By: Rose H.B. No. 3568

A BILL TO BE ENTITLED

AN ACT

relating to the operation of certain health benefit plans.

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

SECTION 1. Section 843.108(c), Insurance Code, is amended to read as follows:

(c) Indemnity benefits for services provided under a point-of-service rider may be limited to those services defined in the evidence of coverage and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage, provided that the cost-sharing provisions may not exceed an amount that would effectively prohibit the use of out-of-network providers. For enrollees in a limited provider network, higher cost-sharing may be imposed only when benefits or services are obtained outside the health maintenance organization delivery network. A health maintenance organization may not restrict or penalize an enrollee for using an out-of-network provider other than by imposing higher cost-sharing.

SECTION 2. Subchapter E, Chapter 843, Insurance Code, is amended by adding Section 843.1511 to read as follows:

Sec. 843.1511. ADDITIONAL RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary and proper to regulate the premiums charged by health maintenance organizations

to employers and individuals.

SECTION 3. Section 843.306, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) A health maintenance organization may not terminate participation of a physician or provider because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers. A physician or provider that is terminated may bring an action in court to challenge the termination on the grounds that the termination was due to the physician's or provider's communication of physician and provider options to the enrollee. A court that finds that a physician or provider was terminated in violation of this subsection may award damages, order reinstatement of the physician or provider, and order other equitable relief considered appropriate by the court.

SECTION 4. Section 843.314(a), Insurance Code, is amended to read as follows:

(a) A health maintenance organization may not use a financial incentive, [~~or~~] make a payment to a physician or provider, or penalize a physician or provider, if the incentive, [~~or~~] payment, or penalty acts directly or indirectly as an inducement to limit medically necessary services.

SECTION 5. Section 843.348(c), Insurance Code, is amended to read as follows:

(c) If proposed health care services require preauthorization as a condition of the health maintenance organization's payment to a participating physician or provider,

the health maintenance organization shall determine whether the health care services proposed to be provided to the enrollee are medically necessary and appropriate. A preauthorization of services provided through a point-of-service plan may not be denied because the enrollee requests to use an out-of-network physician or provider.

SECTION 6. Section 843.363(a), Insurance Code, is amended to read as follows:

(a) A health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the terms, requirements, or services of the health care plan as they relate to the medical needs of the patient; [~~or~~]

(3) the termination of the physician's, dentist's, or provider's contract with the health care plan or the fact that the physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan; or

(4) information regarding the availability of facilities, both in-network and out-of-network, for the treatment

of a patient's medical condition.

SECTION 7. Subchapter B, Chapter 1204, Insurance Code, is amended by adding Section 1204.056 to read as follows:

Sec. 1204.056. RESPONSIBILITY FOR PROVIDER AND PHYSICIAN PAYMENTS. (a) An insurer shall pay full benefits to a physician or other health care provider under an assignment of benefits regardless of whether a covered person has a contractual obligation to pay a deductible or copayment.

(b) A physician's or other health care provider's waiver of a deductible or copayment does not relieve an insurer of the insurer's obligations under this section.

SECTION 8. Section 1301.001, Insurance Code, is amended by adding Subdivisions (5-a) and (5-b) to read as follows:

(5-a) "Out-of-network benefit" means a benefit allowing an insured to use out-of-network providers to provide all or some of the insured's health care.

(5-b) "Out-of-network provider" means a physician or health care provider who is not a preferred provider.

SECTION 9. Section 1301.0045, Insurance Code, is amended to read as follows:

Sec. 1301.0045. CONSTRUCTION OF CHAPTER. This [~~Except as provided by Section 1301.0046, this~~] chapter may not be construed to limit the authority of the department to regulate the level of reimbursement or the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions, that are applicable to preferred providers or out-of-network [~~nonpreferred~~] providers.

SECTION 10. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Sections 1301.0051 and 1301.0052 to read as follows:

Sec. 1301.0051. AVAILABILITY OF OUT-OF-NETWORK BENEFIT. (a) An insurer must provide a level of coverage and reimbursement sufficient to ensure that each insured has reasonable access to medical and health care by out-of-network providers. An insurer may not set a deductible, copayment, coinsurance, or other method of cost sharing so as to deny an insured reasonable access to medical and health care from out-of-network providers.

(b) An insurer may not terminate, or threaten to terminate, an insured's participation in a preferred provider benefit plan because the insured uses an out-of-network provider.

(c) An insurer may not deny preauthorization of a medical or health care service because an insured uses an out-of-network provider.

Sec. 1301.0052. PROTECTION OF PREFERRED PROVIDERS. (a) An insurer may not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict a preferred provider from discussing with or communicating with an insured with respect to information regarding the availability of out-of-network providers for the provision of the insured's medical or health care services.

(b) An insurer may not terminate the contract of or otherwise penalize a preferred provider because the provider's patients use out-of-network providers for medical or health care services.

(c) A preferred provider terminated by an insurer is entitled, on request, to all information used by the insurer as reasons for the termination, including the economic profile of the preferred provider, the standards by which the provider is measured, and the statistics underlying the profile and standards.

SECTION 11. Section 1301.007, Insurance Code, is amended to read as follows:

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to[~~:~~

[~~(1)~~] implement this chapter[~~; and~~

[~~(2) ensure reasonable accessibility and availability of preferred provider services to residents of this state~~].

SECTION 12. Section 1301.051, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) An insurer may not enter into a contract with a preferred provider on the condition that another physician or health care provider be excluded from participating as a preferred provider.

SECTION 13. Section 1301.058, Insurance Code, is amended to read as follows:

Sec. 1301.058. ECONOMIC PROFILING; USE OF ECONOMIC CREDENTIALING. (a) An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or

health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

(b) An insurer may not use economic credentialing as a basis for terminating the contract of a preferred provider unless the credentialing demonstrates materially higher costs incurred for patients of the preferred provider.

SECTION 14. Section 1301.061, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) A preferred provider organization that has entered into an agreement with an insurer shall comply with the requirements of this subchapter.

SECTION 15. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Section 1301.070 to read as follows:

Sec. 1301.070. SUIT BY PERSON HARMED. (a) A person, including an insured or a physician or a health care provider, who is harmed by a violation of this subchapter may petition a district court for a declaratory judgment, injunctive relief, damages, reasonable attorney's fees, and other appropriate relief.

(b) Venue for a suit brought under this section is in the county in which the person resides or, if the person is not a resident of this state, in Travis County.

(c) The relief available under this section is in addition to any other relief available to an insured or a physician or health care provider.

SECTION 16. Section 1301.155, Insurance Code, is amended by

adding Subsection (c) to read as follows:

(c) An insurer shall pay for emergency care performed by out-of-network providers at the usual and customary rate or at a rate negotiated with the provider. If a rate cannot be agreed on or the parties cannot agree on the usual and customary rate, either party may request that the other party participate in binding arbitration and the other party shall participate in the binding arbitration. The commissioner may establish procedural rules to govern the arbitration process. All costs of arbitration under this section shall be paid equally by each party.

SECTION 17. Sections 1204.055, 1301.0046, and 1301.005, Insurance Code, are repealed.

SECTION 18. (a) Except as provided by this section, the changes in law made by this Act apply only to an insurance policy or health maintenance organization contract delivered, issued for delivery, or renewed on or after January 1, 2008. A policy or contract issued before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) Sections 843.306, 843.314, 843.363, 1301.051, and 1301.058, Insurance Code, as amended by this Act, and Section 1301.0052, Insurance Code, as added by this Act, apply only to a contract between a health maintenance organization or preferred provider benefit plan issuer and a physician or health care provider that is entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before the effective date of this Act is governed by the law in effect

immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(c) Section 1301.061, Insurance Code, as amended by this Act, applies only to a contract between a preferred provider organization and an insurer entered into or renewed on or after the effective date of the Act. A contract entered into or renewed before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(d) Section 1301.070, Insurance Code, as added by this Act, applies only to a cause of action that accrues on or after the effective date of this Act. A cause of action that accrues before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 19. This Act takes effect September 1, 2007.