BILL ANALYSIS

Senate Research Center

C.S.S.B. 385
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Economic Development
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Committee Report (Substituted)

DIGEST

Currently, managed care systems continue to change the delivery of health care in Texas. Since the onset of managed care, the state's market has seen tremendous growth, with the number of HMO enrollees increasing by 64.4 percent since 1992. During the 74th Interim, the Senate Interim Committee on Managed Care and Consumer Protections was charged with reviewing Texas statutes and agency regulations to ensure the availability and effectiveness of important consumer safeguards. This legislation establishes the transfer of quality of care oversight functions from the Texas Department of Health (TDH) to the Texas Department of Insurance (TDI). In addition, this bill provides strengthening and codification of certain TDI and TDH rules regarding access and quality of care, and recommendations of the Interim Committee for improved consumer protections.

PURPOSE

As proposed, C.S.S.B. 385 establishes the regulation of health maintenance organizations.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the commissioner of insurance in SECTIONS 3, 5, 7, 11, 12, 16, 18, 19, 23, and 24 (Articles 20A.04(b), 20A.09(m), 20A.12(a), 20A.15(g), 20A.15A(h), 20A.19(b), 20A.22(a)-(c), 20A.23(a), 20A.36(e), and 20A.37(b), Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Article 20A.02, Insurance Code (Texas Health Maintenance Organization Act), to define "adverse determination," "capitation," "complainant," "complaint," and "emergency care," "life threatening," and "prospective enrollee." Redefines "basic health care services." Deletes the definitions for "board" and "emergency care." Makes conforming changes.

SECTION 2. Amends Article 20A.03, Insurance Code, by adding Subsections (e)-(g), to prohibit a person or provider from directly or indirectly performing any of the acts of a health maintenance organization (HMO), except in accordance with this Act, and requires any person or provider in violation of this prohibition to be subject to all enforcement processes and procedures of an authorized insurer pursuant to Sections 3 and 3A, Article 1.14-1, Insurance Code. Requires the commissioner of insurance (commissioner) to have subpoena authority in accordance with Article 1.19-1, Insurance Code.

SECTION 3. Amends Article 20A.04, Insurance Code, to establish the conditions by which each application for a certificate of authority is required to contain a written description of health care plan terms and conditions; network configuration information; a written description of the types of compensation arrangements; documentation demonstrating that the HMO will pay for emergency care services performed by non-network physicians or providers at certain rates; and that the health care plan contains certain provisions and procedures for coverage of emergency care services. Sets forth the terms by which the commissioner, rather than the State Board of Insurance, is authorized to promulgate rules and regulations requiring an HMO to submit modifications or amendments to the operations or documents described in Subsection (a) of this section to the commissioner. Makes conforming changes.

SECTION 4. Amends Article 20A.05, Insurance Code, to delete the provision requiring the commissioner to begin consideration of an application for issuance of a certificate of authority and transmit copies of the application and accompanying documents to the board upon receipt of the application. Deletes the provision requiring the Texas Board of Health to determine whether the applicant has met certain requirements. Sets forth the terms by which the commissioner is required to issue or deny a certificate within 75 days of the receipt of a completed application, provided certain conditions exist. Requires the issuance of the certificate of authority to be granted upon payment of the application fee if the commissioner is satisfied that the applicant has demonstrated the willingness and ability to assure that such health care services will be provided in a suitable manner; has arrangements for an ongoing quality of health care assurance program; and has a procedure to compile, evaluate, and report statistics relating to the cost of operation and utilization and quality of its services. Makes conforming changes.

SECTION 5. Amends Article 20A.09, Insurance Code, to establish the terms by which evidence of coverage under a health care plan is required to contain a provision requiring an HMO to allow referral to a nonnetwork physician or provider if medically necessary covered services are unavailable through network providers; allowing enrollees which chronic, disabling, or life-threatening illnesses to apply for a nonprimary care physician specialist as a primary care physician; authorizing an enrollee who is denied the request for a nonprimary care physician specialist to appeal the decision; and prohibiting the effective date regarding the new designation of a nonprimary care physician from being retroactive. Requires an HMO to comply with Article 21.55, Insurance Code, with respect to prompt payment to enrollees, and deletes existing subsection. Sets forth the terms by which an HMO is required to make payment to a physician or provider, and provide basic health care services to its enrollees. Defines "covered services." Provides that nothing in this Act shall require an HMO, physician, or provider to recommend, offer advice concerning, pay for, provide, or perform any health care service that violates its religious convictions; but requires an HMO with such convictions to set forth those limitations in the evidence of coverage. Authorizes the commissioner to adopt minimum standards relating to basic health care services. Makes conforming changes.

