BILL ANALYSIS

Senate Research Center

C.S.H.B. 2828
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Business & Commerce
5/2/2001
Committee Report (Substituted)

DIGEST AND PURPOSE

The 76th Legislature set standards for health maintenance organizations (HMO) delegating certain responsibilities to physician networks. During the interim, representatives of health plans, consumers, and physician networks met to develop modifications to the statute. It was determined that confusion still remains among consumers about the excess requirements for limited provider networks. Additionally, HMO network failures prompted the establishment of requirements and enforcement provisions to ensure compliance with the statute. C.S.H.B. 2828 modifies provisions relating to the complaint and reporting requirements of a written agreement between a delegated entity and an HMO and provides penalties for failure to comply with the agreement.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Commissioner of Insurance in SECTION 4 (Article 20A.18C), Insurance Code.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 2, Texas Health Maintenance Organization Act (Article 20A.02, V.T.I.C.), by amending Subsection (ee) and adding Subsections (ff), (gg), and (hh), as follows:

(ee) Defines "delegated entity."

(ff) Defines "delegated network."

(gg) Defines "delegated third party."

(hh) Defines "limited provider network."

SECTION 2. Amends Section 11(b), Texas Health Maintenance Organization Act (Article 20A.11, V.T.I.C.), to require health maintenance organization (HMO) to provide an accurate written description of health care plan terms and conditions, including an explanation of, and a description of the restrictions or limitations related to, limited provider networks or delegated entities within a health care plan, to allow any current or prospective group contract holder and current or prospective enrollee eligible for enrollment in a health care plan to make comparisons and informed decisions before selecting among health care plans. Requires the written description to be in a readable and understandable format as prescribed by the commissioner and to include a telephone number a person may call to obtain more information and a current list of physicians and providers, including delineation of limited provider networks and delegated entities. Authorizes the HMO to provide its handbook to satisfy this requirement provided the handbook's content is substantially similar to and achieves the same level of disclosure as the written description prescribed by the commissioner and the current list of physicians and providers is also provided. Requires the HMO, if an enrollee designates a primary care physician who practices in a limited provider network or delegated entity, not later than the 30th day after the date of the enrollee's enrollment, to provide the information required under this subsection to the enrollee with the enrollee's identification card or in a mailing separate from other information.

SECTION 3. Amends Sections 12(o), (p), and (q), Texas Health Maintenance Organization Act (Article 20A.12, V.T.I.C.), are amended to read as follows:

(o) Requires the record to include complaints relating to limited provider networks and delegated entities.

(p) Requires the log to identify those complaints relating to limited provider networks and delegated entities.

(q) Requires each HMO to maintain documentation on each complaint received and the action taken on each complaint, including a complaint relating to a limited provider network or delegated entity, until the third anniversary of the date of receipt of the complaint. Authorizes the Texas Department of Insurance to review documentation maintained under this subsection, including original documentation, during any investigation of the health maintenance organization.

SECTION 4. Amends Section 18C, Texas Health Maintenance Organization Act (Article 20A.18C, V.T.I.C.), as follows:

Art. 20A.18C. New heading: DELEGATION OF CERTAIN FUNCTIONS. (a) Requires an HMO that delegates any function required by this Act to execute a written agreement with each delegated entity. Requires the HMO to file the written agreement with the Texas Department of Insurance not later than the 30th day after the date the agreement is executed. Requires the parties to each agreement to determine the party that will bear the expense of compliance with any requirement of this subsection, including the cost of any examinations required by the department under Article 1.15, Insurance Code, if applicable. Requires the written agreement to contain certain provisions.

(b) Requires the Commissioner of Insurance (commissioner) to determine the information that an HMO shall provide to each delegated entity with which the HMO has a delegation agreement. Requires the information to include certain specified information, provided in standard electronic format at least monthly unless otherwise stated in the agreement.

(c) Requires an HMO to provide to a delegated entity certain items, in addition to the information required by Subsection (b) of this section.

