By: Dukes H.B. No. 664

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 a health maintenance organization must 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 a day, seven days a week, within the health maintenance organization's service area.

(c) A health maintenance organization shall arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis on request in accordance with the following guidelines:

(1) urgent care must be available within 24 hours for medical, dental, and behavioral health conditions;

(2) routine care must 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; and

(3) preventive health services must 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 the service area to a point of service do not exceed:

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

(2) 75 miles for specialty care.

(e) A health maintenance organization is not required to expand services outside the health maintenance organization's service area to accommodate enrollees who live outside the service area but work within the service area.

(f) A health maintenance organization must provide 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 a day, seven days a week, within the health maintenance organization's service area to meet the health care needs of the health maintenance organization's enrollees. 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 the health maintenance organization does not have a contractual relationship with:

(1) all physicians or physician groups providing medical services under exclusive arrangements between the participating hospital and physicians or physician groups;

(2) all physicians or physician groups who are compensated by the participating hospital for emergency room call coverage; or

(3) a particular physician or particular physician group exclusively providing specialty medical services in a participating hospital by virtue of being the only specialist or specialist group of that type practicing within the general geographic area around the participating hospital.

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

(h) Except as provided by Chapter 1456, in addition to any corrective action plan the department may require, a health maintenance organization is subject to an administrative penalty under Chapter 84 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. Section 1271.055, Insurance Code, is amended by amending Subsection (b) and adding Subsections (d), (e), and (f) to

read as follows:

(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 submitted on the claim by the non-network physician or provider [~~at the usual and customary rate or at an agreed rate~~].

(d) If medical services are provided by a non-network physician or provider 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 submitted on the claim by the non-network physician or provider.

(e) A physician or provider who submits a claim to and accepts payment from a health maintenance organization under Subsection (b) or (d) may not bill the enrollee for the services for which the claim was made.

(f) This section does not limit or modify the enforceability of:

(1) Section 552.003, regarding charging of different prices;

(2) Section 311.0025, Health and Safety Code, regarding audits of billing; or

(3) Section 164.053, Occupations Code, regarding unprofessional or dishonorable conduct.

SECTION 3. Section 1271.155, Insurance Code, is amended by amending Subsection (a) and adding Subsections (f) and (g) to read as follows:

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

(f) A physician or provider who submits a claim to and accepts payment from a health maintenance organization under Subsection (a) may not bill the enrollee for the services for which the claim was made.

(g) This section does not limit or modify the enforceability of:

(1) Section 552.003, regarding charging of different prices;

(2) Section 311.0025, Health and Safety Code, regarding audits of billing; or

(3) Section 164.053, Occupations Code, regarding unprofessional or dishonorable conduct.

SECTION 4. Section 1301.005, Insurance Code, is amended by amending Subsection (b) and adding Subsections (d)-(h) to read as follows:

(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.

(d) Preferred provider benefits are not reasonably available within a designated service area if the preferred provider benefit plan does not have a contractual relationship with:

(1) all physicians or physician groups providing medical services under exclusive arrangements between the preferred provider hospital and physicians or physician groups;

(2) all physicians or physician groups who are compensated by the preferred provider hospital for emergency room call coverage; or

(3) a particular physician or particular physician group exclusively providing specialty medical services in the preferred provider hospital by virtue of being the only specialist or specialist group of that type practicing within the general geographic area around the preferred provider hospital.

(e) Reimbursement and insured responsibility for services provided by a nonpreferred provider under this section shall be computed based solely on the unadjusted amount submitted on the claim by the nonpreferred provider.

(f) Except as provided by Chapter 1456, in addition to any corrective action plan the department may require, a preferred provider benefit plan is subject to an administrative penalty under Chapter 84 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) A nonpreferred provider who submits a claim to and accepts payment from an insurer under Subsection (e) may not bill the insured for the services for which the claim was made.

(h) This section does not limit or modify the enforceability of:

(1) Section 552.003, regarding charging of different prices;

(2) Section 311.0025, Health and Safety Code, regarding audits of billing; or

(3) Section 164.053, Occupations Code, regarding unprofessional or dishonorable conduct.

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

CHAPTER 1456. MANDATORY MEDIATION

Sec. 1456.001. DEFINITIONS. In this chapter:

(1) "Consensus panel" means a panel of three mediators that facilitates the agreement of the parties.

(2) "Health plan issuer" means a health maintenance organization or an insurer offering a preferred provider benefit plan that is authorized to engage in business in this state.