SECTION 6. Amends Article 20A.11, Insurance Code, as follows:

> Sec. 11. New heading: INFORMATION TO PROSPECTIVE AND CURRENT GROUP CONTRACT HOLDERS AND ENROLLEES. Requires a plan application form to include a space in which the enrollee is required to make a selection of a primary care physician or provider. Sets forth the terms by which an enrollee is required to have the right to make that selection, and authorizes an HMO to limit an enrollee's requested changes to no more than four in any 12-month period. Establishes the conditions by which an HMO is required to provide on request a written description of health care plan terms and conditions, and notify a group contract holder of any substantive changes to the payment arrangements between the organization and health care providers. Prohibits an HMO from permitting the use or distribution of prospective enrollee information which is untrue or misleading. Makes a conforming change.

SECTION 7. Amends Article 20A.12, Insurance Code, as follows:

> Sec. 12. New heading: COMPLAINT AND APPEAL SYSTEM. Establishes the conditions by which every HMO is required to establish and maintain a complaint resolution system including a process for the notice and appeal of complaints. Authorizes the commissioner to promulgate rules and regulations necessary or proper to implement and administer this section. Requires a complaint resolution system to be implemented and maintained by an HMO. Requires the complaint procedure to include provisions to meet certain requirements regarding receipt and investigation of complaints; total time for complaint resolution; complaint and appeal acknowledgment letters; complaint appeal process and panel; complaint records; and notice of the final decision on the appeal. Authorizes the commissioner to examine such complaint system for compliance with this Act and require the HMO to make corrections as deemed necessary by the commissioner. Provides that if any provision of Article 21.58A, Insurance Code, conflicts with any provision of this section, the provisions of this section shall prevail. Makes conforming changes.

SECTION 8. Amends Article 20A.01 et seq., Insurance Code, by adding Section 12A, as follows:

Sec. 12A. FILING COMPLAINTS WITH THE TEXAS DEPARTMENT OF INSURANCE. Sets forth the terms by which a person is authorized to report an alleged violation of this Act to the Texas Department of Insurance, by which the commissioner is required to investigate a complaint against an HMO, and by which the commissioner is authorized to extend the time necessary to complete the investigation in certain circumstances.

SECTION 9. Amends Articles 20A.13(a)-(c) and (f)-(h), Insurance Code, to set forth the terms by which each HMO is required to deposit with the comptroller, rather than the State Treasurer, cash, securities, or other guarantees acceptable to the commissioner. Makes conforming changes.

SECTION 10. Amends Article 20A.14, Insurance Code, by adding Subsections (i)-(l), to prohibit an HMO from prohibiting, attempting to prohibit, or discouraging a physician or provider, as a condition of a contract, from communicating information to a patient regarding the patient's health care, or provisions or services of the health care plan. Prohibits an HMO from penalizing, terminating, or refusing to compensate a physician or provider for communicating with a patient pursuant to this section. Establishes the conditions by which an HMO is prohibited from engaging in any retaliatory action against certain people or groups, and is prohibited from using any financial incentive or payment to a physician or provider as an inducement to limit medically necessary services.

SECTION 11. Amends Article 20A.15, Insurance Code, as follows:

Sec. 15. New heading: REGULATION OF AGENTS. Requires the commissioner to collect in advance from HMO agent applicants a nonrefundable license fee in a certain amount. Requires all fees collected under this section to be used by the commissioner to administer the provisions of this Act. Requires all of such funds to be paid into the State Treasury to the credit of the Texas Department of Insurance, rather than the State Board of Insurance, operating fund. Authorizes the commissioner, rather than the State Board of Insurance, after notice and hearings, to promulgate rules and regulations necessary to provide for the licensing of agents. Makes conforming changes.

SECTION 12. Amends Article 20A.15A, Insurance Code, to make conforming changes.

SECTION 13. Amends Article 20A.17, Insurance Code, to set forth the terms by which the commissioner is authorized to make an examination concerning the quality of health care services and of the affairs of any applicant for a certificate of authority or any HMO. Requires a copy of any contract or agreement between an HMO and a physician or provider to be provided to the commissioner on request, and to be deemed confidential and not subject to the open records law. Includes Article 1.04A, Insurance Code, among the list of articles required to be construed to apply to HMOs, except in certain circumstances. Makes conforming changes.

