

BILL ANALYSIS

Senate Research Center

H.B. 2766
By: Smithee (Turner)
Economic Development
6-6-95
Enrolled

BACKGROUND

Managed care is a growing part of health care delivery in Texas. Many Texans are covered by such plans. While managed care has succeeded in reducing some costs, patients and providers have experienced various problems, including consumer confusion over coverage, interruption of long-standing doctor-patient relationships, and denial of needed and appropriate medical care.

PURPOSE

As enrolled, H.B. 2766 establishes standards for managed care organizations. The standards address the delivery and payment for emergency care; ensure that prospective enrollees in managed care plans receive information about how the plans operate; and provide a process by which physicians, dentists, and other providers may be removed from managed care plans.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is granted to the commissioner of insurance under SECTION 1 (Section 21.103, Insurance Code) and to the State Board of Insurance under SECTION 3 (Section 14(h), Article 21.58A, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 21, Insurance Code, by adding Subchapter G, as follows:

SUBCHAPTER G. PATIENT PROTECTION ACT

Art. 21.101. SHORT TITLE: Patient Protection Act.

Art. 21.102. DEFINITIONS. Defines "commissioner," "emergency care services," "emergency medical condition," "managed care plan," "prospective enrollee," "provider," "physician," and "dentist."

Art. 21.103. STANDARDS. Authorizes the commissioner of insurance (commissioner) to adopt rules regarding standards ensuring compliance with this subchapter by managed care entities that conduct business in this state, and to appoint an advisory committee to assist in the implementation of this subchapter.

Art. 21.104. ENROLLEE INFORMATION. (a) Requires a managed care entity to provide a prospective enrollee a written plan description of the terms and conditions of the plan. Requires the written plan to be in a readable and understandable format, and to include certain information.

(b) Authorizes the managed care entity to provide the information under Subsection (a)(6) in the entity's annual financial statement most recently submitted to the Texas Department of Insurance (department).

(c) Requires the managed care entity to demonstrate that each covered enrollee has adequate access through the entity's provider network to all items and services contained in the package of benefits for which coverage is provided. Requires the access to be adequate.

(d) Prohibits anything in Subsection (c) of this article from being interpreted to mean

that a comprehensive cancer center shall be the exclusive provider of cancer care services for the managed care plan (plan).

(e) Prohibits anything in Subsection (c) of this article from being interpreted to circumvent the plan's normal referral and authorization processes.

(f) Requires the plan to establish and follow certain procedures if the plan uses a capitation method of compensation.

Art. 21.105. NETWORK CONFIGURATION. Requires the managed care entity to provide to the commissioner, for information, an explanation of the targeted physician, dentist, and other provider network configuration. Sets forth requirements for the information required by this subsection. Prohibits this section from requiring a particular ratio for any type of provider. Requires the information to be made available to the public by the department on request. Authorizes the department to charge a reasonable fee for providing the information.

Art. 21.106. HOSPITAL PARTICIPATION. Requires the plan, in the development of the plan's criteria for hospital participation, if a hospital is certified under the Medicare program under Title XVIII of the Social Security Act, as amended, or accredited by the Joint Commission on Accreditation of Healthcare Organizations, to accept such certification or accreditation. Declares that this article does not prohibit a managed care plan from establishing additional criteria for hospital participation.

Art. 21.107. FINANCIAL INCENTIVE PROGRAMS. Prohibits a plan from using a financial incentive program that limits medically necessary and appropriate services.

Art. 21.108. PARTICIPATING PROVIDERS. (a) Requires each plan to establish a mechanism under which physicians or dentists participating in the plan provide consultation and advice on the plan's medical or dental policy. Requires other participating providers to be given an opportunity to comment on the plan's policies affecting their services. Requires each plan to make available to providers the application process and qualification requirements for participation in the plan. Requires the plan to give a provider not selected on initial application each reason the initial application was denied.

(b) Requires each physician or dentist under consideration for inclusion in a plan to be reviewed by a credentialing committee composed of network participating physicians or dentists selected by the medical director of the managed care entity. Sets forth requirements in the event that there are no credentialed physicians or dentists in the newly created plan. Authorizes other providers to be credentialed as appropriate as determined by the plan. Requires the credentialing committee, when a provider other than a physician or dentist is credentialed by the plan, to include providers with the same license.

(c) Requires credentialing of providers to be based on identified standards developed after consultation with providers credentialed in the plan. Sets forth requirements in the event that there are no credentialed providers in a newly created plan. Requires the plan to make the credentialing standards available to applicants.

(d) Requires the plan to use identified criteria and to be available to applicant and participating providers, if economic considerations are part of the decision to select a provider or terminate a contract with a provider. Requires the plan, if it uses an economic profile of a provider, to adjust the profile to recognize the characteristics of a provider's practice that may account for variations from expected costs.

(e) Requires a plan that conducts or uses economic profiling of providers within the plan to make the profile available to the provider profiled.

(f) Declares that a plan is not required to disclose proprietary information regarding

marketplace strategies.

(g) Prohibits a plan from excluding a provider solely because of a specialty practice or the anticipated characteristics of the patients of that provider.

(h) Sets forth requirements for the plan before terminating a contract with a provider.

(i) Requires the physician's or dentist's procedural rights, if the action that is under consideration is of a type that must be reported to the National Practitioner Data Bank or a state medical or dental board under federal or state law, to meet the standards of the federal Health Care Quality Improvement Act of 1986. Describes a managed care entity.

(j) Prohibits a communication relating to the subject matter provided for under Subsections (a) and (h) of this article from being the basis for a cause of action for libel or slander except for disclosures or communications with parties other than the plan or provider.

