BILL ANALYSIS

Senate Research Center

C.S.S.B. 714
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Committee Report (Substituted)

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.

C.S.S.B. 714 amends current law relating to regulation of certain health care rental network contract arrangements and providing penalties.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1458.053, 1458.056, and 1458.104, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1458, as follows:

CHAPTER 1458. RENTAL NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. Defines "affiliate," "contracting entity," "covered individual," "direct notification," "health care services," "person," "provider," "provider network contract," and "third party."

Sec. 1458.002 DEFINITION OF HEALTH BENEFIT PLAN. Defines "health benefit plan."

Sec. 1458.003. EXEMPTIONS. Provides that this chapter does not apply:

(1) to a provider network contract for services provided to a beneficiary under the Medicaid program, the Medicare program, or the state child health plan established under Chapter 62 (Child Health Plan For Certain Low-Income Children), Health and Safety Code, or the comparable plan under Chapter 63 (Health Benefits Plan For Certain Children), Health and Safety Code;

(2) under circumstances in which access to the provider network is granted to an entity that operates under the same brand licensee program as the contracting entity; or

(3) except as provided by Section 1458.104, to a contract between a contradicting entity and a discount health care program.

[Reserves Sections 1458.004-1458.050 for expansion.]

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Requires a person, unless the person holds a certificate of authority issued by the Texas Department of Insurance (TDI) to engage in the business of insurance in this state or operate a health maintenance organization under Chapter 843 (Health Maintenance Organizations), to register with TDI not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

(b) Authorizes a contracting entity that holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is a health maintenance organization, notwithstanding Subsection (a), under Section 1458.055, to file with the commissioner of insurance (commissioner) an application for exemption from registration for its affiliates.

Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) Requires a person required to register under Section 1458.051 to disclose certain information.

(b) Requires that the disclosure made under Subsection (a) include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks and the internal organizational structure of the contracting entity's management.

Sec. 1458.053. SUBMISSION OF INFORMATION. Requires that information required under this subchapter be submitted in a written or electronic format adopted by the commissioner by rule.

Sec. 1458.054. FEE. Authorizes TDI to collect a reasonable fee set by the commissioner as necessary to administer the registration process.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) Authorizes the commissioner to grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that multiple registrations would require the filing of duplicative information or would be wasteful of state resources; the affiliate is not subject to a disclaimer of affiliation under Chapter 823 (Insurance Holding Company Systems); and the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks, are disclosed.

(b) Provides that an exemption granted under this section applies only to registration. Provides that an entity granted an exemption is otherwise subject to this chapter.

Sec. 1458.056. RULES CONCERNING EXEMPTIONS FROM REGISTRATION REQUIREMENTS. Provides that the commissioner by rule:

(1) is required to prescribe the form for filing for an exemption under Section 1458.055;

(2) is required to establish the time frames for filing for an initial and renewal exemption;

(3) is required to establish a reasonable fee as necessary to administer the exemption process; and

(4) is authorized to require disclosure of any information necessary to implement and administer Section 1458.055.

[Reserves Sections 1458.057-1458.100 for expansion.]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. Prohibits a contracting entity from providing a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the contracting entity may contract with a third party to provide access to the contracting entity's rights and responsibilities under a provider network contract and the third party must comply with all applicable terms, limitations, and conditions of the provider network contract.

Sec. 1458.102. DUTIES OF CONTRACTING ENTITY. (a) Requires a contracting entity that has granted access to health care services and contractual discounts under a provider network contract to:

(1) notify each provider of the identity of, and contact information for, each third party that has or may obtain access to the provider's health care services and contractual discounts;

(2) disclose to each third party all relevant terms, limitations, and conditions necessary to comply with the provider network contract;

(3) require each third party to disclose the identity of the contracting entity and the existence of a provider network contract on each remittance advice or explanation of payment form; and

(4) notify each third party of the termination of the third party's provider network contract not later than the 30th day after the effective date of the contract termination and require the third party to cease making claims under the provider network contract after the termination.

(b) Provides that the notice required under Subsection (a)(1):

(1) must be provided, at least each calendar quarter, through electronic mail, after provision by the affected provider of a current electronic mail address and posting of the information on an Internet website; and

(2) must include a separate prominent section that lists each third party that the contracting entity knows will have access to a discounted fee of the provider in the succeeding calendar quarter and the effective date and termination or renewal dates, if any, of the third party's contract to access the network.

(c) Authorizes the electronic mail notice described by Subsection (b) to contain a link to an Internet web page that contains a list of third parties that complies with this section.