SECTION 14. Amends Articles 20A.18(d) and (f), Insurance Code, to make conforming changes.

SECTION 15. Amends Article 20A.01 et seq., Insurance Code, by adding Section 18A, as follows:

Sec. 18A. PHYSICIAN AND PROVIDER CONTRACTS. Requires an HMO, on request, to disclose to physicians and providers written application procedures and qualification requirements for contracting with the HMO. Sets forth the terms by which each physician and provider who is denied a contract is required to be provided written notice of the reasons. This subsection does not prohibit an HMO plan from rejecting an application in certain cases. Sets forth the terms by which an HMO is required to terminate a contract with a physician or provider. Sets forth the terms by which each contract must provide that advance notice be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee; and that the termination of the contract does not release the HMO from the obligation to reimburse the physician or provider who is treating an enrollee of special circumstance. Defines "special circumstance." Sets forth the obligation

of an HMO to reimburse a terminated physician or provider, or enrollee for services to an enrollee who is past the 24th week of pregnancy at the time of the termination. Requires a contract to require a physician or provider to post notice to enrollees on the process for resolving complaints with the HMO. Sets forth other regulations regarding physician and provider contracts.

SECTION 16. Amends Article 20A.19, Insurance Code, to authorize the commissioner, rather than the State Board of Insurance, by rules and regulations, to fix uniform standards and criteria for early warning that the continued operation of any HMO might be hazardous, and to fix standards for evaluating the financial condition of any HMO. Makes conforming changes.

SECTION 17. Amends Article 20A.20(a), Insurance Code, to authorize the commissioner, after notice and opportunity for hearing, to suspend or revoke any certificate of authority issued to an HMO under this Act; impose sanctions under Section 7, Article 1.10, Insurance Code; impose administrative penalties under Article 1.10E, Insurance Code; or issue a cease and desist order under Article 1.10A, Insurance Code, if the commissioner finds that certain conditions exist, including that the HMO has failed to carry out corrective action the commissioner considers necessary to correct a failure to comply with certain rules and provisions. Makes conforming changes.

SECTION 18. Amends Article 20A.22, Insurance Code, to authorize the commissioner, rather than the State Board of Insurance, to promulgate rules and regulations as necessary and proper to carry out the provisions of this Act; to meet the requirements of federal law and regulations; to prescribe authorized investments for HMOs in certain cases; to ensure that enrollees have adequate access to health care services; and to establish other regulations relating to patient care. Makes conforming and nonsubstantive changes.

SECTION 19. Amends Article 20A.23, Insurance Code, to require the commissioner, rather than the State Board of Insurance, to make rules and regulations with respect to applications for review of a rule, ruling, or decision of the Texas Department of Insurance or the commissioner, and their consideration, as it considers to be advisable. Makes conforming changes.

SECTION 20. Amends Article 20A.26(f)(4), Insurance Code, to provide that a physician or provider who conducts utilization review during the ordinary course of treatment of patients pursuant to a joint or delegated review agreement(s) is prohibited from being required to obtain certification under Section 3, Article 21.58A, Insurance Code.

SECTION 21. Amends Article 20A.28, Insurance Code, to make conforming changes.

SECTION 22. Amends Article 20A.32, Insurance Code, to require every organization subject to this chapter to pay to the commissioner a fee not to exceed $18,000, rather than $15,000, as determined by the commissioner for filing and review of its original application for a certificate of authority; and the expenses of an examination under Section 17(a) of this Act, regarding the affairs of any HMO, incurred by the commissioner or under the commissioner's authority, provided certain conditions are met. Makes conforming changes.

SECTION 23. Amends Articles 20A.36(a)-(c), (e), and (g), Insurance Code, to prohibit a public representative of the Health Maintenance Organization Solvency Surveillance Committee from being a person required to register with the Texas Ethics Commission, rather than the secretary of state, under Chapter 305, Government Code. Authorizes the commissioner, rather than the State Board of Insurance, to adopt rules as necessary to implement this Act in certain circumstances. Makes conforming changes.

