BILL ANALYSIS

Senate Research Center
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S.B. 1257
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1257 addresses a lack of transparency from health benefit plans, as well as certain market conduct in which health benefit plans engage that tends to adversely affect providers/patients.

As proposed, S.B. 1257 amends current law relating to the regulation of certain market conduct activities of certain life, accident, and health insurers and health benefit plan issuers; providing civil liability and administrative and criminal penalties.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1.002 (Section 1202.110, Insurance Code), SECTION 2.001 (Section 1301.010, Insurance Code), SECTION 3.006 (Section 1501.652, Insurance Code), SECTION 4.001 (Section 1458.003, Insurance Code), and SECTION 6.001 (Sections 1302.052, 1302.053, and 1302.053A, Insurance Code) of this bill.

Rulemaking authority previously granted to the commissioner of insurance is modified in SECTION 1.003 (Section 4202.002, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

ARTICLE 1. CANCELLATION OF HEALTH BENEFIT PLAN

SECTION 1.001. Amends Subchapter B, Chapter 541, Insurance Code, by adding Section 541.062, as follows:

> Sec. 541.062. BAD FAITH CANCELLATION. Provides that it is an unfair method of competition or an unfair or deceptive act or practice for a health benefit plan issuer to set cancellation goals, quotas, or targets; pay compensation of any kind, including a bonus or award, that varies according to the number of cancellations; set, as a condition of employment, a number or volume of cancellations to be achieved; or set a performance standard, for employees or by contract with another entity, based on the number or volume of cancellations.

SECTION 1.002. Amends Chapter 1202, Insurance Code, by adding Subchapter C, as follows:

SUBCHAPTER C. INDEPENDENT REVIEW OF CERTAIN CANCELLATION DECISIONS

> Sec. 1202.101. DEFINITIONS. Defines "affected individual," "independent review organization," and "screening criteria."
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> Sec. 1202.102. APPLICABILITY. (a) Provides that this subchapter applies only to a health benefit plan, including a small or large employer health benefit plan written under Chapter 1501 (Health Insurance Portability and Availability Act), that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by certain insurance organizations.

(b) Provides that this subchapter does not apply to certain plans or policies.

Sec. 1202.103. CANCELLATION FOR MISREPRESENTATION OR PREEXISTING CONDITION. Prohibits a health benefit plan, notwithstanding any other law, from canceling a health benefit plan on the basis of a misrepresentation or a preexisting condition except as provided by this subchapter.

Sec. 1202.104. NOTICE OF INTENT TO CANCEL. (a) Prohibits a health benefit plan issuer from canceling a health benefit plan on the basis of a misrepresentation or a preexisting condition without first notifying an affected individual in writing of the issuer's intent to cancel the health benefit plan and the individual's entitlement to an independent review.

(b) Requires that the notice required under Subsection (a) include certain information regarding the cancellation of a health benefit plan.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) Authorizes an affected individual to appeal a health benefit plan issuer's cancellation decision to an independent review organization not later than the 45th day after the date the individual receives notice under Section 1202.104.

(b) Requires a health benefit plan issuer to comply with all requests for information made by the independent review organization and with the independent review organization's determination regarding the appropriateness of the issuer's decision to cancel.

(c) Requires a health benefit plan issuer to pay all otherwise valid medical claims under an individual's plan until the later of the date on which an independent review organization determines that the decision to cancel is appropriate; or the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

Sec. 1202.106. CANCELLATION AUTHORIZED; RECOVERY OF CLAIMS PAID. (a) Authorizes a health benefit plan issuer to cancel a health benefit plan covering an affected individual on the later of the date an independent review organization determines that cancellation is appropriate; or the 45th day after the date an affected individual receives notice under Section 1202.104, if the individual has not initiated an appeal

(b) Authorizes an issuer that cancels a health benefit plan under this section to seek to recover from an affected individual amounts paid for the individual's medical claims under the canceled health benefit plan.

(c) Prohibits an issuer that cancels a health benefit plan under this section from offsetting against or recouping or recovering from a physician or health care provider amounts paid for medical claims under a canceled health benefit plan. Prohibits this subsection to be waived, voided, or modified by contract.

Sec. 1202.107. CANCELLATION RELATED TO PREEXISTING CONDITION; STANDARDS. (a) Provides that for purposes of this subchapter, a cancellation for a preexisting condition is appropriate if, within the 18-month period immediately preceding the date on which an application for coverage under a health benefit plan is made, an affected individual received or was advised by a physician or health care provider to seek medical advice, diagnosis, care, or treatment for a physical or mental condition, regardless of the cause, and the individual's failure to disclose the condition affects the risks assumed under the health benefit plan, and is undertaken with the intent to deceive the health benefit plan issuer.