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

(4) "Mediator" means an impartial person who is

appointed as a member of the consensus panel.

(5) "Parties" or "party" means the health plan issuer or the physician or physician group participating in the mediation.

Sec. 1456.002. QUALIFICATIONS OF MEDIATOR. (a) Except as provided by this section, 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 not qualified as a mediator under this section may be appointed on the agreement of the parties.

(c) Except as provided by Section 1456.008, a mediator may not impose the mediator's own judgment on the issues for that of the parties.

Sec. 1456.003. COMPOSITION OF CONSENSUS PANEL; FEES. (a) A consensus panel is composed of:

(1) one mediator appointed by the health plan issuer;

(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:

(A) the mediators appointed under Subdivisions (1) and (2); or

(B) the commissioner, as provided by Subsection (b).

(b) If the mediators appointed by the parties are unable to

agree on the appointment of the third mediator, the commissioner shall make a random assignment from a list maintained by the department of qualified mediators.

(c) All costs of a mediation conducted under this chapter and the mediators shall be paid by the health plan issuer requesting the mediation.

Sec. 1456.004. REQUEST FOR AND NOTICE OF MANDATORY MEDIATION. (a) To facilitate compliance with Section 843.114(f) or 1301.005(d), a health plan issuer may request mandatory mediation under this chapter.

(b) Notice of a request for mandatory mediation must:

(1) be provided on a form adopted by the commissioner; and

(2) include:

(A) the name of the health plan issuer requesting mediation;

(B) a brief description of the mediation process;

(C) a statement informing the physician or physician group of the health plan issuer's reasons for requesting mandatory mediation;

(D) contact information, including a telephone number, for each of the health plan issuer's employees responsible for initiating the mediation; and

(E) any other information the commissioner requires by rule.

(c) The notice of request for mandatory mediation shall be provided to the commissioner and the affected physician or

physician group.

Sec. 1456.005. CONDUCT OF MEDIATION. (a) A mediation session under this chapter shall be conducted under the control of the consensus panel.

(b) Except as provided by Sections 1456.006 and 1456.008, the consensus panel shall hold in strict confidence all information provided by the parties to the mediation, including the communications of the parties during the mediation.

(c) Each party to the mediation must have the opportunity to speak and state the party's positions.

(d) Legal counsel for a party may be present to represent and advise the party regarding legal rights and the implications of suggested solutions.

(e) The first mediation session under this chapter may not take place before the 60th day after the date on which notice required by Section 1456.004 is received by the commissioner and the affected physician or physician group.

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

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

(c) Parties who do not reach agreement may request another mediation session or an extension of time for mediation in writing

or verbally to any mediator on the consensus panel. The request may be declined by either party.

(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.

Sec. 1456.007. MITIGATION. A health plan issuer that requests mandatory mediation under this chapter and is not reported for negotiating in bad faith under Section 1456.008 is not subject to administrative penalties for a violation of Section 843.114(f)(1), (2), or (3) or 1301.005(d).

Sec. 1456.008. BAD FAITH. (a) For the purposes of this chapter, a party negotiates in bad faith if the party:

(1) fails to:

(A) attend the mediation;

(B) provide information the consensus panel considers necessary to facilitate an agreement; or

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

(2) insists 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 by a health plan issuer to the commissioner and by a physician or physician group to the Texas Medical Board following the conclusion of the mediation.

(d) Bad faith negotiation is grounds for imposition of an administrative penalty by the commissioner or Texas Medical Board, as appropriate, on the party who committed the violation.

(e) On a report of the consensus panel and receipt of appropriate proof of bad faith negotiation, the commissioner or Texas Medical Board shall impose on the health plan issuer or physician or physician group the maximum administrative penalty provided by this code or the Occupations Code, as appropriate.

(f) For the purposes of Subsection (e), if the Texas Medical Board determines that a physician group has engaged in bad faith negotiation, the board shall impose an administrative penalty on each nonemployee member of the physician group. The total amount of penalties imposed on the nonemployee members in connection with the bad faith negotiation may not exceed $25,000. For the purposes of this subsection, an independent contractor is not considered a member of a physician group.

Sec. 1456.009. RULES. The commissioner shall adopt rules as necessary to implement this chapter.

SECTION 6. The change in law made by this Act applies only to a health insurance policy or evidence of coverage delivered, issued for delivery, or renewed on or after the effective date of this Act. A health insurance policy or evidence of coverage delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law in effect immediately before that date, and that law is continued in effect for that purpose.

SECTION 7. This Act takes effect September 1, 2007.