BILL ANALYSIS

S.B. 586
By: Carona
Insurance
Committee Report (Amended)

BACKGROUND AND PURPOSE

Under current law, insurers are not permitted to interfere with a health care provider's medical care decisions for an insured patient. This prohibition is usually recognized in insurer contracts with providers, including in preferred provider organization (PPO) and health maintenance organization (HMO) contracts. However, insurer contracts often require that health care providers refer patients to other providers in the insurer's network of providers when possible. Insurers have been known to terminate, or threaten to terminate, a provider contract if the provider refers patients to out-of-network providers, sometimes even if there is only one such referral. Insurers have also been known to terminate an insured's coverage for using an out-of-network provider.

Health care providers often have compelling and legitimate reasons for referring a patient to an out-of-network provider or facility, including because an out-of-network provider or facility may be the only reasonably available provider or facility to address a particular patient's needs, or perhaps because an out-of-network provider is the best qualified to address a particular patient's needs.

Moreover, one of the key components of a PPO health insurance policy, which makes up approximately 80 percent of the Texas health insurance market, is the option for the insured to seek care with an out-of-network physician or at an out-of-network facility. PPO policies are more expensive than HMO policies; if an insured chooses to pay the increased cost for a PPO policy, then the insured should have access to PPO services. If physicians are prohibited or discouraged from referring patients to out-of-network providers or facilities, then the insured are paying PPO prices for HMO services.

S.B. 586 prohibits an HMO from terminating a physician or provider solely because the physician or provider informs the patient of the full range of physicians or providers available to the patient, including out-of-network providers. The bill prohibits an HMO from prohibiting, by contract, a provider from providing a patient with information regarding the availability of out-of-network facilities for the treatment of a patient's medical condition; from terminating or threatening to terminate an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider; from prohibiting a health care provider participating in a preferred provider benefit plan from communicating with a patient about the availability of out-of-network providers, or from terminating a contract or otherwise penalizing a health care provider for the same; or from terminating or penalizing a health care provider participating in a preferred provider benefit plan solely because the provider's patient uses an out-of-network provider. The bill provides that a health care provider participating in a preferred provider benefit plan terminated by an insurer is entitled to all information on which the insurer based the decision to terminate. The bill authorizes an insurer's contract with a preferred provider to require the preferred provider, under certain conditions, to inform the insured that the insured is authorized to choose a preferred provider or an out-of-network provider and, if the insured chooses the out-of-network provider, that the insured may incur higher out-of-pocket expenses; and to inform the insured whether the preferred provider has a financial interest in the out-of-network provider.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

S.B. 586 amends the Insurance Code to prohibit a health maintenance organization (HMO) from terminating participation of a physician or provider solely 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.

S.B. 586 prohibits an HMO from, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibiting, attempting to prohibit, or discouraging 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 information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition.

S.B. 586 prohibits an insurer from terminating, or threatening to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider. The bill prohibits an insurer from prohibiting, attempting to prohibit, penalizing, terminating, or otherwise restricting a preferred provider from communicating with an insured about the availability of out-of-network providers for the provision of the insured's medical or health care services. The bill prohibits an insurer from terminating the contract of or otherwise penalizing a preferred provider solely because the provider's patients use out-of-network providers for medical or health care services. The bill entitles, on request, a preferred provider terminated by an insurer to all information on which the insurer wholly or partly based 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. The bill authorizes an insurer's contract with a preferred provider to require the preferred provider, except in a case of a medical emergency as determined by the preferred provider and before the provider is authorized to make an out-of-network referral for an insured, to inform the insured that the insured is authorized to choose a preferred provider or an out-of-network provider and, if the insured chooses the out-of-network provider, that the insured may incur higher out-of-pocket expenses; and to inform the insured whether the preferred provider has a financial interest in the out-of-network provider.

S.B. 586 makes its provisions applicable to an insurance policy, HMO contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2010. The bill defines "out-of-network provider."

EFFECTIVE DATE

September 1, 2009.

EXPLANATION OF AMENDMENTS

Committee Amendment No. 1:

S.B. 586 is amended to establish that the prohibition against a health maintenance organization terminating participation of a physician or provider solely for certain activity on the part of the physician or provider includes the following conditions: that the physician or provider informs an enrollee of a full range of physicians and providers available to the enrollee including in-network providers, as well as out-of-network providers, and the enrollee chooses an out-of-network provider.