(b) Prohibits a health benefit plan issuer from canceling a health benefit plan based on a preexisting condition of a newborn delivered after the application for coverage is made or as otherwise authorized to be prohibited by law.

Sec. 1202.108. CANCELLATION FOR MISREPRESENTATION; STANDARDS. Provides that for purposes of this subchapter, a cancellation for a misrepresentation not related to a preexisting condition is inappropriate unless the misrepresentation is of a material fact; affects the risks assumed under the health benefit plan; and is made with the intent to deceive the health benefit plan issuer.

Sec. 1202.109. 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 law or at common law.

Sec. 1202.110. RULES. Requires the commissioner of insurance (commissioner) to adopt rules necessary to implement and administer this subchapter.

Sec. 1202.111. SANCTIONS AND PENALTIES. Provides that a health benefit plan issuer that violates this subchapter commits an unfair practice in violation of Chapter 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) and is subject to sanctions and penalties under Chapter 82 (Sanctions).

Sec. 1202.112. CONFIDENTIALITY. (a) Provides that a record, report, or other information received or maintained by a health benefit plan issuer, including any material received or developed during a review of a cancellation decision under this subchapter, is confidential.

(b) Prohibits a health benefit plan issuer from disclosing the identity of an individual or a decision to cancel an individual's health benefit plan unless an independent review organization determines the decision to cancel is appropriate, or the time to appeal has expired without an affected individual initiating an appeal.

SECTION 1.003. Amends Section 4202.002, Insurance Code, as follows:

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) Requires the commissioner to adopt standards and rules for the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter C, Chapter 1202 (Cancellation and Continuation of Policies in General), or Subchapter I (Independent Review of Adverse Determination), Chapter 4201 (Utilization Review Agents); and the suspension and revocation of the certification.

(b) Requires that the standards adopted under this section ensure that certain criteria are met, including that review of a cancellation decision based on a preexisting condition be conducted under the direction of a physician. Makes nonsubstantive changes.

SECTION 1.004. Amends Sections 4202.003, 4202.004, and 4202.006, Insurance Code, as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. Requires that the standards adopted under Section 4202.002 (Adoption of Standards For Independent Review Organizations) require each independent review organization to make the organization's determination for certain health conditions, including for a condition other than a life-threatening condition or of the appropriateness of a cancellation under Subchapter C, Chapter 1202, not later than the earlier of the 15th day after the date the organization receives the information necessary to make the determination, or the 20th day after the date the organization receives the request that the determination be made.

Sec. 4202.004. CERTIFICATION. Requires an organization, to be certified as an independent review organization under this chapter, to submit to the commissioner an application in the form required by the commissioner. Requires that the application include certain information, including the procedures to be used by the applicant in

making independent review determinations under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201.

Sec. 4202.006. PAYORS FEES. (a) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Requires a health benefit plan issuer to pay for an independent review of a cancellation decision under Subchapter C, Chapter 1202.

SECTION 1.005. Amends Section 4202.009, Insurance Code, as follows:

Sec. 4202.009. CONFIDENTIAL INFORMATION. (a) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Provides that a record, report, or other information received or maintained by an independent review organization, including any material received or developed during a review of a cancellation decision under Subchapter C, Chapter 1202, is confidential.

(c) Prohibits an independent review organization from disclosing the identity of an affected individual or an issuer's decision to cancel a health benefit plan under Subchapter C, Chapter 1202, unless an independent review organization determines the decision to cancel is appropriate, or the time to appeal a cancellation under that subchapter has expired without an affected individual initiating an appeal.

SECTION 1.006. Amends Section 4202.010(a), Insurance Code, to make a conforming change.

SECTION 1.007. Makes application of this article prospective to the effective date of this Act.

ARTICLE 2. MEDICAL LOSS RATIOS

SECTION 2.001. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.010 as follows:

Sec. 1301.010. MEDICAL LOSS RATIO. (a) Defines "direct losses incurred," "direct losses paid," "direct premiums earned," and "medical loss ratio."

(b) Prohibits an insurer from having or maintaining for a preferred benefit plan a medical loss ratio of less than 72 percent.

(c) Requires that the medical loss ratio be reported annually or more often as required by the commissioner by rule or order.

(d) Provides that a medical loss ratio reported under this section is public information.

