BILL ANALYSIS

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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Currently, the Texas Department of Insurance (TDI) does not regulate preferred provider organization (PPO) networks. These PPO networks are used by preferred provider benefit plans (PPBP), health maintenance organizations (HMO) and other entities that assemble and credential providers and negotiate discounts with the physicians in their networks. TDI only has regulatory jurisdiction over HMOs and group and individual health insurance plans. The market is currently changing with more than 80 percent of this group obtaining care through PPBPs. This means that a large portion of the healthcare system goes unregulated.

The number of intermediary entities involved in the health care claims payment process is also increasing dramatically. While the discounter profits from discounting the appropriate payment to the physician, it shares little, if any, information regarding its actions with the patient or physician. Without this information, it becomes extremely difficult for individual physicians to detect and/or identify how much they are going to be paid for a particular services, and by whom, and for patients to determine their share of the cost of their medical care. As a result, the patient may pay a greater portion of the total bill and the payer ends up paying less.

This bill seeks to balance access to PPO networks with transparency of physician reimbursement and control of "silent" PPOs. It establishes criteria for network and discount access and contract termination; sets out contracting entity rights and responsibilities; requires disclosure to providers and contracting entities of third-party access; provides for registration of unlicensed contracting entities of third-party access; provides for registration of unlicensed contracting entities; allows physicians to refuse a network discount without a contractual basis; and provides physicians with remedies when a contract is taken without a contractual basis.

As proposed, S.B. 714 relates to regulation of the secondary market in certain physician and health care provider discounts and provides administrative penalties.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 1302.052, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle D, Title 8, Insurance Code, by adding Chapter 1302, as follows:

CHAPTER 1302. REGULATION OF SECONDARY MARKET IN CERTAIN PHYSICIAN AND HEALTH CARE PROVIDER DISCOUNTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1302.001. DEFINITIONS. Defines "discount broker," "health care provider," "payor," "physician," and "transfer."

Sec. 1302.002. EXEMPTIONS. Provides that this chapter does not apply to:

(1) the activities of a health maintenance organization's network that are subject to Subchapter J (Payment of Claims to Physicians and Providers), Chapter 843; or an insurer's preferred provider network that are subject to Subchapters C (Prompt

Payment of Claims) and C-1 (Other Provisions Relating to Payment of Claims), Chapter 1301 (Preferred Provider Benefit Plans); or

(2) any aspect of the administration or operation of the state child health plan; or any medical assistance program using a managed care organization or managed care principal, including the state Medicaid managed care program under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code.

Sec. 1302.003. APPLICABILITY OF OTHER LAW. (a) Requires a discount broker, and any payor for whom a discount broker acts or who contracts with a discount broker, except as provided by Subsection (b), with respect to payment of claims, to comply with Subchapters C and C-1, Chapter 1301, in the same manner as an insurer.

(b) Provides that this section does not apply to a payor that is a fully self-insured health plan.

Sec. 1302.004. RETALIATION PROHIBITED. Prohibits a discount broker from engaging in any retaliatory action against a physician or health care provider because the physician or provider has filed a complaint against the discount broker, or appealed a decision of the discount broker.

[Reserves Sections 1302.005-1302.050 for expansion.]

SUBCHAPTER B. REGISTRATION; POWERS AND DUTIES OF COMMISSIONER AND DEPARTMENT

Sec. 1302.051. REGISTRATION REQUIRED. Requires each discount broker that does not hold a certificate of authority or license otherwise issued by the Texas Department of Insurance (TDI) under this code to register with TDI in the manner prescribed by the commissioner of insurance (commissioner) before engaging in business in this state.

Sec. 1302.052. RULES. Requires the commissioner to adopt rules in the manner prescribed by Subchapter A (Rules), Chapter 36 (Department Rules and Procedures), as necessary to implement and administer this chapter.

[Reserves Sections 1302.053-1302.100 for expansion.]

SUBCHAPTER C. PROHIBITION OF CERTAIN TRANSFERS; NOTICE REQUIREMENTS

Sec. 1302.101. PROHIBITION OF CERTAIN TRANSFERS. (a) Prohibits a discount broker from transferring a physician's or health care provider's contracted discounted fee or any other contractual obligation unless the transfer is authorized by a contractual agreement that complies with this chapter.

(b) Provides that this section does not affect the authority of the commissioner or the commissioner of worker's compensation under this code or Title 5 (Worker's Compensation), Labor Code, to request and obtain information.