Sec. 1458.103. EFFECT OF CONTRACT TERMINATION. Provides that subject to continuity of care requirements, agreements, or contractual provisions a third party may not access health care services and contractual discounts after the date the provider network contract terminates; claims for health care services performed after the termination date may not be processed or paid under the provider network contract after the termination; and claims for health care services performed before the termination date and processed after the termination date may be processed and paid under the provider network contract after the date of termination.

Sec. 1458.104. OFFER FOR DIRECT CONTRACT BY CONTRACTING ENTITY. (a) Defines "line of business."

(b) Prohibits a contract between a contracting entity and a provider from requiring the provider to consent to access to, or transfer of, except as provided by Subsection (c), the provider's name and contracted discount fee for use with more than one line of business.

(c) Authorizes a contracting entity to require a contract for more than one line of business only if the provider's assent is invited through a separate signature line for each line of business.

Sec. 1458.105. AVAILABILITY OF CODING GUIDELINES. (a) Requires that a contract between a contracting entity and a provider provide that the provider may request a description and copy of the coding guidelines, including any underlying bundling recoding, or other payment process and fee schedules applicable to specific procedures that the provider will receive under the contract; the contracting entity or the contracting entity's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the contracting entity receives the request; the contracting entity or the contracting entity's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and the contract may be terminated by the provider on or before the 30th day after the date the provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) Authorizes a provider who receives information under Subsection (a) to only use or disclose the information for the purpose of practice management, billing activities, and other business operations and disclose the information to a governmental agency involved in the regulation of health care or insurance.

(c) Requires the contracting entity, on request of the provider, to provide the name, edition, and model version of the software that the contracting entity uses to determine bundling and unbundling of claims.

(d) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

[Reserves Sections 1458.106-1458.150 for expansion.]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY

Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. (a) Requires a third party that grants access to a provider's health care services and contractual discounts to another third party to comply with the responsibilities of the contracting entity under Subchapters C and E.

(b) Requires a third party that obtains access to a provider's health care services and contractual discounts from a third party acting as a contracting entity to comply with this subchapter.

Sec. 1458.152. DISCLOSURE BY THIRD PARTY. (a) Requires a third party to disclose, to the contracting entity and providers under the provider network contract, the identity of a person to whom the third party grants access to the provider's health care services and contractual discounts through an electronic notification that complies with Section 1458.102 and includes a link to the Internet website described by Section 1458.102(b).

(b) Requires a third party that uses the Internet website under this section to update the website on a quarterly basis. Requires a contracting entity, on request, to disclose the information by telephone or through direct notification.

[Reserves Sections 1458.153-1458.200 for expansion.]

SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS

Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT. (a) Provides that a person who knowingly accesses or uses a provider's contractual discount under a provider network contract without a contractual relationship established under this chapter commits an unfair or deceptive act in the business of insurance that violates Subchapter B (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined), Chapter 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices). Provides that the remedies available for a violation of Subchapter B, Chapter 541, under this subsection, do not include a private cause of action under Subchapter D (Private Action for Damages), Chapter 541, or a class action under Subchapter F (Class Actions by Attorney General or Private Individual), Chapter 541.

(b) Requires a contracting entity or third party to comply with the disclosure requirements under Sections 1458.052(a)(2) (relating to the mailing address and main telephone number of the contracting entity's headquarters) or 1458.152 concerning the services listed on a remittance advice or explanation of payment. Authorizes a provider to refuse a discount taken without a contract under this chapter or in violation of those sections.

(c) Authorizes an error in the remittance advice or explanation of payment, notwithstanding Subsection (b), to be corrected by a contracting entity or third party not later than the 30th day after the date the provider notifies in writing the contracting entity or third party of the error.

Sec. 1458.202. ACCESS TO THIRD PARTY. Prohibits a contracting entity from providing a third party access to a provider network contract unless the third party is a payor or person who administers or processes claims on behalf of the payor; a preferred provider benefit plan issuer or preferred provider network, including a physician-hospital organization; or a person who transports claims electronically between the contracting entity and the payor and does not provide access to the provider's services and discounts to any other third party.

[Reserves Sections 1458.203-1458.250 for expansion.]

SUBCHAPTER F. ENFORCEMENT

Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) Provides that a contracting entity that violates this chapter commits an unfair claim settlement practice under Subchapter A (Unfair Claim Settlement Practices), Chapter 542 (Processing and Settlement of Claims), and is subject to sanctions under that subchapter as if the contracting entity were an insurer.

(b) Authorizes a provider who is adversely affected by a violation of this chapter to make a complaint under Subchapter A, Chapter 542.

Sec. 1458.252. REMEDIES NOT EXCLUSIVE. Provides that the remedies provided by this subchapter are not exclusive and are in addition to any other remedy or procedure provided by another law or at common law.

SECTION 2. Makes application of this Act prospective to September 1, 2009.

SECTION 3. Effective date: September 1, 2009.