Sec. 847.002. LEGISLATIVE FINDINGS; PURPOSES. The legislature finds that to ensure enrollees high quality care, many health benefit plan issuers voluntarily undergo a rigorous accreditation process conducted by nationally recognized accreditation organizations. To maintain accreditation, these health benefit plan issuers are subject to continuing review of their processes and standards. The legislature recognizes that many of these processes and standards are also reviewed by state agencies, resulting in increased agency costs and increased health benefit plan administrative costs. The purpose of this chapter is to allow appropriate recognition of accreditation by nationally recognized accreditation organizations and to foster coordination among state agencies in order to:

(1) help make health benefit plan coverage more affordable for consumers; and

(2) eliminate duplication of effort by both health benefit plan issuers and state agencies.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.003. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission.

(2) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or an individual
or group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) Medicare services under a federal contract;

(E) Medicare supplement and Medicare Select benefit plans regulated in accordance with federal law;

(F) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(G) workers' compensation insurance coverage or similar insurance coverage;

(H) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(I) hospital indemnity or other fixed indemnity insurance coverage;

(J) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(K) short-term major medical contracts;

(L) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

(M) coverage for on-site medical clinics;

(N) coverage that provides other limited benefits specified by federal regulations;

(O) coverage that provides limited scope dental
or vision benefits; or

(P) other coverage that:

   (i) is similar to the coverage described by
   this subdivision under which benefits for medical care are
   secondary or incidental to other coverage benefits; and

   (ii) is specified by federal regulations.

(3) "National accreditation organization" means:

   (A) the Accreditation Association for Ambulatory
   Health Care;

   (B) the Joint Commission on Accreditation of
   Healthcare Organizations;

   (C) the National Committee for Quality
   Assurance;

   (D) the American Accreditation HealthCare
   Commission ("URAC"); or

   (E) any other national accreditation entity
   recognized by rules jointly adopted by the commissioner of
   insurance and the executive commissioner of the commission.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June
17, 2005.

Sec. 847.004. APPLICABILITY OF CHAPTER. This chapter
applies only to an entity that issues a health benefit plan and that
holds a license or certificate of authority issued by the
commissioner and provides benefits for medical or surgical expenses
incurred as a result of a health condition, accident, or sickness,
including:

(1) an insurance company;

(2) a group hospital service corporation operating
under Chapter 842;

(3) a health maintenance organization operating under
Chapter 843;

(4) an approved nonprofit health corporation that
holds a certificate of authority issued by the commissioner under
Chapter 844;

(5) a multiple employer welfare arrangement that holds
a certificate of authority under Chapter 846;
Sec. 847.005. PRESUMED COMPLIANCE WITH CERTAIN STATUTORY AND REGULATORY REQUIREMENTS. (a) A health benefit plan issuer is presumed to be in compliance with state statutory and regulatory requirements if:

(1) the health benefit plan issuer has received nonconditional accreditation by a national accreditation organization; and

(2) the national accreditation organization's accreditation requirements are the same, substantially similar to, or more stringent than the department's statutory or regulatory requirements.

(b) A health benefit plan issuer that offers a Medicare Advantage coordinated care plan under a contract with the federal Centers for Medicare and Medicaid Services is presumed to be in compliance with any state statutory and regulatory requirements that are the same, substantially similar to, or more stringent than the requirements for Medicare Advantage coordinated care plans, as determined by the commissioner.

(c) If the department determines that a health benefit plan issuer is in compliance with a state statutory or regulatory requirement, the commission may presume that a Medicaid or state child health plan program managed care plan offered by a health benefit plan issuer under contract with the commission is in compliance with any contractual Medicaid or state child health plan program managed care plan requirement that is the same as, substantially similar to, or more stringent than the state statutory or regulatory requirement, as determined by the commission.

(d) The commissioner may take appropriate action, including
imposition of sanctions under Chapter 82, against a health benefit plan issuer who is presumed under Subsection (a), (b), or (c) to be in compliance with state statutory and regulatory requirements but does not maintain compliance with the same, substantially similar, or more stringent requirements applicable to the issuer under Subsection (a), (b), or (c).

(e) The department shall monitor and analyze periodically as prescribed by rule by the commissioner updates and amendments made to national accreditation standards as necessary to ensure that those standards remain the same, substantially similar to, or more stringent than the department's statutory or regulatory requirements.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.006. FILING OF ACCREDITATION REPORT; CONFIDENTIALITY REQUIREMENTS. (a) The commissioner may require a health benefit plan issuer to submit to the commissioner the accreditation report issued by the national accreditation organization.

(b) An accreditation report submitted under Subsection (a) is proprietary and confidential information under Chapter 552, Government Code, and is not subject to subpoena. The commissioner shall limit the disclosure of the accreditation report to those department employees who need the accreditation report to perform the duties of their job. A department employee may not further disclose the accreditation report.

(c) The national accreditation organization recommendations summary results are not proprietary information and are subject to public disclosure under Chapter 552, Government Code.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.007. DUTIES OF COMMISSIONER OF INSURANCE. (a) In conducting an examination of a health benefit plan issuer, the commissioner:
(1) shall accept the accreditation report submitted by
the health benefit plan issuer as a prima facie demonstration of the
issuer's compliance with the processes and standards for which the
issuer has received accreditation; and

(2) may adopt relevant findings in a health benefit
plan issuer's accreditation report in the examination report if the
accreditation report complies with applicable state and federal
requirements regarding the nondisclosure of proprietary and
confidential information and personal health information.

(b) Subsection (a) does not apply to any process or standard
of a health benefit plan issuer that is not covered as part of the
issuer's accreditation. This section does not set minimum quality
standards but operates only as a replacement of duplicate
requirements.

(c) The commissioner may by rule determine the application
of compliance with national accreditation requirements by a
delegated entity, delegated third party, or utilization review
agent to compliance by the health benefit plan issuer that
contracts with the delegated entity, delegated third party, or
agent.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June
17, 2005.

Sec. 847.008. COMMISSION DUTIES. (a) The commission may
require the commissioner to submit to the commission the documents
reviewed by the department that substantiate the compliance of the
health benefit plan issuer with applicable state statutory and
regulatory requirements.

(b) Documents submitted under Subsection (a) are
proprietary and confidential information under Chapter 552,
Government Code, and are not subject to subpoena. The commission
shall limit disclosure of the documents to commission employees who
need the documentation to perform the duties of their job. A
commission employee may not further disclose the compliance
documents.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June
17, 2005.
Sec. 847.009. MEMORANDUM OF UNDERSTANDING. The commissioner and the commission must enter into a memorandum of understanding to specify the responsibilities of the department and the commission under this chapter.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.010. ENFORCEMENT. This chapter may not be construed to prohibit the commissioner or the commission from enforcing laws or rules relating to:

(1) the operation of a health benefit plan; or
(2) violation of a contract.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.