(e) Requires the Texas Department of Insurance (TDI) to include information on the medical loss ratio on TDI's Internet website.

(f) Requires an insurer to report to the policyholder the medical loss ratio of the policyholder's preferred provider benefit plan for the nine months following the policy effective date or renewal date. Provides that a medical loss ratio reported under this subsection is not required to include an estimate of future claims not incurred in the nine-month reporting period.

(g) Requires the commissioner to require an insurer that violates Subsection (b) to implement a premium rate adjustment; file with TDI an actuarial memorandum, prepared by a qualified actuary, in accordance with any rules adopted by the commissioner to implement this section; and remit to the Texas Health Insurance Risk Pool an amount equal to the direct premiums earned by the insurer during

the relevant reporting period multiplied by a percentage equal to the actual medical loss ratio subtracted from the minimum medical loss ratio prescribed by Subsection (b).

(h) Requires that an actuarial memorandum provided under Subsection (g) include a statement that the past plus future expected experience after a rate adjustment will result in a medical loss ratio equal to, or greater than, the required minimum medical loss ratio; for policies in force less than three years, a demonstration to show that the third-year loss ratio is expected to be equal to, or greater than, the required minimum medical loss ratio; and a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided.

(i) Requires the commissioner to adopt rules as necessary to implement this section, including rules regarding credible experience, whether full credibility, partial credibility, or no credibility should be assigned to particular experience, and the frequency and form of reporting medical loss ratios.

SECTION 2.002. (a) Requires the comissioner, not later than January 1, 2010, to adopt all rules necessary to implement Section 1301.010, Insurance Code, as added by this article. Prohibits the first reporting period under Section 1301.010(c) from covering any period that begins before January 1, 2010.

(b) Makes application of Section 1301.010(f), Insurance Code, as added by this article, prospective to January 1, 2010.

ARTICLE 3. PREMIUM RATE INCREASES FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

SECTION 3.001. Amends Subchapter D, Chapter 501, Insurance Code, by amending Sections 501.151 and 501.153, and adding Section 501.160 as follows:

Sec. 501.151. POWERS AND DUTIES OF OFFICE. Provides that the Office of Public Insurance Counsel (OPIC) is authorized to assess the impact of insurance rates, rules, and forms on insurance consumers in this state; is required to advocate in OPIC's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers; and is required to accept from a small employer, an eligible employee, or an eligible employee's dependent and, if appropriate, refer to the commissioner, a complaint described by Section 501.160. Makes nonsubstantive changes.

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. Authorizes the public counsel to appear or intervene, as a party or otherwise, as a matter of right before the commissioner or TDI on behalf of insurance consumers, as a class, in certain insurance matters, including appearing before the commissioner on behalf of a small employer, eligible employee, or eligible employee's dependent in a complaint OPIC refers to the commissioner under Section 501.160. Makes nonsubstantive changes.

Sec. 501.160. COMPLAINT RESOLUTION FOR CERTAIN PREMIUM RATE INCREASES. (a) Authorizes a small employer, an eligible employee, or an eligible employee's dependent to file a complaint with OPIC alleging that a rate is excessive for the risks to which the rate applies, if the percentage increase in the premium rate charged to a small employer under Subchapter E (Underwriting and Rating of Small Employer Health Benefit Plans), Chapter 1501 (Health Insurance Portability and Availability Act), for a new rating period exceeds 10 percent.

(b) Requires OPIC to refer a complaint received under Subsection (a) to the commissioner if OPIC determines that the complaint substantially attests to a rate charged that is excessive for the risks to which the rate applies.

(c) Authorizes OPIC, with respect to a complaint filed under Subsection (a), to issue a subpoena applicable throughout the state that requires the production of records.

(d) Authorizes a district court, on application of OPIC in the case of disobedience of a subpoena, to issue an order requiring any individual or person, including a small employer health benefit plan issuer described by Section 1501.002 (Definitions), that is subpoenaed to obey the subpoena and produce records, if the individual or person has refused to do so. Requires that an application under this subsection be made in a district court in Travis County.

SECTION 3.002. Amends Section 1501.204, Insurance Code, as follows:

Sec. 1501.204. INDEX RATES. Provides that under a small employer health benefit plan, the index rate for a class of business is prohibited from exceeding the index rate for any other class of business by more than 15, rather than 20, percent; and premium rates charged during a rating period to small employers in a class of business with similar case characteristics for the same or similar coverage, or premium rates that could be charged to those employers under the rating system for that class of business, are prohibited from varying from the index rate by more than 20, rather than 25, percent.

