

By: Dukes

H.B. No. 2279

A BILL TO BE ENTITLED

AN ACT

1  
2 relating to the adequacy of health maintenance organization health  
3 care delivery networks and availability of preferred provider  
4 benefits; providing penalties.

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

6 SECTION 1. Subchapter D, Chapter 843, Insurance Code is  
7 amended by adding Section 843.114 to read as follows:

8 Sec. 843.114. ADEQUACY OF HEALTH MAINTENANCE ORGANIZATION  
9 DELIVERY NETWORK. (a) All covered services that are offered by the  
10 health maintenance organization shall be sufficient in number and  
11 location to be readily available and accessible within the service  
12 area to all enrollees.

13 (b) A health maintenance organization shall make general,  
14 special, and psychiatric hospital care available and accessible 24  
15 hours per day, seven days per week, within the health maintenance  
16 organization's service area.

17 (c) Health maintenance organizations must arrange for  
18 covered health care services, including referrals to specialists,  
19 to be accessible to enrollees on a timely basis upon request and  
20 consistent with guidelines set out in paragraphs (1)-(3) of this  
21 subsection:

22 (1) Urgent care shall be available within 24 hours for  
23 medical, dental, and behavioral health conditions.

24 (2) Routine care shall be available:

1                   (A) within three weeks for medical conditions;  
2                   (B) within eight weeks for dental conditions; and  
3                   (C) within two weeks for behavioral health  
4 conditions.

5                   (3) Preventive health services shall be available:

6                   (A) within two months for a child 16 years of age  
7 or younger;

8                   (B) within three months for an adult; and

9                   (C) within four months for dental services.

10                  (d) All covered services must be accessible and available so  
11 that travel distances from any point in its service area to a point  
12 of service are no greater than:

13                   (1) 30 miles for primary care and general hospital  
14 care; and

15                   (2) 75 miles for specialty care.

16                  (e) The HMO shall not be required to expand services outside  
17 its service area to accommodate enrollees who live outside the  
18 service area, but work within the service area.

19                  (f) There shall be a sufficient number of primary care  
20 physicians and specialists with privileges in each participating  
21 hospital within the health maintenance organization delivery  
22 network who are available and accessible 24 hours per day, seven  
23 days per week, within the health maintenance organization's service  
24 area to meet the health care needs of the health maintenance  
25 organization's enrollees.

26                   (1) The number of primary care physicians and  
27 specialists at a participating hospital is not sufficient to meet

1 the health care needs of the health maintenance organization's  
2 enrollees if any of the following conditions are present:

3 (A) the health maintenance organization does not  
4 have a contractual relationship with all physicians or physician  
5 groups providing medical services pursuant to exclusive  
6 arrangements between the participating hospital and physicians or  
7 physician groups;

8 (B) the health maintenance organization does not  
9 have a contractual relationship with all physicians or physician  
10 groups who are compensated by the participating hospital for  
11 emergency room call coverage; or

12 (C) the health maintenance organization does not  
13 have a contractual relationship with a particular physician or  
14 particular physician group exclusively providing specialty medical  
15 services in a participating hospital by the virtue of being the only  
16 such specialist or specialist group practicing within the general  
17 geographic area around the participating hospital.

18 (g) If a health maintenance organization limits enrollees'  
19 access to a limited provider network, it must ensure that such  
20 limited provider network complies with the provisions of this  
21 section.

22 (h) Except as provided in Chapter 1456, in addition to any  
23 corrective action plan the department may require, a health  
24 maintenance organization shall be subject to an administrative  
25 penalty for failure to meet the requirements of subsection (f).  
26 Each day the health maintenance organization delivery network fails  
27 to meet the requirements of subsection (f) is a separate violation.

1 SECTION 2. Subchapter D, Chapter 1271, Insurance Code,  
2 Section 1271.055, as effective April 1, 2005 is amended to read as  
3 follows:

4 Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence  
5 of coverage must contain a provision regarding non-network  
6 physicians and providers in accordance with the requirements of  
7 this section.

