exclusive provider benefit plan must 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. 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. 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. This Act takes effect September 1, 2011.

President of the Senate

Speaker of the House

I certify that H.B. No. 1772 was passed by the House on May 5, 2011, by the following vote: Yeas 146, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 1772 was passed by the Senate on May 19, 2011, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor