By: Averitt S.B. No. 1257

A BILL TO BE ENTITLED

AN ACT

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.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

ARTICLE 1. CANCELLATION OF HEALTH BENEFIT PLAN

SECTION 1.001. Subchapter B, Chapter 541, Insurance Code, is amended by adding Section 541.062 to read as follows:

Sec. 541.062. BAD FAITH CANCELLATION. It is an unfair method of competition or an unfair or deceptive act or practice for a health benefit plan issuer to:

(1) set cancellation goals, quotas, or targets;

(2) pay compensation of any kind, including a bonus or award, that varies according to the number of cancellations;

(3) set, as a condition of employment, a number or volume of cancellations to be achieved; or

(4) set a performance standard, for employees or by contract with another entity, based on the number or volume of cancellations.

SECTION 1.002. Chapter 1202, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. INDEPENDENT REVIEW OF CERTAIN CANCELLATION DECISIONS

Sec. 1202.101. DEFINITIONS. In this subchapter:

(1) "Affected individual" means an individual who is otherwise entitled to benefits under a health benefit plan that is subject to a decision to cancel.

(2) "Independent review organization" means an organization certified under Chapter 4202.

(3) "Screening criteria" means the elements or factors used in a determination of whether to subject an issued health benefit plan to additional review for possible cancellation, including any applicable dollar amount or number of claims submitted.

Sec. 1202.102. APPLICABILITY. (a) This subchapter applies only to a health benefit plan, including a small or large employer health benefit plan written under Chapter 1501, 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:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a Lloyd's plan operating under Chapter 941;

(7) a health maintenance organization operating under Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan described by Subsection (a).

Sec. 1202.103. CANCELLATION FOR MISREPRESENTATION OR PREEXISTING CONDITION. Notwithstanding any other law, a health benefit plan issuer may not cancel 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) A health benefit plan issuer may not cancel 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) The notice required under Subsection (a) must include, as applicable:

(1) the principal reasons for the decision to cancel the health benefit plan;

(2) the clinical basis for a determination that a preexisting condition exists;

(3) a description of any general screening criteria used to evaluate issued health benefit plans and determine eligibility for a decision to cancel;

(4) a statement that the individual is entitled to appeal a cancellation decision to an independent review

organization;

(5) a statement that the individual has at least 45 days in which to appeal the cancellation decision to an independent review organization, and a description of the consequences of failure to appeal within that time limit;

(6) a statement that there is no cost to the individual to appeal the cancellation decision to an independent review organization; and

(7) a description of the independent review process under Chapters 4201 and 4202.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) An affected individual may 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) A health benefit plan issuer shall 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) A health benefit plan issuer shall pay all otherwise valid medical claims under an individual's plan until the later of:

(1) the date on which an independent review organization determines that the decision to cancel is appropriate; or

(2) 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) A health benefit plan issuer may cancel a health benefit plan covering an affected individual on the later of:

(1) the date an independent review organization determines that cancellation is appropriate; or

(2) the 45th day after the date an affected individual receives notice under Section 1202.104, if the individual has not initiated an appeal.

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

(c) An issuer that cancels a health benefit plan under this section may not offset against or recoup or recover from a physician or health care provider amounts paid for medical claims under a canceled health benefit plan. This subsection may not be waived, voided, or modified by contract.

Sec. 1202.107. CANCELLATION RELATED TO PREEXISTING CONDITION; STANDARDS. (a) 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:

(1) affects the risks assumed under the health benefit plan; and

(2) is undertaken with the intent to deceive the health benefit plan issuer.

(b) A health benefit plan issuer may not cancel a health benefit plan based on a preexisting condition of a newborn delivered after the application for coverage is made or as may otherwise be prohibited by law.

Sec. 1202.108. CANCELLATION FOR MISREPRESENTATION; STANDARDS. For purposes of this subchapter, a cancellation for a misrepresentation not related to a preexisting condition is inappropriate unless the misrepresentation:

(1) is of a material fact;

(2) affects the risks assumed under the health benefit plan; and

(3) is made with the intent to deceive the health benefit plan issuer.

Sec. 1202.109. REMEDIES NOT EXCLUSIVE. 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. The commissioner shall adopt rules necessary to implement and administer this subchapter.

Sec. 1202.111. SANCTIONS AND PENALTIES. A health benefit plan issuer that violates this subchapter commits an unfair practice in violation of Chapter 541 and is subject to sanctions and penalties under Chapter 82.

Sec. 1202.112. CONFIDENTIALITY. (a) 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) A health benefit plan issuer may not disclose the identity of an individual or a decision to cancel an individual's health benefit plan unless:

(1) an independent review organization determines the decision to cancel is appropriate; or

(2) the time to appeal has expired without an affected individual initiating an appeal.

SECTION 1.003. Section 4202.002, Insurance Code, is amended to read as follows:

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall adopt standards and rules for:

(1) the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201; and

(2) the suspension and revocation of the certification.

(b) The standards adopted under this section must ensure:

(1) the timely response of an independent review organization selected under this chapter;

(2) the confidentiality of medical records transmitted to an independent review organization for use in

conducting an independent review;

(3) the qualifications and independence of each physician or other health care provider making a review determination for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making review determinations; [~~and~~]

(5) the timely notice to an enrollee of the results of an independent review, including the clinical basis for the review determination<u>; and</u>

<u>(6) that review of a cancellation decision based on a preexisting condition be conducted under the direction of a physician</u>.

SECTION 1.004. Sections 4202.003, 4202.004, and 4202.006, Insurance Code, are amended to read as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of:

(A) the fifth day after the date the organization receives the information necessary to make the determination; or

(B) the eighth day after the date the organization receives the request that the determination be made; and

(2) 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:

(A) the 15th day after the date the organization receives the information necessary to make the determination; or

(B) the 20th day after the date the organization receives the request that the determination be made.

Sec. 4202.004. CERTIFICATION. To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G);

(5) the percentage of the applicant's revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of the areas of expertise of the physicians or other health care providers making review determinations for the applicant; and

(7) 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) The commissioner shall charge payors fees in accordance with this chapter as necessary to fund the operations of independent review organizations.

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

SECTION 1.005. Section 4202.009, Insurance Code, is amended to read as follows:

Sec. 4202.009. CONFIDENTIAL INFORMATION. (a) Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential.

(b) 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) An independent review organization may not disclose the identity of an affected individual or an issuer's decision to cancel a health benefit plan under Subchapter C, Chapter 1202, unless:

(1) an independent review organization determines the decision to cancel is appropriate; or

(2) the time to appeal a cancellation under that subchapter has expired without an affected individual initiating an appeal.

SECTION 1.006. Section 4202.010(a), Insurance Code, is amended to read as follows:

(a) An independent review organization conducting an independent review under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201, is not liable for damages arising from the review determination made by the organization.

SECTION 1.007. The change in law made by this article applies only to an insurance policy that is delivered, issued for delivery, or renewed on or after the effective date of this Act. An insurance policy that is delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 2. MEDICAL LOSS RATIOS

SECTION 2.001. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.010 to read as follows:

Sec. 1301.010. MEDICAL LOSS RATIO. (a) In this section:

(1) "Direct losses incurred" means the sum of direct losses paid plus an estimate of losses to be paid in the future for all claims arising from the current reporting period and all prior periods, minus the corresponding estimate made at the close of business for the preceding period. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(2) "Direct losses paid" means the sum of all payments made during the period for claimants under a preferred provider benefit plan before reinsurance has been ceded or assumed. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(3) "Direct premiums earned" means the amount of premium attributable to the coverage already provided in a given period before reinsurance has been ceded or assumed.

(4) "Medical loss ratio" means direct losses incurred divided by direct premiums earned.

(b) An insurer may not have or maintain for a preferred provider benefit plan a medical loss ratio of less than 72 percent.

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

(d) A medical loss ratio reported under this section is public information.

(e) The department shall include information on the medical loss ratio on the department's Internet website.

(f) An insurer shall 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. 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) The commissioner shall require an insurer that violates Subsection (b) to:

(1) implement a premium rate adjustment;

(2) file with the department an actuarial memorandum, prepared by a qualified actuary, in accordance with any rules adopted by the commissioner to implement this section; and

(3) 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) An actuarial memorandum provided under Subsection (g) must include:

(1) 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;

(2) 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

(3) a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided.

(i) The commissioner shall adopt rules as necessary to implement this section, including rules regarding:

(1) credible experience;

(2) whether full credibility, partial credibility, or no credibility should be assigned to particular experience; and

(3) the frequency and form of reporting medical loss ratios.

SECTION 2.002. (a) Not later than January 1, 2010, the commissioner of insurance shall adopt all rules necessary to implement Section 1301.010, Insurance Code, as added by this article. The first reporting period under Section 1301.010(c) may not cover any period that begins before January 1, 2010.

(b) Section 1301.010(f), Insurance Code, as added by this article, applies only to a preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after January 1, 2010. A policy delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

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

SECTION 3.001. Subchapter D, Chapter 501, Insurance Code,

is amended by amending Sections 501.151 and 501.153 and adding Section 501.160 to read as follows:

Sec. 501.151. POWERS AND DUTIES OF OFFICE. The office:

(1) may assess the impact of insurance rates, rules, and forms on insurance consumers in this state; [~~and~~]

(2) shall advocate in the office's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers; and

(3) shall 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.

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. The public counsel:

(1) may appear or intervene, as a party or otherwise, as a matter of right before the commissioner or department on behalf of insurance consumers, as a class, in matters involving:

(A) rates, rules, and forms affecting:

(i) property and casualty insurance;

(ii) title insurance;

(iii) credit life insurance;

(iv) credit accident and health insurance; or

(v) any other line of insurance for which the commissioner or department promulgates, sets, adopts, or approves rates, rules, or forms;

(B) rules affecting life, health, or accident

insurance; or

(C) withdrawal of approval of policy forms:

(i) in proceedings initiated by the department under Sections 1701.055 and 1701.057; or

(ii) if the public counsel presents persuasive evidence to the department that the forms do not comply with this code, a rule adopted under this code, or any other law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising from an action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this chapter;

(3) may appear or intervene, as a party or otherwise, as a matter of right on behalf of insurance consumers as a class in any proceeding in which the public counsel determines that insurance consumers are in need of representation, except that the public counsel may not intervene in an enforcement or parens patriae proceeding brought by the attorney general; [~~and~~]

(4) may appear or intervene before the commissioner or department as a party or otherwise on behalf of small commercial insurance consumers, as a class, in a matter involving rates, rules, or forms affecting commercial insurance consumers, as a class, in any proceeding in which the public counsel determines that small commercial consumers are in need of representation; and

(5) may appear before the commissioner on behalf of a small employer, eligible employee, or eligible employee's dependent in a complaint the office refers to the commissioner

under Section 501.160.

Sec. 501.160. COMPLAINT RESOLUTION FOR CERTAIN PREMIUM RATE INCREASES. (a) A small employer, an eligible employee, or an eligible employee's dependent may file a complaint with the office 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, Chapter 1501, for a new rating period exceeds 10 percent.

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

(c) With respect to a complaint filed under Subsection (a), the office may issue a subpoena applicable throughout the state that requires the production of records.

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

SECTION 3.002. Section 1501.204, Insurance Code, is amended to read as follows:

Sec. 1501.204. INDEX RATES. Under a small employer health benefit plan:

(1) the index rate for a class of business may not

exceed the index rate for any other class of business by more than 15 [~~20~~] percent; and

(2) 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, may not vary from the index rate by more than 20 [~~25~~] percent.

SECTION 3.003. Section 1501.205, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) A small employer health benefit plan issuer shall 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. Section 1501.206(a), Insurance Code, is amended to read as follows:

(a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate, measured from the first day of the preceding rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 10 [~~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 dependents 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

(3) 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. Subchapter E, Chapter 1501, Insurance Code, is amended by adding Section 1501.2131 and amending Section 1501.214 to read as follows:

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

Sec. 1501.214. ENFORCEMENT. (a) Subject to Subsection (b), if [~~If~~] the commissioner determines that a small employer health benefit plan issuer subject to this chapter exceeds the applicable premium rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Chapter 82.

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

SECTION 3.006. Chapter 1501, Insurance Code, is amended by adding Subchapter N to read as follows:

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

Sec. 1501.651. DEFINITIONS. In this chapter:

(1) "Honesty-in-premium account" means the account established under Section 1501.656.

(2) "Office" means the office of public insurance counsel.

Sec. 1501.652. COMPLAINT RESOLUTION PROCEDURE. (a) On the receipt of a referral of a complaint from the office of public insurance counsel under Section 501.160, the commissioner shall request written memoranda from the office and the small employer health benefit plan issuer that is the subject of the complaint.

(b) After receiving the initial memoranda described by Subsection (a), the commissioner may request one rebuttal memorandum from the office.

(c) The commissioner may by rule 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. The commissioner shall 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. The office may request, and the commissioner may award to the office, 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) The commissioner may 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) The commissioner shall deposit assessments collected under this section to the credit of the honesty-in-premium account.

Sec. 1501.656. HONESTY-IN-PREMIUM ACCOUNT. (a) The honesty-in-premium account is an account in the general revenue fund that may 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) Interest earned on the honesty-in-premium account shall be credited to the account. The account is exempt from the application of Section 403.095, Government Code.

Sec. 1501.657. RATE CHANGE NOT PROHIBITED. 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. The change in law made by Chapter 1501, Insurance Code, as amended by this article, applies only to a small employer health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2010. A small employer health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2010, is covered by the law in effect at the time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that

purpose.

ARTICLE 4. STANDARDIZED PROCESSING OF CERTAIN HEALTH BENEFIT PLAN CLAIMS

SECTION 4.001. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:

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

Sec. 1458.001. DEFINITIONS. In this chapter:

(1) "Add-on CPT code" means a CPT code listed in Appendix D of the American Medical Association's "Current Procedural Terminology 2009 Professional Edition" or a subsequent edition of that publication adopted by the commissioner by rule.

(2) "CPT code" means the number assigned to identify a specific health care procedure performed by a health care provider 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.

(3) "Multiple procedure logic" means an adjustment to a payment for one or more health care procedures or other services that constitute covered services when multiple procedures are performed at the same visit.

Sec. 1458.002. APPLICABILITY. (a) This chapter applies to any health benefit plan that:

(1) 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:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843;

(F) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) 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.

(b) This chapter applies to a person with whom a health benefit plan contracts to:

(1) process or pay claims; or

(2) obtain the services of physicians or other health care providers to provide health care services to enrollees in the

plan.

(c) This chapter does not apply to the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

Sec. 1458.003. STANDARDIZED RECOGNITION OF CODING; RESTRICTIONS. (a) A health benefit plan issuer may not subject a modifier 51-exempt CPT code to multiple procedure logic.

(b) A health benefit plan issuer shall recognize add-on CPT codes as eligible for payment as separate codes and may not subject add-on CPT codes to multiple procedure logic.

(c) 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, a health benefit plan issuer must recognize both codes as eligible for payment unless the applicable clinical information indicates that use of the modifier 25 was inappropriate.

(d) A health benefit plan issuer shall 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. The health benefit plan issuer may not be required to pay for supervision or interpretation by more than one physician for each of those procedures.

(e) Other than CPT codes specifically identified as modifier 51-exempt or add-on CPT codes, a health benefit plan issuer may not reassign 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. For indented code series contemplating that multiple codes in the series may be properly reported and billed concurrently, the health benefit plan issuer shall recognize all codes properly billed as eligible for payment.

