BILL ANALYSIS

S.B. 1140
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Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

The office of public insurance counsel (OPIC) is an independent state agency tasked with representing the interests of Texas consumers in insurance matters. OPIC reviews and analyzes insurance rates, rules, and policy forms; intervenes in legal and other matters, as appropriate; and provides consumer education on insurance issues. Regarding health insurance, OPIC also prepares certain statutorily required annual report cards on health maintenance organizations (HMOs). The Texas Department of Insurance (TDI) is tasked with assessing network adequacy compliance and approving access plans and waivers when certain managed care plans are unable to meet the network adequacy requirements.

Consumers and stakeholders have raised concerns that inadequate networks may negatively affect patient access to or choice of in-network physicians and providers. Although OPIC is directed under law to represent the interests of consumers, the office does not have powers related to monitoring the adequacy of managed care networks. Additionally, current law expressly provides for OPIC's duties relating to HMOs, including their requirement to develop and issue annual report cards on them. Exclusive provider benefit plans (EPBPs) and preferred provider benefit plans (PPBPs) are not currently included in these annual report card laws. S.B. 1140 seeks to address these issues by requiring OPIC to monitor the adequacy of networks offered by an HMO plan, an EPBP, or a PPBP by reviewing related filings, applications, and requests for accuracy, accessibility of health care services, and reasonable access to covered benefits. S.B. 1140 also seeks to address these issues by requiring OPIC to develop annual consumer report cards that identify and compare, on an objective basis, these three types of managed care plans.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

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

S.B. 1140 amends the Insurance Code to require the office of public insurance counsel (OPIC) to monitor the adequacy of networks offered by managed care plans in Texas by reviewing related filings, applications, and requests, including those related to access plans or waivers of network adequacy requirements, for accuracy, accessibility of health care services, and reasonable access to covered benefits. The bill defines "managed care plan" as a health maintenance organization (HMO) plan provided under the Texas Health Maintenance

Organization Act or a preferred provider benefit plan or an exclusive provider benefit plan defined under statutory provisions governing preferred provider benefit plans.

S.B. 1140 authorizes OPIC to advocate for consumers, in OPIC's own name, positions to strengthen the overall adequacy or oversight of networks offered by managed care plans in Texas and positions to strengthen the adequacy or oversight of a particular network offered by a managed care plan in Texas. The bill authorizes the public counsel to do the following:

- appear or intervene, as a party or otherwise, as a matter of right before the commissioner of insurance or Texas Department of Insurance (TDI) on behalf of insurance consumers, as a class, in matters involving a managed care plan's ability to provide accessible health care services and reasonable access to covered benefits; and
- file objections and request a hearing regarding any application, filing, or request that a managed care plan files with TDI related to an access plan or waiver of a network adequacy requirement, including an application, filing, or request that is currently pending or that has already been approved.

S.B. 1140 entitles OPIC, for purposes of assisting OPIC in determining whether to request a hearing with respect to any such application, filing, or request that managed care plan files with TDI, to review all relevant filings and information that a managed care plan submits to TDI, including communications related to the filing and to communicate with a managed care plan regarding the submission. The bill establishes that a matter for which OPIC files objections and requests a hearing is a contested case that may be subject to informal disposition or heard by the State Office of Administrative Hearings under the Administrative Procedure Act. The bill establishes that nothing, with respect to statutory provisions relating to OPIC, may be construed as authorizing a managed care plan to request a waiver of network adequacy requirements or to use an access plan unless otherwise authorized by law or regulation. The bill entitles the public counsel to all filings, including any attachments and supporting documentation, made by a managed care plan relating to the adequacy of a network offered by the plan, and any regulatory correspondence relating to the filings. The bill clarifies that the prohibition against the public counsel intervening or appearing in a proceeding or hearing that relates to approval or consideration of an individual charter, license, certificate of authority, acquisition, merger, or examination or a proceeding concerning the solvency of an individual insurer, a financial issue, a policy form, advertising, or another regulatory issue affecting an individual insurer or agent applies except as otherwise provided by the Insurance Code.

S.B. 1140 authorizes OPIC to submit written comments to the commissioner of insurance and otherwise participate regarding individual insurer filings relating to the adequacy of a network offered by a managed care plan, regardless of whether the filing is pending or has already been approved. The bill authorizes OPIC to comment on or otherwise participate regarding the effect or implementation of such a filing, including comments regarding concerns that a managed care plan is operating with an inadequate network in Texas, may be in violation of a network adequacy law or regulation, or has an inaccurate provider network directory. The bill requires TDI, for written comments filed with TDI regarding such filings, to respond to the comments promptly and provide updates to OPIC and the managed care plan regarding actions taken by TDI or other actions taken to address issues raised in the comments and to consider conducting a targeted market conduct examination under the Insurance Market Conduct Surveillance Act or another form of investigation to determine the existence and extent of potential violations.

S.B. 1140 replaces the requirement for OPIC to develop and implement a system to compare and evaluate, on an objective basis, the quality of care provided by, and the performance of, HMOs with a requirement for OPIC to develop and implement instead a system to compare and evaluate, on an objective basis, the quality of care provided by, the adequacy of networks offered by, and the performance of, managed care plans. The bill requires OPIC, in conducting comparisons under the system, to compare HMOs to other HMOs, preferred provider benefit plans to other preferred provider benefit plans, and exclusive provider benefit plans to other exclusive provider benefit plans. The bill replaces the requirement for OPIC to develop and

issue annual consumer report cards that identify and compare, on an objective basis, HMOs in Texas with a requirement for OPIC to develop and issue such report cards that identify and compare, on an objective basis, managed care plans. The bill requires the consumer report cards to include comparisons of types of managed care plans in the same manner as OPIC conducts comparisons under the system and, at the discretion of OPIC, to be staggered for release throughout the year based on the type of managed care plan that is the subject of the consumer report card. All consumer report cards for a particular type of managed care plan must be released at the same time. The bill replaces the prohibitions against OPIC endorsing or recommending a specific HMO or plan, or subjectively rating or ranking HMOs or plans, other than through comparison and evaluation of objective criteria with a prohibition against OPIC endorsing or recommending a specific managed care plan, or subjectively rating or ranking managed care plans or managed care plan issuers, other than through comparison and evaluation of objective criteria. The bill establishes legislative intent to provide OPIC with the flexibility to establish a timeline for the implementation, development, and initial issuance of annual consumer report cards that identify and compare managed care plans in a manner that best uses current OPIC resources.

S.B. 1140 amends the Health and Safety Code to expand the definition of a "health benefit plan" for purposes of statutory provisions relating to health care data collection to include a preferred provider or exclusive provider benefit plan issuer.

EFFECTIVE DATE

September 1, 2023.