BILL ANALYSIS

Senate Research Center
88R2046 MEW-F

S.B. 1140
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Health & Human Services
3/27/2023
As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Office of Public Insurance Council (OPIC) is an independent state agency tasked with representing the interests of Texas consumers in insurance matters. The office 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 two statutorily-required "report cards" on health maintenance organizations: the Guide to HMO Quality and Comparing Texas HMOs.

The Texas Department of Insurance (TDI) is tasked with assessing network adequacy compliance and approving access plans and waivers when a managed care plan is unable to meet the network adequacy requirements. As of March 2018, 67 percent of HMO, PPO, and EPO networks had access plans. Consumers and stakeholders have raised concerns that inadequate networks increase the risk of "surprise bills," which can occur when a patient is unknowingly treated by an out-of-network provider at an in-network facility. Although OPIC is directed in statute to represent the interests of consumers, the office does not have powers related to monitoring the adequacy of managed care networks.

Additionally, statute expressly sets forth OPIC's duties relating to HMOs, including their requirement to develop and issue annual report cards on them. Exclusive provider organizations (EPOs) were not an authorized product in Texas until 2011, so they, along with preferred provider organizations (PPOs), are not included in the statutory language, as it was last modified in 2003. For this reason, OPIC does not currently produce report cards for PPOs and EPOs.

As proposed, S.B. 1140 amends current law relating to the adequacy and effectiveness of managed care plan networks.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 108.002(9), Health and Safety Code, to redefine "health benefit plan."

SECTION 2. Amends Section 501.001, Insurance Code, as follows:

> Sec. 501.001. New heading: DEFINITIONS. Defines "managed care plan" and makes a nonsubstantive change.

SECTION 3. Amends Section 501.151, Insurance Code, as follows:

> Sec. 501.151. POWERS AND DUTIES OF OFFICE. Provides that the office of public insurance counsel (office):
>
> (1)-(2) makes nonsubstantive changes;

(3) is required to monitor the adequacy of networks offered by managed care plans in this state by reviewing related filings, applications, and requests, including filings, applications, and requests related to access plans or waivers of network adequacy requirements, for accuracy, accessibility of health care services, and reasonable access to covered benefits; and

(4) is authorized to advocate for consumers in the office's own name:

(A) positions to strengthen the overall adequacy or oversight of networks offered by managed care plans in this state; and

(B) positions to strengthen the adequacy or oversight of a particular network offered by a managed care plan in this state.

SECTION 4. Amends Section 501.153, Insurance Code, as follows:

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. (a) Provides that the public counsel:

(1) is authorized to appear or intervene, as a party or otherwise, as a matter of right before the commissioner of insurance (commissioner) and the Texas Department of Insurance (TDI) on behalf of insurance consumers, as a class, in matters involving:

(A) makes no change;

(B) makes a nonsubstantive change;

(C) a managed care plan's ability to provide accessible health care services and reasonable access to covered benefits; or

(D) makes a nonsubstantive change;

(2) makes no change;

(3)-(4) makes nonsubstantive changes; and

(5) is authorized to 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.

(b) Provides that the office, to assist the office in determining whether to request a hearing under Subsection (a)(5), is entitled to:

(1) review all relevant filings and information that a managed care plan submits to TDI, including communications related to the filing; and

(2) communicate with a managed care plan regarding a submission described by Subdivision (1).

(c) Provides that a matter described by Subsection (a)(5) is a contested case that is authorized to be subject to informal disposition or heard by the State Office of Administrative Hearings under Chapter 2001 (Administrative Procedure), Government Code.

(d) Prohibits anything in this chapter from being 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.

SECTION 5. Amends Section 501.154, Insurance Code, as follows:

Sec. 501.154. ACCESS TO INFORMATION. Provides that the public counsel:

(1)-(2) makes nonsubstantive changes; and

(3) is entitled 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.

SECTION 6. Amends Section 501.157, Insurance Code, as follows:

Sec. 501.157. PROHIBITED INTERVENTIONS OR APPEARANCES. Prohibits the public counsel, except as otherwise provided by this code, from intervening or appearing in:

(1)-(2) makes no change.

SECTION 7. Amends Section 501.159, Insurance Code, by amending Subsection (a) and adding Subsections (a-1) and (a-2), as follows:

(a) Authorizes the office, notwithstanding Chapter 501 (Office of Public Insurance Counsel), to submit written comments to the commissioner and otherwise participate regarding individual insurer filings:

(1) makes nonsubstantive changes; or

(2) 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.

(a-1) Authorizes the office to comment on or otherwise participate regarding the effect or implementation of a filing described by Subsection (a)(2), including comments regarding concerns that a managed care plan:

(1) is operating with an inadequate network in this state;

(2) may be in violation of a network adequacy law or regulation; or

(3) has an inaccurate provider network directory.

(a-2) Requires TDI, for written comments filed with TDI regarding filings described by Subsection (a)(2), to:

(1) respond to the comments promptly and provide updates to the office and the managed care plan regarding actions taken by TDI or other actions taken to address issues raised in the comments; and

(2) consider conducting a targeted market conduct examination under Chapter 751 (Market Conduct Surveillance) or another form of investigation to determine the existence and extent of potential violations.

SECTION 8. Amends the heading to Subchapter F, Chapter 501, Insurance Code, to read as follows:

SUBCHAPTER F. DUTIES RELATING TO MANAGED CARE PLANS

SECTION 9. Amends Section 501.251, Insurance Code, as follows:

Sec. 501.251. New heading: COMPARISON OF MANAGED CARE PLANS (a) Requires the office to develop and implement 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. Deletes existing text requiring the office to develop and implement a system to compare and evaluate, on an objective basis, the quality of care provided by and the performance of health maintenance organizations established under Chapter 843 (Health Maintenance Organizations).

(b) Requires the office, in conducting comparisons under the system described by Subsection (a), to compare:

(1) health maintenance organizations to other health maintenance organizations;

(2) preferred provider benefit plans to other preferred provider benefit plans; and

(3) exclusive provider benefit plans to other exclusive provider benefit plans.

(c) Creates this subsection from existing text. Makes no further changes to this subsection.

SECTION 10. Amends Section 501.252, Insurance Code, as follows:

Sec. 501.252. ANNUAL CONSUMER REPORT CARDS. (a) Requires the office to develop and issue annual consumer report cards that identify and compare, on an objective basis, managed care plans. Makes conforming changes.

(b) Requires that the consumer report cards required by Subsection (a):

(1) include comparisons of types of managed care plans in the same manner as provided by Section 501.251(b); and

(2) at the discretion of the office, be staggered for release throughout the year based on the type of managed care plan that is the subject of the consumer report card.

(c) Requires that all consumer report cards for a particular type of managed care plan, notwithstanding Subsection (b)(2), be released at the same time.

(d) Creates this subsection from existing text.

(e) Prohibits the office from endorsing or recommending a specific managed care plan, or subjectively rate or rank managed care plans or managed care plan issuers, other than through comparison and evaluation of objective criteria. Makes conforming changes.

(f) Creates this subsection from existing text.

SECTION 11. Provides that it is the intent of the legislature to provide the office with the flexibility to establish a timeline for the implementation, development, and initial issuance of annual consumer report cards under Section 501.252, Insurance Code, as amended by this Act, in a manner that best uses current office resources.

SECTION 12. Effective date: September 1, 2023.