(k) Requires the plan to establish reasonable procedures for assuring a transition of enrollees of the plan to new physicians, providers, or dentists.

(l) Sets forth requirements relating to the cost of copies of certain medical or dental records in the event that a contract with a provider is terminated by a plan, or that a provider terminates the contract with the plan.

(m) Declares that this subchapter does not prohibit a plan from rejecting an application from a provider based on the determination that the plan has sufficient qualified providers.

(n) Authorizes a plan to charge certain fees to a provider other than a physician or dentist.

(o) Limits the definition of "managed care plan" for the purposes of this article.

(p) Provides that certain subsections of this article apply to hospitals, hospices, and home health agencies.

Art. 21.109. EMERGENCY SERVICES. Requires a plan to cover emergency care services provided to covered individuals; provide that the prior authorization requirement for medically necessary services provided or originating in a hospital emergency room following treatment or stabilization of an emergency medical condition are approved, except under certain circumstances; and cover any medical screening examination to determine whether an emergency medical condition exists or other evaluation required by state or federal law to be provided in the emergency room of a hospital.

Art. 21.110. PRIOR AUTHORIZATION; CONSENT. Requires a plan for which prior authorization is a condition to coverage of a service to ensure that enrollees are required to sign medical and dental information release consent forms on enrollment.

Art. 21.111. UTILIZATION REVIEW. Requires a plan to be subject to and meet the requirements of Article 21.58A of this code.

Art. 21.112. POINT OF SERVICE OFFERING. (a) Requires a health maintenance organization that has a point-of-service plan available in its service area and is the only entity providing services under a health benefit plan, to offer to all enrollees the opportunity to obtain coverage for out-of-network services through the point-of-service place at the time of enrollment and at least annually.

(b) Defines "point-of-service plan."

(c) Requires the premium for the point-of-service plan to be based on the actuarial value of such coverage.

(d) Requires any additional costs for the point-of-service plan to be the responsibility of the enrollee. Authorizes the employer to impose a reasonable administrative cost for providing the point-of-service option.

(e) Prohibits the plan, when five percent or less of the group's eligible employees elect to purchase the point-of-service option, from being required to offer the point-of-service option during subsequent enrollment periods.

(f) Prohibits this article from applying to a small employer as defined in Article 26.02, Insurance Code.

Art. 21.113. PRIVATE CAUSE OF ACTION. Declares that this subchapter and related rules do not provide a private cause of action for damages or create a standard of care, obligation, or duty that provides a basis for a private cause of action for damages; or abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available and existing before June 1, 1996.

Art. 21.114. ANNUAL PERFORMANCE REPORT. (a) Requires the office of public insurance counsel (office) to issue an annual report to consumers on the performance of managed care entities.

(b) Grants the office access to certain information.

(c) Requires the office to provide a copy of the report to a person on request on payment of a reasonable fee. Requires the office to set the fee in the amount necessary to defray the cost of producing the report.

Art. 21.115. RETALIATION PROHIBITED. Prohibits a plan from taking any retaliatory actions against an employer or enrollee solely because the enrollee has filed complaints with the plan or appealed a decision of the plan.

SECTION 2. Amends Section 4(i), Article 21.58A, Insurance Code, to require screening criteria and review procedures applicable with respect to services delivered through a health maintenance organization to include guidelines for appeals on behalf of a person with a special circumstance who is denied services as a result of established conditions of the plan, limitations of coverage, network configuration, or requirements for participating specialists.

SECTION 3. Amends Sections 14(g) and (h), Article 21.58A, Insurance Code, as follows:

(g) Provides that this article does not prohibit or limit the distribution of a proportion of certain savings. Deletes provisions relating to licensure of a health maintenance organization that performs utilization review.

(h) Provides that an insurer or health maintenance organization which delivers or issues for delivery a health insurance policy or evidence of coverage in Texas and is subject to this code is not subject to this article. Requires a health maintenance organization, if it performs utilization review as defined in this article, to comply with this article, and requires the State Board of Insurance (board) to adopt rules for appropriate verification and enforcement of compliance. Requires such insurers and organizations to be subject to Article 20A.33, Insurance Code, to cover the costs of ensuring compliance under this section. Makes conforming changes.

SECTION 4. Amends Section 161.091(f), Health and Safety Code, to provide that this section shall not apply to, among others, preferred provider organizations.

SECTION 5. (a) Amends Article 21.102, Insurance Code, by adding Subdivision (4), to define "managed care entity."

(b) Provides that this section takes effect only if the 74th Legislature, Regular Session, does not enact H.B. 3111 or other legislation adding Article 21.52F, Insurance Code, relating to authorizing the issuance of a certificate of authority to an approved nonprofit health corporation or that legislation does not become law.

SECTION 6. (a) Amends Article 21.102, Insurance Code, by adding Subdivision (4), to define "managed care entity."

(b) Provides that this section takes effect only if the 74th Legislature, Regular Session, enacts H.B. 3111 or other legislation adding Article 21.52F, Insurance Code, relating to authorizing the issuance of a certificate of authority to an approved nonprofit health corporation and that legislation becomes law.

SECTION 7. (a) Effective date: September 1, 1995.

(b) and (c) Make application of this Act prospective beginning June 1, 1996.

(d) Requires the commissioner to conduct a study of the costs of compliance by managed care entities with, and the economic impact on employees in this state, of Chapter 21G, Insurance Code. Authorizes the commissioner to direct department personnel to assist the committee that conducts the study. Requires the commissioner to issue a report on the results of the study to the 75th Legislature not later than January 31, 1997.

SECTION 8. Emergency clause.