SECTION 24. Amends Article 20A.01 et seq., Insurance Code, by adding Section 37, as follows:

Sec. 37. HEALTH MAINTENANCE ORGANIZATION QUALITY ASSURANCE. Sets forth the terms by which an HMO is required to establish procedures which assure availability, accessibility, quality, and continuity of health care. Establishes the conditions by which an HMO is required to have an internal quality assurance program to monitor and evaluate its health care services. Authorizes the commissioner, by rule, to establish minimum standards

and requirements for these programs. Sets forth the terms by which an HMO is required to record formal proceedings and maintain documentation of program activities; establish and maintain a physician review panel; ensure the use and maintenance of a patient record system; and establish a mechanism for the periodic reporting of program activities. Requires enrollees' clinical records to be confidential, and available to the commissioner for examination and review to determine compliance. Requires an HMO to establish a mechanism for periodic reporting of program activities to the governing body, providers, and staff.

SECTION 25. Effective date: September 1, 1997.

SECTION 26. Emergency clause.

SUMMARY OF COMMITTEE CHANGES

Amends SECTION 1, Article 20A.02, Insurance Code, to amend the definition of "complaint" and "emergency care." Defines "life threatening" and "prospective enrollee."

Amends SECTION 3, Article 20A.04, Insurance Code, to replace references to "emergency department of a hospital" with "hospital emergency facility or comparable facility."

Amends SECTION 5, Article 20A.09, Insurance Code, to provide that nothing in this Act shall require an HMO, physician, or provider to recommend, offer advice concerning, pay for, provide, or perform any health care service that violates its religious convictions; and requires an HMO with such convictions to set forth those limitations in the evidence of coverage.

Amends SECTION 6, Article 20A.11, Insurance Code, to delete the reference to 28 T.A.C. Section 11.301(5)(I), and replace the reference to "enrollees" with "a group contract holder."

Amends SECTION 7, Article 20A.12, Insurance Code, to assign a new heading entitled, "COMPLAINT AND APPEAL SYSTEM" and make the following changes:

- Deletes the references to different aspects of an HMO's operation which might become the subject of a complaint.
- Authorizes the commissioner to promulgate rules and regulations necessary to implement and administer this section.
- Requires a system for the resolution of complaints to be implemented and maintained by an HMO as provided under this subsection.
- Requires an HMO to send both a complaint-receipt acknowledgment letter and one-page complaint form to a complainant after receipt of a complaint. Sets forth their contents.
- Establishes the conditions under which an HMO is authorized to extend the time for complaint resolution.
- Prohibits resolution of complaints regarding emergencies or denials of continued stays for hospitalization from exceeding 72 hours, rather than one working day, from receipt of the complaint.
- Requires a letter in response to resolution of a complaint to explain the proper procedure for making a complaint.
- Requires an HMO to make a good faith effort to meet an enrollee's needs in selecting a site for the complaint appeal panel.
- Sets forth the contents of an appeal request acknowledgment letter.
- Provides that a complainant has the right to appear in person, or through a representative, before the complaint appeal panel.
- Provides for a complainant response to documentation to be presented to the complaint appeal panel.
- Requires a notice of the final decision on an appeal to state the procedure for making a complaint, and deletes the provision regarding inclusion of a information related to the Texas Department of Insurance.
- Requires resolution of appeals relating to poststabilization care following an emergency condition or denials of continued stays for hospitalization to be concluded not later than 72 hours, rather than one working day, from the request for appeal.

- Deletes the provision regarding resolution of appeals after emergency care has been provided. Requires an HMO to maintain records of appeals as well as complaints, and authorizes the commissioner to examine this documentation for compliance.
- Deletes the provisions regarding complainants' rights to copies of records, maintenance by an HMO of complaint and appeal logs, and maintenance of complaint and action documentation.

- Provides that the provisions of this section shall prevail over any provision of Article 21.58A, Insurance Code, in case of conflict.

Amends SECTION 13, Article 20A.17, Insurance Code, to set forth the terms by which a copy of any contract or agreement between an HMO and a physician or provider is required to be provided to the commissioner on request, and is not subject to the open records law.

Amends SECTION 15, Article 20A.01, et seq., Insurance Code, to provide that the obligation of the HMO to reimburse a terminated physician or provider, or enrollee for services to an enrollee who is past the 24th week of pregnancy extends through delivery, postpartum care, and the six-week follow-up checkup. Requires a contract to require a physician or provider to post a notice to enrollees on the process for resolving complaints. Deletes the provision prohibiting a contract from prohibiting an HMO, physician, or provider from contracting with other physicians, providers, other HMOs, or insurers, with certain exceptions.

Amends SECTION 22, Article 20A.28, Insurance Code, to remove the provision requiring the amount paid by an HMO in each taxable year to be allowed as a credit. Reinstates deleted provisions regarding the payment of certain fees to the board.