SECTION 3.003. Amends Section 1501.205, Insurance Code, by adding Subsection (d), to require a small employer health benefit plan issuer to disclose the risk load assessed to a small employer group to the group, along with a description of the risk characteristics material to the risk load assessment.

SECTION 3.004. Amends Section 1501.206(a), Insurance Code, to prohibit the percentage increase in the premium rate charged to a small employer for a new rating period from exceeding the sum of any adjustment, not to exceed 10, rather than 15, percent annually and adjusted pro rata for a rating period of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependants of employees of the small employer, as determined under the small employer health benefit plan issuer's rate manual for the class of business; and any adjustment, not to exceed five percent annually and adjusted pro rata for a rating period of less than one year, due to change in coverage or change in the case characteristics of the small employer, as determined under the issuer's rate manual for the class of business.

SECTION 3.005. Amends Subchapter E, Chapter 1501, Insurance Code, by adding Section 1501.2131 and amending Section 1501.214, as follows:

Sec. 1501.2131. COMPLAINT FACILITATION FOR PREMIUM RATE ADJUSTMENTS. Authorizes the small employer, an eligible employee, or an eligible employee's dependent to file a complaint with OPIC as provided by Section 501.160 if the percentage increase in the premium rate charged to a small employer for a new rating period exceeds 10 percent.

Sec. 1501.214. ENFORCEMENT. (a) Creates an exception under Subsection (b).

(b) Requires the commissioner to enter an order under this section if the commissioner makes the finding described by Section 1501.653.

SECTION 3.006. Amends Chapter 1501, Insurance Code, by adding Subchapter N, as follows:

SUBCHAPTER N. RESOLUTION OF CERTAIN COMPLAINTS AGAINST SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUERS

Sec. 1501.651. DEFINITIONS. Defines "honesty-in-premium account" and "office."

Sec. 1501.652. COMPLAINT RESOLUTION PROCEDURE. (a) Requires the commissioner, on the receipt of a referral of a complaint from OPIC under Section

501.160, to request written memoranda from OPIC and the small employer health benefit plan issuer that is the subject of the complaint.

(b) Authorizes the commissioner, after receiving the initial memoranda described by Subsection (a), to request one rebuttal memorandum from OPIC.

(c) Authorizes the commissioner by rule to limit the number of exhibits submitted with or the time frame allowed for the submittal of the memoranda described by Subsection (a) or (b).

Sec. 1501.653. ORDER; FINDINGS. Requires the commissioner to issue an order under Section 1501.214(b) if the commissioner determines that the rate complained of is excessive for the risks to which the rate applies.

Sec. 1501.654. COSTS. Authorizes OPIC to request, and the commissioner to award to OPIC, reasonable costs and fees associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

Sec. 1501.655. ASSESSMENT. (a) Authorizes the commissioner to make an assessment against each small employer health benefit plan issuer in an amount that is sufficient to cover the costs of investigating and resolving a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) Requires the commissioner to deposit assessments collected under this section to the credit of the honesty-in-premium account.

Sec. 1501.656. HONESTY-IN-PREMIUM ACCOUNT. (a) Sets forth that the honesty-in-premium account is an account in the general revenue fund that is authorized to be appropriated only to cover the cost associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) Requires that interest earned on the honesty-in-premium account be credited to the account. Provides that the account is exempt from the application of Section 403.095 (Use of Dedicated Revenue), Government Code.

Sec. 1501.657. RATE CHANGE NOT PROHIBITED. Provides that nothing in this subchapter prohibits a small employer health benefit plan issuer from, at any time, offering a different rate to the group whose rate is the subject of a complaint.

SECTION 3.007. Makes application of Chapter 1501, as amended by this Article, prospective to January 1, 2010.

ARTICLE 4. STANDARDIZED PROCESSING OF CERTAIN HEALTH BENEFIT PLAN CLAIMS

SECTION 4.001. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1458, as follows:

CHAPTER 1458. REQUIREMENTS FOR STANDARDIZED PROCESSING OF CERTAIN HEALTH BENEFIT PLAN CLAIMS

Sec. 1458.001. DEFINITIONS. Defines "add-on CPT code," "CPT code," and "multiple procedure logic."

Sec. 1458.002. APPLICABILITY. (a) Provides that this chapter applies to any health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by certain health corporations

or entities, or provides health and accident coverage through a risk pool created under Chapter 172 (Texas Political Subdivisions Uniform Group Benefits Program), Local Government Code, notwithstanding Section 172.014 (Application of Certain Laws), Local Government Code, or any other law.

