By: Smithee H.B. No. 2299

A BILL TO BE ENTITLED

AN ACT

relating to the payment of physicians and providers who do not have contractual relationships with a preferred provider benefit plan or a health maintenance organization.

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

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

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

(b) If services are not available through a preferred provider within the service area <u>or if services are provided by nonpreferred providers within a preferred provider hospital</u>, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

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

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

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

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

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

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

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

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

(d) If medical services are provided by a non-network physician or provider within a network provider hospital, the

health maintenance organization shall fully reimburse the non-network physician or provider the amount as submitted on the claim by the non-network physician or provider.

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

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

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

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

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

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

(c) A health maintenance organization shall approve or deny

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

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

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

SECTION 4. This Act takes effect September 1, 2005.