By: Taylor of Galveston (Senate Sponsor - Duncan) H.B. No. 1772

(In the Senate - Received from the House May 6, 2011; May 9, 2011, read first time and referred to Committee on State Affairs; May 13, 2011, reported favorably by the following vote: Yeas 9, Nays 0; May 13, 2011, sent to printer.)

A BILL TO BE ENTITLED
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.

2-1 (c) This chapter does not apply to:
2-2 (1) the child health plan program under Chapter 62,
2-3 Health and Safety Code; or
2-4 (2) a Medicaid managed care program under Chapter 533,
2-5 Government Code.
2-6 SECTION 5. Subchapter A, Chapter 1301, Insurance Code, is
2-7 amended by adding Section 1301.0042 to read follows:
2-8 Sec. 1301.0042. APPLICABILITY OF INSURANCE LAW. (a)
2-9 Except as provided by Subsection (b), a provision of this code or
2-10 another insurance law of this state that applies to a preferred
2-11 provider benefit plan applies to an exclusive provider benefit plan
2-12 except to the extent that the commissioner determines the provision
2-13 to be inconsistent with the function and purpose of an exclusive
2-14 provider benefit plan.
2-15 (b) An exclusive provider benefit plan may not provide
2-16 dental care benefits.
2-17 SECTION 6. Section 1301.0045, Insurance Code, is amended to
2-18 read as follows:
2-19 Sec. 1301.0045. CONSTRUCTION OF CHAPTER. (a) Except as
2-20 provided by Section 1301.0046, this chapter may not be construed to
2-21 limit the level of reimbursement or the level of coverage,
2-22 including deductibles, copayments, coinsurance, or other
2-23 cost-sharing provisions, that are applicable to preferred
2-24 providers or, for plans other than exclusive provider benefit
2-25 plans, nonpreferred providers.
2-26 (b) Except as provided by Sections 1301.0052 and 1301.155,
2-27 this chapter may not be construed to require an exclusive provider
2-28 benefit plan to compensate a nonpreferred provider for services
2-29 provided to an insured.
2-30 SECTION 7. Section 1301.0046, Insurance Code, is amended to
2-31 read as follows:
2-32 Sec. 1301.0046. COINSURANCE REQUIREMENTS FOR SERVICES OF
2-33 NONPREFERRED PROVIDERS. The insured's coinsurance applicable to
2-34 payment to nonpreferred providers may not exceed 50 percent of the
2-35 total covered amount applicable to the medical or health care
2-36 services. This section does not apply to an exclusive provider
2-37 benefit plan.
2-38 SECTION 8. Sections 1301.005(a) and (b), Insurance Code,
2-39 are amended to read as follows:
2-40 (a) An insurer offering a preferred provider benefit plan
2-41 shall ensure that both preferred provider benefits and basic level
2-42 benefits are reasonably available to all insureds within a
2-43 designated service area. This subsection does not apply to an
2-44 exclusive provider benefit plan.
2-45 (b) If services are not available through a preferred
2-46 provider within a designated [the] service area under a preferred
2-47 provider benefit plan or an exclusive provider benefit plan, an
2-48 insurer shall reimburse a physician or health care provider who is
2-49 not a preferred provider at the same percentage level of
2-50 reimbursement as a preferred provider would have been reimbursed
2-51 had the insured been treated by a preferred provider.
2-52 SECTION 9. Subchapter A, Chapter 1301, Insurance Code, is
2-53 amended by adding Sections 1301.0051, 1301.0052, 1301.0053, and
2-54 1301.0056 to read as follows:
2-55 Sec. 1301.0051. EXCLUSIVE PROVIDER BENEFIT PLANS: QUALITY
2-56 IMPROVEMENT AND UTILIZATION MANAGEMENT. (a) An insurer that offers
2-57 an exclusive provider benefit plan shall establish procedures to
2-58 ensure that health care services are provided to insureds under
2-59 reasonable standards of quality of care that are consistent with
2-60 prevailing professionally recognized standards of care or
2-61 practice. The procedures must include:
2-62 (1) mechanisms to ensure availability, accessibility,
2-63 quality, and continuity of care;
2-64 (2) subject to Section 1301.059, a continuing quality
2-65 improvement program to monitor and evaluate services provided under
2-66 the plan, including primary and specialist physician services and
2-67 ancillary and preventive health care services, provided in
2-68 institutional or noninstitutional settings;
2-69 (3) a method of recording formal proceedings of