8 (b) If medically necessary covered services are not  
9 available through network physicians or providers, the health  
10 maintenance organization, on the request of a network physician or  
11 provider and within a reasonable period, shall:

12 (1) allow referral to a non-network physician or  
13 provider; and

14 (2) fully reimburse the non-network physician or  
15 provider the amount as submitted on the claim by the non-network  
16 physician or provider [~~at the usual and customary rate or at an~~  
17 ~~agreed rate~~].

18 (c) Before denying a request for a referral to a non-network  
19 physician or provider, a health maintenance organization must  
20 provide for a review conducted by a specialist of the same or  
21 similar type of specialty as the physician or provider to whom the  
22 referral is requested.

23 (d) If medical services are provided by a non-network  
24 physician within a hospital participating in the health maintenance  
25 organization delivery network, the health maintenance organization  
26 shall fully reimburse the non-network physician or provider the  
27 amount as submitted on the claim by the non-network physician or

1 provider.

2 (1) This subsection shall not be construed to limit or  
3 modify the enforceability of Section 552.003, regarding charging of  
4 different prices.

5 SECTION 3. Subchapter D, Chapter 1271, Insurance Code,  
6 Section 1271.155 as effective April 1, 2005 is amended to read as  
7 follows:

8 Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance  
9 organization shall pay for emergency care performed by non-network  
10 physicians or providers at the amount as submitted on the claim  
11 ~~[usual and customary rate or at an agreed rate]~~.

12 (b) A health care plan of a health maintenance organization  
13 must provide the following coverage of emergency care:

14 (1) a medical screening examination or other  
15 evaluation required by state or federal law necessary to determine  
16 whether an emergency medical condition exists shall be provided to  
17 covered enrollees in a hospital emergency facility or comparable  
18 facility;

19 (2) necessary emergency care shall be provided to  
20 covered enrollees, including the treatment and stabilization of an  
21 emergency medical condition; and

22 (3) services originated in a hospital emergency  
23 facility or comparable facility following treatment or  
24 stabilization of an emergency medical condition shall be provided  
25 to covered enrollees as approved by the health maintenance  
26 organization, subject to Subsections (c) and (d).

27 (c) A health maintenance organization shall approve or deny

1 coverage of poststabilization care as requested by a treating  
2 physician or provider within the time appropriate to the  
3 circumstances relating to the delivery of the services and the  
4 condition of the patient, but not to exceed one hour from the time  
5 of the request.

6 (d) A health maintenance organization shall respond to  
7 inquiries from a treating physician or provider in compliance with  
8 this provision in the health care plan of the health maintenance  
9 organization.

10 (e) A health care plan of a health maintenance organization  
11 shall comply with this section regardless of whether the physician  
12 or provider furnishing the emergency care has a contractual or  
13 other arrangement with the health maintenance organization to  
14 provide items or services to covered enrollees.

15 (f) Nothing in this section shall be construed to limit or  
16 modify the enforceability of Section 552.003, regarding charging  
17 different prices.

18 SECTION 4. Subchapter A, Chapter 1301, Insurance Code,  
19 Section 1301.005, as effective April 1, 2005 is amended to read as  
20 follows:

21 Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a)  
22 An insurer offering a preferred provider benefit plan shall ensure  
23 that both preferred provider benefits and basic level benefits are  
24 reasonably available to all insureds within a designated service  
25 area.

26 (b) If services are not available through a preferred  
27 provider within the service area or if services are provided by

1 nonpreferred providers within a preferred provider hospital, an  
2 insurer shall reimburse a physician or health care provider who is  
3 not a preferred provider at the same percentage level of  
4 reimbursement as a preferred provider would have been reimbursed  
5 had the insured been treated by a preferred provider.

6 (c) Subsection (b) does not require reimbursement at a  
7 preferred level of coverage solely because an insured resides out  
8 of the service area and chooses to receive services from a provider  
9 other than a preferred provider for the insured's own convenience.

