By: Bonnen H.B. No. 3195

A BILL TO BE ENTITLED

AN ACT

relating to conduct of insurers providing preferred provider benefit plans with respect to physician and health care provider contracts and claims.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Sections 1301.066 and 1301.103, Insurance Code, are amended to read as follows:

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. (a) An insurer may not engage in any retaliatory action against a physician or health care provider[~~, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract,~~] because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer.

(b) A retaliatory action under Subsection (a) includes:

(1) terminating the physician's or provider's participation in the preferred provider benefit plan;

(2) refusing to renew the physician's or provider's contract;

(3) implementing measurable penalties in the contract negotiation process;

(4) engaging in an unfair or deceptive practice,

including not listing the physician or provider in the network directory or requiring the physician or provider to submit medical records with each claim;

(5) arbitrarily reducing the physician's or provider's fees on the insurer's fee schedule; and

(6) otherwise making changes to material contractual terms that are adverse to the physician or provider.

(c) Subsections (b)(3)-(6) do not apply to a freestanding emergency medical care facility.

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. (a) Except as provided by Sections 1301.104 and 1301.1054, not later than the 45th day after the date an insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date an insurer receives a clean claim from a preferred provider that is electronically submitted, the insurer shall make a determination of whether the claim is payable and:

(1) if the insurer determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) if the insurer determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not payable, notify the preferred provider in writing why the claim will not be paid.

(b) An insurer shall provide notice under Subsection (a)

electronically if the preferred provider's clean claim was electronically submitted and the provider is not a freestanding emergency medical care facility.

SECTION 2. Section 1301.105, Insurance Code, is amended by amending Subsection (d) and adding Subsection (e) to read as follows:

(d) If the preferred provider does not supply information reasonably requested by the insurer in connection with the audit, the insurer shall or, if the provider is a freestanding emergency medical care facility, may:

(1) notify the provider in writing that the provider must provide the information not later than the 45th day after the date of the notice or forfeit the amount of the claim; and

(2) if the provider does not provide the information required by this section, recover the amount of the claim.

(e) An insurer shall make a request or provide information under this section electronically if the preferred provider's clean claim was electronically submitted and the provider is not a freestanding emergency medical care facility.

SECTION 3. Sections 1301.1051 and 1301.1052, Insurance Code, are amended to read as follows:

Sec. 1301.1051. COMPLETION OF AUDIT. (a) The insurer must complete an audit under Section 1301.105 on or before the 180th day after the date the clean claim is received by the insurer, and any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the completion of the audit.

(b) An insurer may not recover a payment on an audited claim until a final audit is completed if the claim was submitted by a preferred provider other than a freestanding emergency medical care facility.

(c) An insurer shall provide written notice to the preferred provider, other than a freestanding emergency medical care facility, of the insurer's failure to complete an audit in the time required by Subsection (a) not later than the 15th day after the date on which the insurer is required to complete the audit under that subsection.

Sec. 1301.1052. PREFERRED PROVIDER APPEAL AFTER AUDIT. (a) If a preferred provider disagrees with a refund request made by an insurer based on an audit under Section 1301.105, the insurer shall provide the provider with an opportunity to appeal in accordance with this section, and the insurer may not attempt to recover the payment until all appeal rights are exhausted.

(b) An insurer shall provide a reasonable mechanism for an appeal requested under Subsection (a) by a preferred provider other than a freestanding emergency medical care facility. The review mechanism must incorporate, in an advisory role only, a review panel.

(c) A review panel described by Subsection (b) must be composed of at least three preferred provider representatives of the same or similar specialty as the affected preferred provider selected by the insurer from a list of preferred providers. The preferred providers contracting with the insurer in the applicable service area shall provide the list of preferred provider

representatives to the insurer.

(d) On request and if applicable, the insurer shall provide to the affected preferred provider:

(1) the panel's composition and recommendation; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

SECTION 4. Subchapter C, Chapter 1301, Insurance Code, is amended by adding Section 1301.10525 to read as follows:

Sec. 1301.10525. DEPARTMENT REVIEW OF AUDITS. (a) The commissioner by rule shall establish procedures for a preferred provider, other than a freestanding emergency medical care facility, to submit a request for the department to review an audit conducted by an insurer under this subchapter. The department review of an audit is a contested case under Chapter 2001, Government Code.

(b) If the department determines that an audit for which a preferred provider requested review under Subsection (a) resulted in unreasonable costs for the preferred provider, unnecessarily delayed or prevented payment of a claim, or otherwise violated this subchapter or rules adopted under this subchapter, the department shall:

(1) award compensatory damages to the preferred provider incurred as a result of the audit; and

(2) order the insurer to pay to the department the costs incurred by the department in reviewing the audit.

SECTION 5. Section 1301.132, Insurance Code, is amended by

adding Subsections (c), (d), and (e) to read as follows:

(c) An insurer shall provide a reasonable mechanism for an appeal requested under Subsection (b) by a physician or health care provider other than a freestanding emergency medical care facility. The review mechanism must incorporate, in an advisory role only, a review panel.

(d) A review panel described by Subsection (c) must be composed of at least three preferred provider representatives of the same or similar specialty as the affected preferred provider selected by the insurer from a list of preferred providers. The preferred providers contracting with the insurer in the applicable service area shall provide the list of preferred provider representatives to the insurer.

(e) On request and if applicable, the insurer shall provide to the affected preferred provider:

(1) the panel's composition and recommendation; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

SECTION 6. (a) The changes in law made by this Act apply to a claim for payment made on or after the effective date of this Act unless the claim is made under a contract that was entered into before the effective date of this Act and that, at the time the claim is made, has not been renewed or was last renewed before the effective date of this Act.

(b) A claim made before the effective date of this Act or made on or after the effective date of this Act under a contract

described by Subsection (a) of this section is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 7. This Act takes effect September 1, 2023.