86R13731 PMO-D

By:  Sheffield H.B. No. 4391

A BILL TO BE ENTITLED

AN ACT

relating to certain group and individual health benefit plans and the provision of health care benefits under health care plans through provider networks.

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

SECTION 1.  Subtitle C, Title 6, Insurance Code, is amended by adding Chapter 849 to read as follows:

CHAPTER 849. PROHIBITION OF PROVIDER NETWORKS

Sec. 849.0001.  PURPOSE; CERTAIN PRACTICES PROHIBITED. The purpose of this chapter is to prohibit the provision of health care benefits by entities such as insurers and health maintenance organizations through provider networks, preferred providers, or similar arrangements.

Sec. 849.0002.  DEFINITION. In this chapter, "health benefit plan issuer" means:

(1)  a health maintenance organization operating under Chapter 843 or other person who arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan; and

(2)  a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, 1301, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

Sec. 849.0003.  PROHIBITION OF NETWORKS. (a) A health benefit plan issuer may not:

(1)  arrange for or provide to covered persons health care services using a delivery network that directly or indirectly contracts or subcontracts with physicians and other health care providers;

(2)  provide, through a policy or plan, for the payment of a level of coverage that is different from the basic level of coverage provided by the policy or plan if the covered person uses a physician or health care provider, or an organization of physicians or health care providers, who contracts to provide medical or health care services to persons covered by the policy or plan; or

(3)  otherwise provide health care benefits or arrange for health care benefits to be provided to a covered person by contracting directly or indirectly with a physician or health care provider, or an organization of physicians or health care providers, to provide medical or health care services to a covered person on a capitation basis or otherwise.

(b)  This section applies without regard to whether the physician or health care provider who is a party to a contract described by Subsection (a) is designated as a network provider or a preferred provider or uses another designation.

(c)  Notwithstanding any other law, a health benefit plan issuer may provide health care benefits only by indemnifying the covered person for medical or health care expenses.

Sec. 849.0004.  EXCEPTION. Notwithstanding Section 849.0003, health care benefits under the following programs may be provided through health maintenance organizations, provider networks, preferred providers, or similar arrangements:

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

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

(3)  the Medicaid managed care program operated under Chapter 533, Government Code;

(4)  the group benefits program under Chapter 1551;

(5)  the group program under Chapter 1575;

(6)  the uniform group coverage program under Chapter 1579; and

(7)  the uniform program under Chapter 1601.

SECTION 2.  Subtitle B, Title 8, Insurance Code, is amended by adding Chapter 1255 to read as follows:

CHAPTER 1255. RESTRICTION OF AVAILABILITY OF GROUP HEALTH COVERAGE IN CERTAIN CIRCUMSTANCES

Sec. 1255.0001.  APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar coverage document that is issued by:

(1)  an insurance company;

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

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

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

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

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

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

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

(9)  an exchange operating under Chapter 942.

(b)  Notwithstanding any other law, this chapter applies to a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter.

Sec. 1255.0002.  RESTRICTION ON AVAILABILITY OF GROUP HEALTH COVERAGE. (a) Notwithstanding Chapter 1251 or any other law, a group health benefit policy that provides health benefits to an employer group may not require that each employee eligible to receive group health benefit coverage as a member of the employer group be covered by the policy.

(b)  An employee who is eligible to receive group health benefit coverage as a member of an employer group may elect to instead obtain health benefit coverage in the individual market or from another source.

SECTION 3.  The commissioner of insurance shall adopt rules not later than January 1, 2020, to implement Chapters 849 and 1255, Insurance Code, as added by this Act.

SECTION 4.  The changes in law made by this Act apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2021. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2021, 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 5.  This Act takes effect September 1, 2019.