BILL ANALYSIS

Senate Research Center

H.B. 3269
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Economic Development
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Engrossed

DIGEST

Under current health maintenance (HMO) rules, enrollee patients are only covered when receiving services provided by physicians included in the HMO's provider network. Often, this reduces access to important medically necessary care or requires patients to pay for these services themselves.

This bill would allow patients who need necessary services covered by the HMO, but not available through the HMO's network of physicians, access to health care from a non-network provider. In addition, H.B. 3269 would codify language taken verbatim from existing Texas Department of Insurance rules.

PURPOSE

As proposed, H.B. 3269 allows patients who need necessary services covered by the HMO, but not available through the HMO's network of physicians, to access to health care from a non-network provider.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 9, Article 20A.09, V.T.C.S. (Texas Health Maintenance Organization Act), as follows:

Sec. 9. EVIDENCE OF COVERAGE CHARGES. (a)-(c) Makes conforming changes.

(d) Requires each evidence of coverage to contain provisions regarding the requirements adopted under Subsections (e)-(i) of this section.

(e) Sets forth requirements for each evidence or coverage. Makes a conforming change.

(f) Requires the health maintenance organization (HMO), under certain conditions, and on the request of a network physician or provider, within a reasonable period, to allow referral to a non-network physician or provider and to fully reimburse the non-network physician or provider at the usual and customary or an agreed rate. Requires the evidence of coverage to provide for a review by a specialist of the same specialty or a similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral. Makes conforming changes.

(g) Sets forth provisions regarding an enrollee with a chronic, disabling, or life-threatening illness. Makes conforming changes.

(h) Sets forth provisions regarding a request for special consideration described by Subsection (g). Makes conforming changes.

(i) Sets forth prohibitions regarding the effective date of the designation of a nonprimary case physician specialist as an enrollee's primary care physician, and the reduction of the

amount of compensation owed to the original primary care physician. Makes conforming changes.

(j) Sets forth provisions regarding evidence of coverage or group contract. Makes conforming changes.

(k) Makes a conforming change.

(l) Authorizes the commissioner of insurance (commissioner), after notice and hearing, to withdraw previous approval of any form, if the commissioner makes a certain determination.

(m) Makes a conforming change.

(n) Provides that certain articles apply to HMOs other than those HMOs offering only a single health care service plan.

(o) Deletes existing Subsection (f). Makes conforming changes.

(p) Deletes text regarding the application of Article 3.70-1(F)(5) of the Insurance Code.

(q) Sets forth the application of Article 21.55, Insurance Code.

(r) Makes a conforming change.

SECTION 2. Makes application of Section 9, Article 20A.09, V.T.C.S., as amended by this Act, prospective to January 1, 1998.

SECTION 3. Emergency clause.
Effective date: 90 days after adjournment.