(b) Provides that this chapter applies to a person with whom a health benefit plan contracts to process or pay claims, or obtain the services of physicians or other health care providers to provide health care services to enrollees in the plan.

(c) Provides that this plan does not apply to the state child health plan operated under Chapter 62 (Child Health Plan for Certain Low-Income Children) or 63 (Health Benefit Plan for Certain Children), Health and Safety Code.

Sec. 1458.003. STANDARDIZED RECOGNITION OF CODING; RESTRICTIONS. (a) Prohibits a health benefit plan issuer from subjecting a modifier 51-exempt CPT code to multiple procedure logic.

(b) Requires a health benefit plan issuer to recognize add-on CPT codes as eligible for payment as separate codes and is prohibited from subjecting add-on CPT codes to multiple procedure logic.

(c) Requires a health benefit plan issuer, if a claim contains both a CPT code for performance of an evaluation and management service procedure appended with a modifier 25 and a CPT code for performance of a non-evaluation and management service procedure, to recognize both codes as eligible for payment unless the applicable clinical information indicates that use of the modifier 25 was inappropriate.

(d) Requires a health benefit plan issuer to separately recognize a CPT code that includes supervision and interpretation as eligible for payment to the extent that the associated CPT code is recognized and eligible for payment. Prohibits the health benefit plan issuer from being required to pay for supervision or interpretation by more than one physician for each of those procedures.

(e) Prohibits a health benefit plan issuer, other than CPT codes specifically identified as modifier 51-exempt or add-on CPT codes, from reassigning into another CPT code a CPT code that is considered an indented code under the American Medical Association's "Current Procedural Terminology 2009 Professional Edition" or a subsequent edition of that publication adopted by the commissioner by rule unless more than one indented code under the same indentation is also submitted with respect to the same service, in which case only one such code is eligible for payment. Requires the health benefit plan issuer, for indented code series contemplating that multiple codes in the series may be properly reported and billed concurrently, to recognize all codes properly billed as eligible for payment.

(f) Requires a health benefit plan issuer to recognize a CPT code appended with a modifier 59 as separately eligible for payment to the extent the code designates a distinct or independent procedure performed on the same day by the same physician, but only to the extent that those procedures or services are not normally reported together but are appropriately reported together under the particular circumstances, and it would not be more appropriate under the American Medical Association's "Current Procedural Terminology 2009 Professional Edition" or a subsequent edition of that publication adopted by the commissioner by rule to append any other modifier to the CPT code.

(g) Prohibits global periods for surgical procedures from being longer than any period designated on a national basis by the Centers for Medicare and Medicaid Services for those surgical procedures as in effect on September 1, 2009, or any successor designation by the Centers for Medicare and Medicaid Services that is adopted by the commissioner.

(h) Prohibits a health benefit plan issuer from changing a CPT code to a CPT code reflecting a reduced intensity of the service if that CPT code is among a series that differentiates among simple, intermediate, and complex procedures.

Sec. 1458.004. CONSTRUCTION OF CHAPTER. Provides that this chapter is not intended, and is prohibited from being construed, to require a health benefit plan issuer to pay for health care services other than covered services or to supply health care services other than covered services.

ARTICLE 5. PHYSICIAN RANKING BY HEALTH BENEFIT PLAN ISSUERS

SECTION 5.001. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1460 as follows:

CHAPTER 1460. PHYSICIAN RANKING BY HEALTH BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1460.001. DEFINITIONS. Defines "hearing panel" and "physician."

Sec. 1460.002. APPLICABILITY. Provides that this chapter applies to any health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by certain health corporations or entities, or provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

[Reserves Sections 1460.003-1460.050 for expansion.]

SUBCHAPTER B. RESTRICTIONS ON PHYSICIAN RANKING

Sec. 1460.051. PHYSICIAN RANKING. Prohibits a health benefit plan issuer, including a subsidiary or an affiliate of the health benefit plan issuer, in any manner, from disseminating information to the public that compares, rates, tiers, classifies, measures, or ranks a physician's performance, efficiency, or quality of practice against objective standards or the practice of other physicians unless the objective standards or comparison criteria used by the health benefit plan issuer are disclosed to the physician prior to the evaluation period, the data used to establish satisfaction of the objective criteria or to make the comparison are available to the physician for verification before any dissemination of information to the public, and the health benefit plan issuer provides due process to the physician as provided by this chapter.

