BILL ANALYSIS

Senate Research Center

C.S.S.B. 382
By: Madla
Economic Development
3-3-97
Committee Report (Substituted)

DIGEST

Currently, under Article 20A, Insurance Code, the Health Maintenance Insurance Act, a health maintenance organization (HMO) is licensed by the commissioner of insurance as a basic service HMO to provide a broad range of health services or a single service HMO to provide a single health care service to an enrolled population. Provider sponsored networks have begun to take on characteristics identical to or closely resembling HMOs. Often, individual and small groups of providers join forces with each other or with a health care facility such as a hospital to create an integrated provider network. Many of these networks contract with an HMO to provide services or contract directly with an employer group. This bill creates a limited service HMO in which physicians and providers may provide services beyond a single service HMO. Additionally, this bill would prohibit an HMO organized to do business in Texas from going to federal bankruptcy court upon the determination that it is insolvent, authorize the commissioner to deal with such HMOs, and readjust the surpluses required to be maintained by certain HMOs.

PURPOSE

As proposed, C.S.S.B. 382 provides for the regulation by the commissioner of insurance of health maintenance organizations (HMOs) that provide limited health care service plans, the regulation of insolvent HMOs by the commissioner instead of the proceedings of federal bankruptcy court, and the readjustment of the surpluses required to be maintained by certain HMOs.

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 Subsections (i)-(u), Article 20A.02, Insurance Code (Texas Health Maintenance Organization Act), to define "limited health care services" and "limited health care service plan." Makes conforming changes.

SECTION 2. Amends Section 4(a), Article 20A.04, Insurance Code, to require an application for a certificate of authority for a limited health care service plan to include a specific description of the health care services to be provided, among other things. Makes conforming changes.

SECTION 3. Amends Section 5, Article 20A.05, Insurance Code, by amending Subsection (b) and by adding Subsection (e), to provide that an HMO agrees and admits that it is not subject to the U.S. Bankruptcy Code and is not eligible to proceed under the Bankruptcy Code by applying for and receiving a certificate of authority to do business in the State of Texas.

SECTION 4. Amends Section 9(a), Article 20A.09, Insurance Code, to make conforming and nonsubstantive changes.

SECTION 5. Amends Section 13, Article 20A.13, Insurance Code, as follows:

> (a)-(h) Requires each HMO to deposit with the comptroller, rather than the State Treasurer, cash or securities or other guarantees that are acceptable to the commissioner of insurance (commissioner), instead of the State Board of Insurance, in an amount as set forth in this

section. Requires the initial deposit required by a health maintenance organization that offers limited health care services to be $75,000. Makes conforming changes.

(i) Provides that the surplus requirements are subject to the phase-in provisions of Subsections (j), (k), and (l) of this section. Readjusts the minimum surpluses required to be maintained by various health maintenance organizations and requires the minimum surplus to be maintained by an HMO offering limited health care services is not less than $1,000,000, net of accrued uncovered liabilities. Provides that if an HMO fails to comply with the surplus requirements of Section (i), rather than Section (j), the commissioner is authorized to take appropriate action to protect the enrollees of the HMO. Makes conforming changes.

(j) Readjusts the amounts and deadlines for phase-in minimum surpluses required by an HMO authorized to provide basic health services and having a surplus of less than $1,500,000, instead of $500,000, for the time period spanning from 1998 to 2002, notwithstanding any other provisions of this section. Makes conforming and nonsubstantive changes.

(k) Readjusts the amounts and deadlines for phase-in minimum surpluses required by an HMO that provides limited health care services, instead of one providing only a single health care service plan, and has a surplus of less than $1,000,000, for a time period spanning from 1998 to 2002, notwithstanding any other provision of this section. Makes conforming and nonsubstantive changes.

(l) Sets forth the amounts and deadlines for phase-in minimum surpluses required by an HMO authorized to offer only a single health care service plan and having a surplus of less than $500,000, for a time period spanning from 1998 to 2002, notwithstanding any other provision of this section.

(m) Requires the commissioner, in the event of the insolvency of an HMO and on order of the commissioner, to allocate equitably the insolvent HMO's group contracts among all HMOs which operate within a portion of the insolvent HMO's service area. Requires each HMO to which a group or groups are allocated to offer such group or groups the HMO's coverage at rates determined in accordance with the successor HMO's existing methodology or as adjusted by the commissioner. Requires the commissioner to allocate equitably among all HMOs which operate within a portion of the insolvent HMO's service area the insolvent HMO's nongroup enrollees. Requires each HMO to which nongroup enrollees are allocated to offer each such nongroup enrollee that HMO's existing coverage for individual or conversion coverage as determined by the nongroup enrollee's type of coverage in the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology or as adjusted by the commissioner. Requires the successor HMOs which do not offer direct nongroup enrollment to provide coverage at rates that reflect the average group rate of the successor HMO.

SECTION 6. Amends Articles 20A.14 (b), (c), and (h), Insurance Code, to make conforming and nonsubstantive changes.

SECTION 7. Amends Article 20A.20(a), Insurance Code, to authorize the commissioner to suspend or revoke any certificate of authority issued to an HMO under this Act if the commissioner finds, among other things, that a limited health care service plan does not provide or arrange for its limited health care services or an HMO is unable to furnish the limited health care services as required under its limited health care service plan.

SECTION 8. Amends Article 20A.26(f), Insurance Code, to make conforming changes.

SECTION 9. Amends Section 31, Article 20A.31, Insurance Code, as follows:

Sec. 31. New heading: JURISDICTION FOR INJUNCTIONS AND RECEIVERSHIP AND DELINQUENCY PROCEEDINGS. Authorizes the commissioner to bring suit in a district court of Travis County to be named receiver when it appears to the commissioner that

an HMO or other person is insolvent or does not meet the surplus requirements of Section 13 of this Act. Authorizes a court to find that a receiver should take charge of the assets of an HMO and name the commissioner as the receiver of the HMO. Provides that the operations and business of an HMO represent the business of insurance for purposes of Section 21 of this Act and Articles 21.28 and 21.28-A, Insurance Code. Requires Travis County to be exclusive venue of receivership and delinquency proceeding for a HMO. Makes a conforming change.

SECTION 10. Amends Section 33(d), Article 20A.33, Insurance Code, to make a conforming change.

SECTION 11. Amends Sections 36(a), (b), (c), (e), and (g), Article 20A.36, Insurance Code, to provide that, among others, a public representative who is a member of the Health Maintenance Organization Solvency Surveillance Committee is prohibited from being a person required to register as a lobbyist under Chapter 305, Government Code.

SECTION 12. Effective date: September 1, 1997.

SECTION 13. Emergency clause.

SUMMARY OF COMMITTEE CHANGES

Amends SECTION 5, Section 13(m), Article 20A.13, V.T.C.S. (Texas Health Maintenance Organization Act), to require the commissioner to allocate equitably among all HMOs which operate within a portion of the insolvent HMO's service area, the insolvent HMO's nongroup enrollees and not just those who are unable to obtain other coverage. Revises the proposed provisions to require each HMO to which nongroup enrollees are allocated to offer such nongroup enrollee that HMO's existing coverage at rates adjusted by the commissioner, among other rates. Revises the proposed provisions to provide the successor HMOs which do not offer direct nongroup enrollment to provide coverage at rates that reflect the average group rate of the successor HMO rather than authorizing such HMOs to aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

Amends SECTION 11, Section 36(a), Article 20A.36, V.T.C.S., to provide that a public representative on a certain committee cannot be a lobbyist.