Sec. 1302.102. IDENTIFICATION OF PAYORS; TERMINATION OF CONTRACT. (a) Requires a discount broker to notify each physician and health care provider of the identity of the payors and discount brokers authorized to access a contracted discounted fee of the physician or provider. Provides that the notice requirement under this subsection does not apply to an employer authorized to access a discounted fee through a discount broker.

(b) Requires that the notice required under Subsection (a):

(1) be provided, at least every 45 days through electronic mail, after provision by the affected physician or health care provider of a current electronic mail address; and posting of a list on a secure Internet website; and

(2) include a separate prominent section that lists the payors that the discount broker knows will have access to a discounted fee of the physician or health care provider in the succeeding 45-day period.

(b-1) Authorizes the notice required under Subsection (a), notwithstanding Subsection (b), and on the request of the affected physician or health care provider, to be provided through United States mail. Provides that this subsection expires September 1, 2011.

(c) Requires that the identity of a payor or discount broker authorized to access a contracted discounted fee of the physician or provider that becomes known to the discount broker required to submit the notice under Subsection (a) be included in the subsequent notice.

(d) Authorizes a physician or health care provider to terminate its contract by providing written notice to the discount broker not later than the 30th day after the date on which the physician or health care provider receives the notice required under Subsection (a) if, after receipt of the notice required under Subsection (a), the physician or health care provider objects to the addition of a payor to access to a discount fee, other than a payor that is an employer or a discount broker listed in the notice required under Subsection (a). Provides that termination of a contract under this subsection is subject to applicable continuity of care requirements under Section 843.362 (Continuity of Care; Obligation of Health Maintenance Organization) and Subchapter D (Relations Between Insureds and Preferred Providers), Chapter 1301.

[Reserves Sections 1302.103-1302.150 for expansion.]

SUBCHAPTER D. RESTRICTIONS ON TRANSFERS

Sec. 1302.151. RESTRICTIONS ON TRANSFERS; EXCEPTION. (a) Defines "line of business."

(b) Prohibits a contract between a discount broker and a physician or health care provider from requiring the physician or health care provider to:

(1) consent to the disclosure or transfer of the physician's or health care provider's name and a contracted discounted fee for use with more than one line of business;

(2) accept all insurance products; or

(3) consent to the disclosure or transfer of the physician's or health care provider's name and access to a contracted discounted fee of the physician or provider in a chain of transfers that exceeds two transfers.

(c) Authorizes a contract between a discount broker and a physician or health care provider to require the physician or health care provider, notwithstanding Subsection (b)(2), to accept all insurance products within a line of business covered by the contract.

[Reserves Sections 1302.152-1302.199 for expansion.]

SUBCHAPTER E. DISCLOSURE REQUIREMENTS

Sec. 1302.200. IMPLEMENTATION. (a) Effective date, this subchapter: January 1, 2010.

(b) Provides that this section expires January 2, 2010.

Sec. 1302.201. IDENTIFICATION OF DISCOUNT BROKER. Requires that an explanation of payment or remittance advice in an electronic or paper format include the identity of the discount broker authorized to disclose or transfer the name and associated discounts of a physician or health care provider.

Sec. 1302.202. IDENTIFICATION OF ENTITY ASSUMING FINANCIAL RISK; DISCOUNT BROKER. Requires that a payor or representative of a payor that processes claims or claims payments clearly identify in an electronic or paper format on the explanation of payment or remittance advice the identity of the payor that assumes the risk for payment of claims or reimbursement for services; and the discount broker through which the payment rate and any discount rate are claimed.

Sec. 1302.203. INFORMATION ON IDENTIFICATION CARDS. Requires that if a discount broker or payor issues member or subscriber identification cards, the identification cards identify, in a clear and legible manner, any third-party entity, including any discount broker who is responsible for paying claims and through whom the payment rate and any discount rate are claimed.

[Reserves Sections 1302.204-1302.250 for expansion.]

SUBCHAPTER F. ENFORCEMENT

Sec. 1302.251. PENALTIES. (a) Provides that a discount broker who holds a certificate of authority or license under this code and who violates this chapter commits an unfair settlement practice in violation of Chapter 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices); commits an unfair claim settlement practice in violation of Subchapter A (Unfair Claim Settlement Practices), Chapter 542 (Processing and Settlement of Claims); and is subject to administrative penalties in the manner prescribed by Chapters 82 (Sanctions) and 84 (Administrative Penalties).

