BILL ANALYSIS

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C.S.S.B. 586
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

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 also 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 make 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 contracts are more expensive than HMO type contracts; and, if an insured chooses to pay the increased cost for a PPO policy, then the insured should have access to PPO-type 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 level services.

C.S.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. 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; 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; prohibits an insurer 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; prohibits an insurer 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; and 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.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 843.306, Insurance Code, by adding Subsection (f), 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.

SECTION 2. Amends Section 843.363(a), Insurance Code, to prohibit an HMO, as a condition of a contract with a physician, dentist, provider, or in any other manner, from 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. Makes nonsubstantive changes.

SECTION 3. Amends Section 1301.001, Insurance Code, by adding Subdivision (5-a), to define "out-of-network provider."

SECTION 4. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.0051 and 1301.0052, as follows:

Sec. 1301.0051. ACCESS TO OUT-OF-NETWORK PROVIDERS. Prohibits an insurer, except as provided by Section 1501.108(a)(4) (relating to an exception to requiring a small or large employer health benefit plan to renew), 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.

Sec. 1301.0052. PROTECTED COMMUNICATIONS BY PREFERRED PROVIDERS. (a) Prohibits an insurer in any manner 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.

(b) 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.

(c) Provides that a preferred provider terminated by an insurer is entitled, on request, 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.

(d) Authorizes an insurer's contract with a preferred provider to require that, except in a case of a medical emergency as determined by the preferred provider, before the provider is authorized to make an out-of-network referral for an insured, the preferred provider is required to inform the insured that the insured may choose a preferred provider or an out-of-network provider, and if the insured chooses the out-of-network provider the insured may incur higher out-of-pocket expenses; and whether the preferred provider has a financial interest in the out-of-network provider.

(e) Requires a preferred provider who is required by an insurer to disclose information as described by Subsection (d) to obtain from the insured a written acknowledgement, signed by the insured, of receipt of the information and maintain the signed acknowledgement in the provider's records.

SECTION 5. (a) Makes application of this Act, except as provided by this section, prospective to January 1, 2010.

(b) Makes application of Sections 843.306 and 843.363, Insurance Code, as amended by this Act, and Section 1301.0052, Insurance Code, as added by this Act, prospective to September 1, 2009.

SECTION 6. Effective date: September 1, 2009.