10 (d) Preferred provider benefits are not reasonably  
11 available within a designated service area if any of the following  
12 conditions are present:

13 (1) the preferred provider benefit plan does not have  
14 a contractual relationship with all physicians or physician groups  
15 providing medical services pursuant to exclusive arrangements  
16 between the preferred provider hospital and physicians or physician  
17 groups;

18 (2) the preferred provider benefit plan does not have  
19 a contractual relationship with all physicians or physician groups  
20 who are compensated by a preferred provider hospital for emergency  
21 room call coverage; or

22 (3) the preferred provider benefit plan does not have  
23 a contractual relationship with a particular physician or  
24 particular physician group exclusively providing specialty medical  
25 services in a preferred provider hospital by the virtue of being the  
26 only such specialist or specialist group practicing within the  
27 general geographic area around the preferred provider hospital.

1       (e) Reimbursement for services provided by a nonpreferred  
2 provider pursuant to this section shall be calculated based solely  
3 upon the unadjusted amount as submitted on the claim by the  
4 nonpreferred provider.

5       (f) Except as provided in Chapter 1456, in addition to any  
6 corrective action plan the department may require, a preferred  
7 provider benefit plan shall be subject to an administrative penalty  
8 for failure to meet the requirements of subsection (d). Each day  
9 the preferred provider benefit plan fails to meet the requirements  
10 of subsection (d) is a separate violation.

11       (g) Nothing in this section shall be construed to limit or  
12 modify the enforceability of Section 552.003, regarding charging  
13 different prices.

14       SECTION 5. Title 8, Texas Insurance Code is amended by  
15 adding Chapter 1456 to read as follows:

16               CHAPTER 1456. MANDATORY MEDIATION.

17       Section 1456.001. DEFINITIONS. In this chapter:

18       (a) "Consensus Panel" is a panel of three mediators that  
19 facilitates the agreement of the parties.

20       (b) "Health Plan" means a health maintenance organization  
21 or preferred provider benefit plan authorized to do business in  
22 this state.

23       (c) "Mediation" means a process in which an impartial  
24 consensus panel facilitates and promotes voluntary agreement  
25 between the parties in regard to participation in a health care  
26 delivery network.

27       (1) Except as provided in Section 1456.008, a mediator



1 may not impose his own judgement on the issues for that of the  
2 parties.

3  
4 (d) "Mediator" means an impartial person who is appointed as  
5 a member of the consensus panel.

6 (e) "Parties" or "Party" means the health plan and/or the  
7 physician or physician group participating in the mediation.

8 Section 1456.002. QUALIFICATIONS OF MEDIATOR. (a) Except  
9 as provided by subsections (b), to qualify for an appointment as a  
10 mediator under this chapter a person must have completed a minimum  
11 of 40 classroom hours of training in dispute resolution techniques  
12 in a course conducted by an alternative dispute resolution system  
13 or other dispute resolution organization approved by the  
14 commissioner.

15 (b) A person otherwise not qualified as a mediator may be  
16 appointed upon the agreement of the parties.

17 Section 1456.003. COMPOSITION OF CONSENSUS PANEL; FEES.

18 (a) A consensus panel shall be comprised of a total of three  
19 mediators as follows:

20 (1) One mediator appointed by the health plan;

21 (2) One mediator appointed by the physician or  
22 physician group; and

23 (3) One mediator, who shall act as chair of the  
24 consensus panel, appointed by the mediators appointed by the health  
25 plan and physician group.

26 (b) Should the mediators appointed by the parties be unable  
27 to agree on the appointment of the third mediator, the commissioner

1 shall make a random assignment from a list of qualified mediators  
2 maintained by the department.

3 (c) All costs of the mediation and mediators shall be paid  
4 by the health plan requesting mandatory mediation.

5 Sec. 1456.004. NOTICE OF MANDATORY MEDIATION. (a) To  
6 facilitate compliance with Sections 843.114(f) or 1301.005(d), a  
7 health plan may request mandatory mediation, pursuant to this  
8 chapter.

9 (b) The notice of request for mandatory mediation shall be  
10 provided on a form adopted by the commissioner and shall include the  
11 following:

12 (1) The name of the health plan requesting mediation;

13 (2) A brief description of the mediation process;

14 (3) A statement informing the physician or physician  
15 group at a participating hospital of the health plan's reasons for  
16 requesting mandatory mediation;

17 (4) Contact information, including a telephone  
18 number, for the person(s) responsible at the health plan for  
19 initiating the mediation; and

20 (5) Any other information the commissioner may require  
21 by rule.