(d) Requires an HMO that becomes aware of any information that indicates the delegated entity is not operating in accordance with its written agreement or is operating in a condition that renders the continuance of its business hazardous to the enrollees, to take certain actions.

(e) Requires a delegated entity to respond to a request from an HMO under Subsection (d) of this section in writing not later than the 30th day after the date the request is received.

(f) Makes a conforming change.

(g) Authorizes the department, on receipt of a notice under Subsection (d) of this section, or if complaints are filed with the Texas Department of Insurance, to examine the matters contained in the notice as well as any other matter relating to the financial solvency of the delegated entity or the delegated entity's ability to meet its responsibilities in connection with any function delegated to the entity by the HMO. Deletes language regarding financial and operational documents, on site audit and violation of a monitoring plan.

(h) Requires the Texas Department of Insurance, except as provided by this subsection, on completion of the department's examination, to report to the delegated entity and the HMO results of the department's examination and any action the department determines is necessary

to ensure that the health maintenance organization meets its responsibilities under this Act, the Insurance Code, any other insurance laws of this state, and rules adopted by the commissioner, and that the delegated entity can meet its responsibilities in connection with any function delegated to the entity by the health maintenance organization. Prohibits the department from reporting to the HMO any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

(i) Requires the delegated entity and the HMO to respond to the department's report and submit a corrective plan to the Texas Department of Insurance not later than the 30th day after the date of receipt of the department's report. Deletes language regarding withholding of information.

(j) Requires reports and corrective plans required under Subsection (h) or (i) of this section to be treated as public documents, except that health care provider fee schedules, prices, costs of care, or other information not relevant to the monitoring plan and any other information that is considered confidential by law shall be considered confidential.

(k) Authorizes the department to request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that relate to any matters delegated by the health maintenance organization to the delegated entity or are necessary to ensure the health maintenance organization's compliance with statutory and regulatory requirements.

(l) Authorizes the commissioner, regardless of whether a delegated entity complies with a request for corrective action, to order the health maintenance organization to take any action the commissioner determines is necessary to ensure that the health maintenance organization is in compliance with this Act, including certain actions.

(m) Requires the department to maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities. Requires the department to periodically issue a report on the complaints received by the department that includes a list of complaints by category, by action taken on the complaint, and by entity or network name and type. Requires the department to make the report available to the public and to include information to assist the public in evaluating the information contained in the report.

(n) Authorizes the commissioner, notwithstanding any other provision of this Act, the Insurance Code, or any other insurance law of this state, to suspend or revoke the license of any third party administrator or utilization review agent that fails to comply with this section.

(o) Authorizes the commissioner to impose sanctions or penalties under Chapters 82, 83, and 84, Insurance Code, against a health maintenance organization that does not provide timely information required by Subsections (b) and (c) of this section.

(p) Requires an HMO to by contract establish penalties for delegated entities that do not provide timely information required under a monitoring plan as required by Subsection (a)(1) of this section.

(q) Provides that this section does not apply to a group model HMO, as defined by Section 6A of this Act.

(r) Authorizes the commissioner to adopt rules as necessary to implement this section.

SECTION 5. Amends The Texas Health Maintenance Organization Act (Chapter 20A, V.T.I.C.) by adding Sections 18D, 18E, 18F, and 18G as follows:

Sec. 18D. RESERVE REQUIREMENTS FOR DELEGATED NETWORK. (a) Requires a delegated network to establish and maintain reserves that are adequate for the liabilities and risks assumed by the delegated network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks reserved for, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Requires the dedicated network, except as provided by Subsections (c) and (d), to establish and maintain reserves as described by Subsection (e)(1) or (2) only with respect to the portion of services assumed under the delegation agreement that are not within the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(c) Requires the dedicated network, if the scope of services assumed under the delegation agreement includes both medical care and hospital or institutional services, to establish and maintain reserves that are adequate to cover the liabilities and risks associated with medical care or with hospital or institutional services, whichever type of services has been allocated the largest portion of the premium by the health maintenance organization.

(d) Requires the network, if the delegated network assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, to establish and maintain reserves that are adequate to cover the liabilities and risks associated with the prescription drug benefits, in addition to any other reserves required under this section.