Sec. 1460.052. INJUNCTIVE RELIEF. (a) Authorizes a writ of injunction to be granted by any district court if a health benefit plan issuer disseminates, or intends to disseminate, information that compares, rates, tiers, classifies, measures, or ranks physician performance, efficiency, or quality without meeting the criteria required under Section 1460.051.

(b) Authorizes an action under Subsection (a) to be brought by any affected physician or on the behalf of affected physicians.

(c) Provides that Subchapter B (Class Actions Involving Jurisdiction of State Agency), Chapter 26 (Class Actions), Civil Practice and Remedies Code, does not apply to an action brought under this chapter.

Sec. 1460.053. DUE PROCESS; NOTICE OF INTENT. (a) Requires the issuer, before a health benefit plan issuer declines to invite a physician into a preferred tier, classifies a physician into a particular tier, or otherwise differentiates a physician from the

physician's peers based on performance, efficiency, or quality, to notify the affected physician of its intent in a written notice that meets the requirements of this section.

(b) Requires that a notice of intent issued under Subsection (a) include certain information regarding the proposed action and how the affected physician may request a hearing on the proposed action.

Sec. 1460.054. NOTICE OF HEARING. Requires the physician, if a hearing is requested by a physician who receives a notice of intent under Section 1460.053, not later than the 30th day after the date on which the physician requests the hearing, to be given a written notice of the hearing that includes certain information regarding the hearing.

Sec. 1460.055. PHYSICIAN RIGHTS. Sets forth certain rights of a physician who requests a hearing under this chapter.

Sec. 1460.056. HEARING PANEL; CONDUCT OF HEARING. (a) Requires that a hearing requested under Section 1460.054 be held before a panel of three physicians who practice the same medical specialty as the affected physician or a similar medical specialty.

(b) Sets forth the order of presentation in the hearing.

Sec. 1460.057. EFFECT OF NONAPPEARANCE; WAIVER. (a) Provides that the hearing panel is not precluded from proceeding with a hearing conducted under this chapter by the failure to appear at all or any part of the hearing of the affected physician or the physician's legal counsel, if any; or any witness.

(b) Provides that failure of a physician not represented by counsel or failure of both a physician and the physician's counsel to appear at the hearing is deemed a waiver of all procedural rights under this chapter that could have been exercised by, or on behalf of, the affected physician at the hearing.

Sec. 1460.058. EXAMINATION OF WITNESSES. Authorizes each of certain individuals present at a hearing conducted under this chapter to examine or cross-examine any witness testifying at the hearing in person, telephonically, or electronically through the Internet or otherwise.

Sec. 1460.059. BURDEN OF PROOF; DECISION. (a) Requires the health benefit plan issuer to prove, by a preponderance of evidence, that in the case of a methodology using objective standards, the affected physician's performance, efficiency, or quality and the effectiveness of the medical care delivered by the physician have not met the standards disclosed under Section 1460.051, or in the case of a methodology using relative comparison criteria, the data is accurate and correctly portrays the affected physician's performance, efficiency, or quality relative to other physicians in the same or similar medical specialty with comparable patient populations.

(b) Provides that the decision of the hearing panel is binding.

(c) Authorizes the health benefit plan issuer, if the hearing panel's decision is that the health benefit plan issuer has met its burden of proof, to publish the comparison, rating, tier, classification, measurement, or ranking.

(d) Requires the hearing panel, if the hearing panel's decision is that the health benefit plan issuer has not met its burden of proof, to instruct the health benefit plan issuer to appropriately modify the comparison, rating, tier, classification, measurement, or ranking before publication.

Sec. 1460.060. EFFECT OF CONTINUED DISAGREEMENT. (a) Requires the health benefit plan issuer, on written notice that the affected physician disagrees with the health benefit plan issuer's comparison, rating, tier, classification, measurement, or ranking or the decision of the hearing panel, to prominently display a symbol indicating the

physician disputes the comparison, rating, tier, classification, measurement, or ranking next to any comparison, rating, tier, classification, measurement, or ranking information for that physician.

(b) Requires that each Internet web page displaying comparison, rating, tier, classification, measurement, or ranking information contain a key explaining the meaning of the symbol required by Subsection (a).

ARTICLE 6. REGULATION OF SECONDARY MARKET IN CERTAIN PHYSICIAN AND PROVIDER DISCOUNTS

SECTION 6.001. 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 "contracting agent," "health care provider," "payor," "physician," and "transfer."