3-1 quality improvement program activities and maintaining quality
3-2 improvement program documentation in a confidential manner;
3-3 (4) subject to Section 1301.059, a physician review
3-4 panel to assist the insurer in reviewing medical guidelines or
3-5 criteria;
3-6 (5) a patient record system that facilitates
3-7 documentation and retrieval of clinical information for the
3-8 insurer's evaluation of continuity and coordination of services and
3-9 assessment of the quality of services provided to insureds under
3-10 the plan;
3-11 (6) a mechanism for making available to the
3-12 commissioner the clinical records of insureds for examination and
3-13 review by the commissioner on request of the commissioner; and
3-14 (7) a specific procedure for the periodic reporting of
3-15 quality improvement program activities to:
3-16 (A) the governing body and appropriate staff of
3-17 the insurer; and
3-18 (B) physicians and health care providers that
3-19 provide health care services under the plan.
3-20 (b) Minutes of a formal proceeding of the quality
3-21 improvement program established under Subsection (a) shall be made
3-22 available to the commissioner on request of the commissioner.
3-23 (c) Insured records made available to the commissioner
3-24 under Subsection (a)(6) are confidential and privileged, and are
3-25 not subject to Chapter 552, Government Code, or to subpoena, except
3-26 to the extent necessary for the commissioner to enforce this
3-27 chapter.
3-28 Sec. 1301.0052. EXCLUSIVE PROVIDER BENEFIT PLANS:
3-29 REFERRALS FOR MEDICALLY NECESSARY SERVICES. (a) If a covered
3-30 service is medically necessary and is not available through a
3-31 preferred provider, the issuer of an exclusive provider benefit
3-32 plan, on the request of a preferred provider, shall:
3-33 (1) approve the referral of an insured to a
3-34 nonpreferred provider within a reasonable period; and
3-35 (2) fully reimburse the nonpreferred provider at the
3-36 usual and customary rate or at a rate agreed to by the issuer and the
3-37 nonpreferred provider.
3-38 (b) An exclusive provider benefit plan must provide for a
3-39 review by a health care provider with expertise in the same
3-40 specialty as or a specialty similar to the type of health care
3-41 provider to whom a referral is requested under Subsection (a)
3-42 before the issuer of the plan may deny the referral.
3-43 Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS:
3-44 EMERGENCY CARE. If a nonpreferred provider provides emergency care
3-45 as defined by Section 1301.155 to an enrollee in an exclusive
3-46 provider benefit plan, the issuer of the plan shall reimburse the
3-47 nonpreferred provider at the usual and customary rate or at a rate
3-48 agreed to by the issuer and the nonpreferred provider for the
3-49 provision of the services.
3-50 Sec. 1301.0056. EXAMINATIONS AND FEES. (a) The
3-51 commissioner may examine an insurer to determine the quality and
3-52 adequacy of a network used by an exclusive provider benefit plan
3-53 offered by the insurer under this chapter. An insurer is subject to
3-54 a qualifying examination of the insurer's exclusive provider
3-55 benefit plans and subsequent quality of care examinations by the
3-56 commissioner at least once every five years. Documentation
3-57 provided to the commissioner during an examination conducted under
3-58 this section is confidential and is not subject to disclosure as
3-59 public information under Chapter 552, Government Code.
3-60 (b) An insurer examined under this section shall pay the
3-61 cost of the examination in an amount determined by the
3-62 commissioner.
3-63 (c) The department shall collect an assessment in an amount
3-64 determined by the commissioner from the insurer at the time of the
3-65 examination to cover all expenses attributable directly to the
3-66 examination, including the salaries and expenses of department
3-67 employees and all reasonable expenses of the department necessary
3-68 for the administration of this chapter.
3-69 (d) The department shall deposit an assessment collected

4-1 under this section to the credit of the Texas Department of
4-2 Insurance operating account. Money deposited under this subsection
4-3 shall be used to pay the salaries and expenses of examiners and all
4-4 other expenses relating to the examination of insurers under this
4-5 section.
4-6 SECTION 10. Subchapter D, Chapter 1301, Insurance Code, is
4-7 amended by adding Section 1301.1581 to read as follows:
4-8 Sec. 1301.1581. INFORMATION CONCERNING EXCLUSIVE PROVIDER
4-9 BENEFIT PLANS. (a) In this section, "prospective insured" has the
4-10 meaning assigned by Section 1301.158.
4-11 (b) In addition to the information required to be provided
4-12 under Section 1301.158, an insurer that offers an exclusive
4-13 provider benefit plan shall provide to a current or prospective
4-14 group contract holder or current or prospective insured notice that
4-15 the benefit plan includes limited coverage for services provided by
4-16 a physician or health care provider that is not a preferred
4-17 provider.
4-18 (c) An identification card or similar document issued by an
4-19 insurer to an insured in an exclusive provider benefit plan must
4-20 display:
4-21 (1) the first date on which the insured became insured
4-22 under the plan;
4-23 (2) a toll-free number that a physician or health care
4-24 provider may use to obtain the date on which the insured became
4-25 insured under the plan; and
4-26 (3) the acronym "EPO" or the phrase "Exclusive
4-27 Provider Organization" on the card in a location of the insurer's
4-28 choice.
4-29 SECTION 11. The change in law made by this Act applies only
4-30 to an exclusive provider benefit plan that is delivered, issued for
4-31 delivery, or renewed on or after January 1, 2012. An exclusive
4-32 provider benefit plan that is delivered, issued for delivery, or
4-33 renewed before January 1, 2012, is governed by the law as it existed
4-34 immediately before the effective date of this Act, and that law is
4-35 continued in effect for that purpose.
4-36 SECTION 12. This Act takes effect September 1, 2011.

4-37 * * * * *