(b) Provides that a violation of this chapter by a discount broker who does not hold a certificate of authority or license under this code constitutes a violation of Subchapter E (Deceptive Trade Practices and Consumer Protection), Chapter 17 (Deceptive Trade Practices), Business & Commerce Code.

Sec. 1302.252. PRIVATE CAUSE OF ACTION. Authorizes an affected physician or health care provider to bring a private action for damages in the manner prescribed by Subchapter D (Private Action for Damages), Chapter 541, against a discount broker who violates this chapter.

SECTION 2. Amends Sections 1301.001(4) and (6), Insurance Code, to redefine "institutional provider" and "physician."

SECTION 3. Amends Section 1301.056, Insurance Code, as follows:

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) Prohibits an insurer, third-party administrator, or other entity from reimbursing a physician or other practitioner, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless certain conditions have been satisfied. Makes conforming changes.

(b) Prohibits a party to a preferred provider contract, including a contract with a preferred provider organization, from selling, leasing, assigning, aggregating, disclosing, or otherwise transferring the discounted fee, or any other information regarding the discount, payment, or reimbursement terms of the contract without the express authority of and adequate notification, rather than prior adequate notification, to the other contracting parties. Provides that this subsection does not prohibit a payor from disclosing any information, including fees, to an insured; or affect the authority of the commissioner or the commissioner of workers' compensation under this code or Title 5, Labor Code, to request and obtain information.

(c) Prohibits an insurer, third-party administrator, or other entity from accessing a discounted fee, other than through a direct contract, unless notice has been provided to the contracted physicians, practitioners, institutional providers, and organizations of physicians and health care providers. Provides that for the purposes of the notice requirements of this subsection, the term "other entity" does not include an employer that contracts with an insurer or third-party administrator.

(d) Requires that the notice required under Subsection (c):

(1) be provided, at least every 45 days, through electronic mail, after provision by the affected physician or health care provider of a current electronic mail address; and posting of a list on a secure Internet website; and

(2) include a separate prominent section that lists the insurers, third-party administrators, or other entities that the contracting party knows will have access to a discounted fee of the physician or health care provider in the succeeding 45-day period.

(d-1) Authorizes the notice required under Subsection (c), notwithstanding Subsection (d), and on the request of the affected physician or health care provider, to be provided through United States mail. Provides that this subsection expires September 1, 2011.

(e) Requires that the identity of an insurer, third party administrator, or other entity authorized to access a contracted discounted fee of the physician or provider that becomes known to the contracting party required to submit the notice under Subsection (c) be included in the subsequent notice.

(f) Authorizes a physician or other practitioner, institutional provider, or organization of physicians and health care providers to terminate its contract by providing written notice to the contracting party not later than the 30th day after the date of the receipt of the notice required under Subsection (c) if, after receipt of the notice required under Subsection (c), the physician or other practitioner, institutional provider, or organization of physicians and health care providers objects to the addition of an insurer, third-party administrator, or other entity to access to a discounted fee.

(g) Requires an insurer, third-party administrator, or other entity that processes claims or claims payments to clearly identify in an electronic or paper format on the explanation of payment or remittance advice the identity of the party responsible for administering the claims; and if the insurer, third-party administrator, or other entity does not have a direct contract with the physician or other practitioner, institutional provider, or organization of physicians and health care providers, the identity of the preferred provider organization or other contracting party that authorized a discounted fee.

(h) Requires that if an insurer, third-party administrator, or other entity issues member or insured identification cards, the identification cards include, in a clear and legible format, the information required under Subsection (g).

(i) Creates Subsection (i) from existing text to provide that an insurer, third party administrator, or other entity that holds a certificate of authority or license under this code who violates this section commits an unfair settlement practice in violation of Chapter 541, among other things.

(j) Provides that a violation of this section by an entity described by this section who does not hold a certificate of authority or license issued under this code constitutes a violation of Subchapter E, Chapter 17, Business & Commerce Code.

(k) Authorizes a physician or health care provider affected by a violation of this section to bring a private action for damages in the manner prescribed by Subchapter D, Chapter 541, against a discount broker who violates this section.

SECTION 4. Makes application of this Act prospective.

SECTION 5. Requires the commissioner of insurance to adopt rules as necessary to implement Chapter 1302, Insurance Code, as added by this Act, not later than December 1, 2009.

SECTION 6. Makes application of this Act prospective.

SECTION 7. Effective date: September 1, 2009.