Sec. 1302.002. EXEMPTIONS. Provides that this chapter does not apply to the activities of a health maintenance organization's network that are subject to Subchapter J (Payment of Claims to Physicians and Providers), Chapter 843 (Health Maintenance Organizations), 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 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 contracting agent and any payor for whom a contracting agent acts or who contracts with a contracting agent, 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 the 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 contracting agent from engaging in any retaliatory action against a physician or health care provider because the physician or provider has filed a complaint against the contracting agent, or appealed a decision of the contracting agent.

[Reserves Sections 1302.005-1302.050 for expansion.]

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

Sec. 1302.051. REGISTRATION REQUIRED. (a) Requires each contracting agent that does not hold a certificate of authority or license otherwise issued by TDI under this code, except as provided by Subsection (b), to register with TDI in the manner prescribed by the commissioner before engaging in business in this state.

(b) Provides that a certified workers' compensation network is not required to register under this section if the network does not transfer the physician or health care provider contract or contract rates for any other line of business.

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.

Sec. 1302.053. REGISTRATION APPLICATION. Requires that each application for registration as a contracting agent include:

(1) a description or a copy of the applicant's basic organizational structure documents a copy of other related documents, including organizational charts or lists that show the relationships and contracts between the applicant and any affiliates of the applicant, and the internal organizational structure of the applicant's management and administrative staff;

(2) biographical information regarding each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other person having control of the applicant;

(3) a copy of the form of any contract between the applicant and any provider or group of providers, and with any third party performing services on behalf of the applicant;

(4) a copy of the form of each contract with a payor;

(5) a financial statement, current as of the date of the application, that is prepared using generally accepted accounting practices and includes a balance sheet that reflects a solvent financial position, an income statement, a cash flow statement, and the sources and uses of all funds;

(6) a statement acknowledging that lawful process in a legal or proceeding against the contracting agent on a cause of action arising in this state is valid if served in the manner provided by Chapter 804 (Service of Process) for a domestic company; and

(7) any other information that the commissioner requires by rule to implement this chapter.

Sec. 1302.053A. IMMEDIATE REGISTRATION. (a) Provides that, notwithstanding Section 1302.053, a contracting agent is eligible for immediate registration under this chapter if the contracting agent:

(1) has entered into direct contracts during the 18 months immediately preceding January 1, 2009, with physicians or health care providers in this state and with payors;

(2) does not have an officer or director who has been convicted of a felony;

(3) files with TDI an affidavit, signed by an officer with sufficient authority to bind the contracting agent, that attests to the existence of the conditions described in Subsection (a)(1) and (2), contains a statement acknowledging that lawful process in a legal action or proceeding against the contracting agent on a cause of action arising in this state is valid if served in the manner provided by Chapter 804 for a domestic company, and contains basic identifying information as the commissioner may require; and

(4) files with TDI, for informational purposes only, a copy of the form of any contract entered into between the contracting agent and physicians or health care providers in this state or with payors.

(b) Authorizes the commissioner to adopt rules or issue orders as necessary to implement this section.

(c) Provides that this section expires September 1, 2010.

[Reserves Sections 1302.054-1302.100 for expansion.]

SUBCHAPTER C. PROHIBITION OF CERTAIN TRANSFERS; NOTICE REQUIREMENTS

Sec. 1302.101. PROHIBITION OF CERTAIN TRANSFERS. (a) Prohibits a contracting agent from transferring a physician's or health care provider's contracted discount 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 workers' compensation under this code or Title 5 (Workers' Compensation), Labor Code, to request and obtain information.

Sec. 1302.102. IDENTIFICATION OF PAYORS; TERMINATION OF CONTRACT. (a) Requires a contracting agent to notify each physician and health care provider of the identity of, and contact information for, the payors and contracting agents 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 contracting agent.

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

(1) be provided, at least every calendar quarter, 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 contracting agent knows will have access to a discounted fee of the physician or health care provider in the succeeding calendar quarter, and the effective date of any applicable contract and the termination date of the contract.

(c) Authorizes the electronic mail notice under Subsection (b)(1)(A) (relating to the requirement that the notice be provided at least every calendar quarter through electronic mail) to contain a link to a secure Internet website that contains a list of payors that complies with this section.

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

(e) Authorizes the physician or health care provider, if, after receipt of the notice required under Subsection (a), a physician or health care provider objects to the addition of a payor to access the discounted fee, other than a payor that is an employer that is a self-insured health plan, to terminate its contract by providing written notice to the contracting agent not later than the 30th day after the date on which the physician or health care provider receives 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 contracting agent and a physician or health care provider, except as provided by Subsection (d), 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) Requires that a contract between a contracting agent and a physician or health care provider require that any third party who accesses the physician's or health care provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including the lines of business for which the physician or health care provider has agreed to provide services.