22 (c) The notice of request for mandatory mediation shall be  
23 provided to the commissioner and the physician or physician group  
24 in question.

25 Sec. 1456.005. CONDUCT AT MEDIATION. Mediation shall be  
26 conducted as follows:

27 (1) Mediation sessions are under the control of the

1 consensus panel;

2 (2) Except as provided in Sections 1456.006 and  
3 1456.008, the consensus panel must hold in strict confidence all  
4 information provided by the parties to the mediation as well as the  
5 communications of the parties during the mediation;

6 (3) All parties must have the opportunity to speak and  
7 state their positions; and

8 (4) Legal counsel may be present to represent and  
9 advise clients regarding legal rights and the implication of  
10 suggested solutions.

11 Sec. 1456.006. MEDIATION AGREEMENT. (a) If the parties  
12 involved in mediation reach tentative agreement, the consensus  
13 panel shall provide information for the preparation of a mediation  
14 agreement.

15 (b) After the consensus panel marshals the information and  
16 the details of the agreement are reviewed and approved by all  
17 agreeing parties, the parties shall agree upon the person who is to  
18 prepare the actual document.

19 (c) Those parties who do not reach agreement may request  
20 another mediation session, although the request may be declined by  
21 either party.

22 (1) The request may be made in writing or verbally to  
23 any mediator on the consensus panel and may include a request for  
24 extension of time.

25 (d) Notwithstanding any other law, if the parties agree that  
26 a mediated solution is not possible or are unable to come to an  
27 agreement, the consensus panel shall report to the commissioner

1 that the mediation failed to produce an agreement.

2 Section. 1456.007. Mitigation. A health plan that requests  
3 mandatory mediation as provided by this Chapter and is not reported  
4 for bad faith negotiation, as provided by Section 1456.008, is not  
5 subject to administrative penalties for violation of Texas  
6 Insurance Code Sections 843.114(f)(1) or 1301.005(d).

7 Section 1456.008. Bad Faith. (a) Bad faith negotiation is:

8 (1) A failure to attend the mediation;

9 (2) A failure to provide information the consensus  
10 panel believes is necessary to facilitate an agreement;

11 (3) A failure to designate a representative present at  
12 the mediation with full authority to enter into any mediated  
13 agreement; or

14 (4) An insistence on a contract of adhesion in a  
15 mediation.

16 (b) Failure to reach an agreement is not conclusive proof of  
17 bad faith negotiation.

18 (c) Notwithstanding any other law, a consensus panel shall  
19 report bad faith negotiation to the commissioner or the Texas  
20 Medical Board, as appropriate, following the conclusion of the  
21 mediation.

22 (d) Bad faith negotiation is grounds for imposition of an  
23 administrative penalty by the regulatory agency that issued a  
24 license or certificate of authority to the party who committed the  
25 violation.

26 (e) Upon a report of consensus panel and appropriate proof  
27 of bad faith negotiation, the regulatory agency that issued the

1 license or certificate of authority shall impose the maximum  
2 administrative penalty the licensing statute provides.

3 (1) For the purpose of this subsection, in those  
4 circumstances where a physician group is found to have engaged in  
5 bad faith negotiation, an administrative penalty shall be imposed  
6 upon each non-employee member of the physician group. An  
7 independent contractor shall not be considered a member of a  
8 physician group.

9 Section 1456.009. Rules. The commissioner shall adopt  
10 rules as necessary to implement this chapter.

11 SECTION 6. The changes in law made by this Act apply only to  
12 a health insurance policy or evidence of coverage issued or renewed  
13 on or after the effective date of this Act. Health insurance  
14 policies or evidences of coverage issued before the effective date  
15 of this Act are governed by the law in effect immediately before the  
16 effective date of this Act, and that law is continued in effect for  
17 that purpose. Provided, however, that all health insurance policies  
18 or evidences of coverage issued in this state shall be governed by  
19 the changes in law made by this Act eighteen months after the  
20 effective date of this Act.

21 SECTION 7. This Act takes effect September 1, 2005.