By: Deuell S.B. No. 1516

A BILL TO BE ENTITLED

AN ACT

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

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

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

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

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

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

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

(2) Routine care shall be available:

(A) within three weeks for medical conditions;

(B) within eight weeks for dental conditions; and

(C) within two weeks for behavioral health conditions.

(3) Preventive health services shall be available:

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

(B) within three months for an adult; and

(C) within four months for dental services.

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

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

(2) 75 miles for specialty care.

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

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

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

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

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

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

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

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

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

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

Sec. 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 within a hospital participating in the health maintenance organization delivery network, 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.

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

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 as submitted on the claim [~~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.

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

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

Sec. 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 or if services are provided by

nonpreferred providers within a preferred provider hospital, 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) Preferred provider benefits are not reasonably available within a designated service area if any of the following conditions are present:

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

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

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

(e) 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.

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

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

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

CHAPTER 1456. MANDATORY MEDIATION.

Section 1456.001. DEFINITIONS. In this chapter:

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

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

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

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

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

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

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

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

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

Section 1456.003. COMPOSITION OF CONSENSUS PANEL; FEES. (a) A consensus panel shall be comprised of a total of three mediators as follows:

(1) One mediator appointed by the health plan;

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

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

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

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

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

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

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

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

(2) A brief description of the mediation process;

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

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

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

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

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

(1) Mediation sessions are under the control of the

consensus panel;

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

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

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

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

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

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

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

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

that the mediation failed to produce an agreement.

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

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

(1) A failure to attend the mediation;

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

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

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

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

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

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

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

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

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

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

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

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