BILL ANALYSIS

Senate Research Center

H.B. 1498
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Economic Development
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Engrossed

DIGEST

Currently, employees who are provided health care coverage through a health maintenance organization (HMO) paid for by their employer must select a primary care physician within the plan's network and use the services and specialists within that network. H.B. 1498 would require HMOs to offer, through employer-sponsored health plans, an option allowing enrollees to access out-of-network services and providers, and would permit an HMO to offer a point-of-service plan, a preferred provider plan, or any other means by which enrollees may go out-of-network. H.B. 1498 would also allow HMOs to offer, under a single contract, indemnity and HMO benefits without obtaining a separate license.

PURPOSE

As proposed, H.B. 1498 sets forth provisions regarding the availability of health benefit coverage options for health maintenance organization eligible enrollees.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the commissioner of insurance in SECTION 2 (Article 3.64(f), V.T.C.S.) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 26A, Insurance Code, by adding Article 26.09, as follows:

Art. 26.09. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS. (a) Defines "non-network plan," "point-of-service plan," and "preferred provider benefit plan."

(b) Requires each health maintenance organization (HMO) offering coverage under the employer's health benefit plan to offer to all eligible employees the opportunity to obtain health benefit coverage through a non-network plan at the time of enrollment and at least annually, unless all HMOs offering coverage under the employer's health benefit plan enter into an agreement designating one or more of those HMOs to offer that coverage, if the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more HMOs. Authorizes the coverage required under this subsection to be provided through a point-of-service contract, a preferred provider benefit plan, or any coverage arrangement that allows an enrollee to access services outside an HMO or limited provider network's delivery network.

(c) Requires the premium for coverage required to be offered under this article to be based on the actuarial value of that coverage and to be different than the premium for the HMO coverage.

(d) Authorizes different cost-sharing provisions to be imposed for a point-of-service contract offered under this article and to be higher than cost-sharing provisions for in-network HMO coverage. Authorizes higher cost sharing to be imposed only when obtaining benefits or services outside the HMO delivery network, for enrollees in limited provider networks.

(e) Provides that any additional costs for the non-network plan are the responsibility of the employee who chooses the non-network plan, and the employer may impose a reasonable administrative cost for providing the non-network plan option.

(f) Provides that this article does not apply to a small employer health benefit plan.

SECTION 2. Amends Chapter 3F, Insurance Code, by adding Article 3.64, as follows:

Art. 3.64. CONTRACTS BETWEEN HEALTH MAINTENANCE ORGANIZATIONS AND INSURERS. (a) Defines "blended contract," "health maintenance organization," "insurance carrier," and "point-of-service plan."

(b) Authorizes an insurance carrier to contract with an HMO to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care.

(c) Authorizes an insurance carrier and an HMO to offer a blended contract if indemnity benefits are combined with HMO benefits. Provides that the use of a blended contract is limited to point-of-service arrangements between an insurance carrier and an HMO.

(d) Provides that a blended contract delivered, issued, or used in this state is subject to and must be filed with the Texas Department of Insurance (DOI) for approval as provided by Article 3.42 of this code and Section 9(a)(5), Article 20A.09, Insurance Code, Texas Health Maintenance Organization Act.

(e) Authorizes indemnity benefits and services provided under a point-of-service plan to be limited to those services as defined by the blended contract and to be subject to different cost-sharing provisions. Authorizes the cost-sharing provisions for the indemnity benefits to be higher than cost-sharing provisions for in-network HMO coverage. Authorizes higher cost sharing to be imposed only when obtaining benefits or services outside the HMO delivery network, for enrollees in limited provider networks.

(f) Authorizes the commissioner of insurance (commissioner) to adopt rules to implement this article.

SECTION 3. Amends Section 2, Article 20A.02, Insurance Code (Texas Health Maintenance Organization Act), by amending Subsection (i) and by adding Subsections (aa) and (bb), to define "evidence of coverage," "blended contract," and "point-of-service plan."

SECTION 4. Amends Section 6, Article 20A.06, Insurance Code, by amending Subsection (a) and adding Subsection (c), as follows:

(a) Provides that the powers of an HMO include, but are not limited to, the offering of a point-of-service plan under Article 3.64, Insurance Code, or a point-of-service rider under Subsection (c) of this section. Makes a nonsubstantive change.

(c) Authorizes an HMO to offer a point-of-service rider for out-of-network coverage without obtaining a separate insurance carrier license if the expenses incurred under the point-of-service rider do not exceed 10 percent of the total medical hospital expenses incurred for all health plan products sold. Requires HMOs to cease issuing new point-of-service riders until those expenses fall below 10 percent or until the HMO obtains an insurance carrier license under this Act, if the expenses incurred by an HMO under a point-of-service rider exceed 10 percent of the total medical and hospital expenses incurred for all health plan products sold. Authorizes indemnity benefits and services provided under a point-of-service rider to be limited to those services defined in the evidence of coverage and to be subject to different cost-sharing provisions. Authorizes the cost-sharing provisions for indemnity benefits to be higher than the cost-sharing provisions for in-network HMO coverage. Authorizes the higher cost sharing to be imposed only when obtaining benefits or services outside the HMO delivery network, for enrollees in limited provider networks. Requires an HMO that issues a point-of-service rider under this section to meet the net worth requirements promulgated by the commissioner based on the actuarial relation of the amount of insurance risk assumed through the issuance of the point-of-service rider in relation to the amount of solvency and reserve requirements already required of the HMO.

SECTION 5. Effective date: September 1, 1999.

Makes application of this Act prospective to January 1, 2000.

SECTION 6. Emergency clause.