(d) Provides that, notwithstanding Subsection (b)(1):

(1) a contracting agent is authorized to offer, but is prohibited from requiring, a contract containing more than one line of business if:

(A) the physician's or health care provider's assent is invited via a separate signature line for each line of business;

(B) a fee schedule for each line of business is presented in a separate section of the contract or in an appendix to the contract, including applicable Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, and modifiers by which all claims for services submitted by or on behalf of the physician or health care provider will be computed and paid, or that relates to the range of health care services reasonably expected to be delivered under the contract by that physician or health care provider on a routine basis, and

(C) the fee schedule described by Paragraph B is accompanied by a toll-free telephone number or electronic address through which the physician may request the fee schedules, applicable coding methodologies, and bundling processes applicable for any services that the physician intends to provide; and

(2) a contract that uses a single fee schedule for all lines of business may contain a single appendix that is prominently referenced with the signature line for each line of business.

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

[Reserves Sections 1302.152-1302.200 for expansion.]

SUBCHAPTER E. DISCLOSURE REQUIREMENTS

Sec. 1302.201. IDENTIFICATION OF CONTRACTING AGENT. Requires that an explanation of payment or remittance advice in an electronic or paper format include the identity of the contracting agent 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; CONTRACTING AGENT. Requires a payor or representative of a payor 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 payor that assumes the risk for payment of claims or reimbursement for services, and the contracting agent through which the payment rate and any discount are claimed.

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

[Reserves Sections 1302.204-1302.250 for expansion.]

SUBCHAPTER F. ENFORCEMENT

Sec. 1302.251. PENALTIES. (a) Provides that a contracting agent who holds a certificate of authority or license under this code and who violates this chapter is subject to administrative penalties in the manner prescribed by Chapters 82 and 84 (Administrative Penalties).

(b) Provides that a violation of this chapter by a contracting agent 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.

SECTION 6.002. Amends Sections 1301.001(4) and (6), Insurance Code, to redefine "institutional provider" and "physician." Makes a nonsubstantive change.

SECTION 6.003. 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 the insurer, third-party administrator, or other entity has contracted with either the insurer, third-party administrator, or other entity has agreed to provide coverage for those health care services under the health insurance policy. Makes nonsubstantive and 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. Makes nonsubstantive changes.

(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. Defines "other entity."

(d) Requires that the notice required under Subsection (c) be provided, at least every calendar quarter, 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 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 calendar quarter, and the effective date of any applicable contract and the termination date of the contract.

(e) Authorizes the electronic mail notice under Subsection (d)(1)(A) (relating to the requirement that notice be provided at least every calendar quarter through electronic mail after provision by the affected entities of a current electronic mail address) to contain a link to a secure Internet website that contains a list of payors that complies with this section.

(f) 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.

(g) Authorizes a physician or other practitioner, institutional provider, or organization of physicians and health care providers, if, after receipt of the notice required under Subsection (c) one of these entities objects to the addition of an insurer, third-party administrator, or other entity to access to a discounted fee, 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).

(h) 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.

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

(j) Provides 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. Makes nonsubstantive changes.

(k) 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.

(l) 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 (Private Action for Damages), Chapter 541, against a contracting agent who violates this section.

SECTION 6.004. Makes application of this article prospective.

SECTION 6.005. Requires the commissioner to adopt rules as necessary to implement Chapter 1302, Insurance Code, as added by this article, not later than December 1, 2009.

SECTION 6.006. Provides that this article applies only to a contract entered into or renewed on or after January 1, 2010. Provides that a contract entered into or renewed before January 1, 2010, is governed by the law as it existed immediately before the effective date of this article, and that law is continued in effect for that purpose.

SECTION 6.007. Provides that a person is not required to register under Subchapter B, Chapter 1302, Insurance Code, as added by this article, until September 1, 2010.

SECTION 6.008. (a) Effective date, except as provided by Subsections (b) and (c) of this section: September 1, 2009.

(b) Effective date of Subchapter E, Chapter 1302: January 1, 2010.

(c) Effective date of Subchapter F, Chapter 1302, September 1, 2010.

ARTICLE 7. EFFECTIVE DATE

SECTION 7.001. Effective date: upon passage or September 1, 2009.