(e) Requires a delegated network to maintain financial reserves equal to the greater of 80 percent of the risk and liabilities that must be reserved under this section and that have been incurred but not paid by the delegated network or two months of premium amount assumed by the delegated network for services that must be reserved under this section.

(f) Requires the reserves required under this section to be secured by and only consist of legal tender of the United States or bonds of the United States or this state. Requires the reserves to be held at a financial institution in this state that is chartered by the United States or this state. Requires the reserves to be held in trust for, for the benefit of, or to provide health care services to, enrollees of the health maintenance organization under the agreement between the health maintenance organization and the delegated network.

(g)(1) Requires a delegated network required to establish and maintain reserves under this section to establish an escrow account for the payment of claims and deposit such reserves into the escrow account upon providing notice of its intent to terminate or non-renew a contract through which the delegated network assumed liabilities and risks from an HMO. Requires that upon the establishment of the escrow account, the delegated network notify the commissioner.

(2) Requires a delegated network required to establish and maintain reserves under this section to establish an escrow account for the payment of claims and deposit such reserves into the escrow account upon the modification of a contract through which the delegated network assumed liabilities and risks from a HMO if the modified contract eliminates the liabilities and risks previously assumed by the delegated network. Requires that upon the establishment of the escrow account, the delegated network notify the commissioner.

(2) Requires that 270 days after the date the reserves are deposited into the escrow account, the delegated network be entitled to the release of the remaining amount held in escrow.

(3) Requires the amounts released from the escrow account to be distributed to those individuals who contributed to the reserves deposited into escrow in proportion to the individuals' total contribution.

(4) Requires the commissioner to, and provides that hte commissioner has the authority to, take any action necessary to ensure the release of any amounts remaining in escrow in excess of the 270th day time period in subsection (g)(2).

(h) Provides that this section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Sec. 18E. CERTAIN PHYSICIAN AND PROVIDER CONTRACTS; CONTINUITY OF CARE FOR CERTAIN ENROLLEES. (a) Defines "special circumstance."

(b) Requires each contract between a health maintenance organization and a limited provider network or delegated entity to require that each contract between the network or entity and a physician or provider meet certain requirements.

(c) Requires a special circumstance to be identified by the treating physician or provider, who must request that the enrollee be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still in the limited provider network or delegated entity.

(d) Requires that contracts between a limited provider network or delegated entity and physicians or providers provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

(e) Provides that this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. Provides however that the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Sec. 18F. OUT-OF-NETWORK SERVICES OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY. (a) Requires each contract between a HMO and a limited provider network or delegated entity to provide that if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity must, on request of a network physician or provider, allow a referral to a non-network physician or provider and shall fully reimburse the non-network provider at the usual and customary or an agreed-upon rate.

(b) Requires the referral to be allowed within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not later than the fifth business day after the date any reasonably requested documentation is received by the limited provider network or delegated entity.

(c) Provides that the enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or delegated entity.

(d) Requires each contract to also provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the limited provider network or delegated entity may deny a referral.

(e) Provides that a denial of out-of-network services under this section is subject to appeal under Article 21.58A, Insurance Code.

Sec. 18G. COMPLIANCE OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY WITH CERTAIN REQUIREMENTS. Requires a limited provider network or delegated entity to comply with all statutory and regulatory requirements relating to any function, duty, responsibility, or delegation assumed by or carried out by the limited provider network or delegated entity under this Act.

SECTION 6. Repealer: Section 5, Chapter 621, Acts of the 76th Legislature, Regular Session, 1999 (regarding Section 2, Texas Health Maintenance Organization Act).

SECTION 7. Makes application of this Act prospective to January 1, 2002.

SECTION 8. Effective date: September 1, 2001.

SUMMARY OF COMMITTEE CHANGES

SECTION 4. Amends Engrossed H.B. 2828 by amending proposed language in subsection (j).

SECTION 5. Amends Engrossed H.B. 2828 by adding new language to Subsection (g) and adding new Subsection (h).