(f) A health benefit plan issuer shall 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:

(1) those procedures or services are not normally reported together but are appropriately reported together under the particular circumstances; and

(2) 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) Global periods for surgical procedures may not be 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) A health benefit plan issuer may not change a CPT code to a CPT code reflecting a reduced intensity of the service if that CPT code is one among a series that differentiates among simple, intermediate, and complex procedures.

Sec. 1458.004. CONSTRUCTION OF CHAPTER. This chapter is not intended, and may not be 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. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1460 to read as follows:

CHAPTER 1460. PHYSICIAN RANKING BY HEALTH BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1460.001. DEFINITIONS. In this chapter:

(1) "Hearing panel" means the physician panel described by Section 1460.056(a).

(2) "Physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

Sec. 1460.002. APPLICABILITY. This chapter applies to any health benefit plan that:

(1) 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:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843;

(F) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) 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.

[Sections 1460.003-1460.050 reserved for expansion]

SUBCHAPTER B. RESTRICTIONS ON PHYSICIAN RANKING

Sec. 1460.051. PHYSICIAN RANKING. A health benefit plan issuer, including a subsidiary or an affiliate of the health benefit plan issuer, may not, in any manner, disseminate 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:

(1) the objective standards or comparison criteria used by the health benefit plan issuer are disclosed to the physician prior to the evaluation period;

(2) 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

(3) the health benefit plan issuer provides due process to the physician as provided by this chapter.

Sec. 1460.052. INJUNCTIVE RELIEF. (a) A writ of injunction may 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) An action under Subsection (a) may be brought by any affected physician or on the behalf of affected physicians.

(c) Subchapter B, Chapter 26, Civil Practice and Remedies Code, does not apply to an action brought under this chapter.

Sec. 1460.053. DUE PROCESS; NOTICE OF INTENT. (a) 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, the issuer must

notify the affected physician of its intent in a written notice that meets the requirements of this section.

(b) A notice of intent issued under Subsection (a) must include:

(1) a statement describing the proposed action of the health benefit plan issuer and the reasons for that proposed action;

(2) a statement that the affected physician has the right to request a hearing on the proposed action as provided by this chapter;

(3) any time limit within which the physician must request a hearing under this chapter, which may not be less than 60 days from the date on which the notice of intent is issued; and

(4) a summary of the physician's rights under Section 1460.055.

Sec. 1460.054. NOTICE OF HEARING. 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 the physician must be given a written notice of the hearing that includes:

(1) a statement of the place, time, and date of the hearing, which must be conducted:

(A) not less than 60 days after the date the notice of the hearing is received by the physician; and

(B) not more than 90 days after the date the notice of the hearing is received by the physician; and

(2) a list of the witnesses, if any, expected to

testify at the hearing on behalf of the health benefit plan issuer.

Sec. 1460.055. PHYSICIAN RIGHTS. A physician who requests a hearing under this chapter has the following rights at the hearing:

(1) the right to be represented by counsel;

(2) the right to have a record made of the proceedings and to obtain a copy of the record for a reasonable charge;

(3) the right to call, examine, and cross-examine witnesses;

(4) the right to present evidence;

(5) the right to submit a written statement to the hearing panel at the close of the hearing; and

(6) the right to receive, following the hearing, the written decision of the hearing panel, including a statement of the basis for any recommendations by the panel.

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

(b) The order of presentation in the hearing shall be as follows:

(1) opening statements by the health benefit plan issuer followed by the physician or the physician's counsel;

(2) presentation of the case by the health benefit plan issuer followed by presentation of the case by the physician or the physician's counsel;

(3) rebuttal by the health benefit plan issuer

followed by the physician or the physician's counsel; and

(4) closing statements by the health benefit plan issuer followed by the physician or the physician's counsel.

Sec. 1460.057. EFFECT OF NONAPPEARANCE; WAIVER. (a) 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:

(1) the affected physician or the physician's legal counsel, if any; or

(2) any witness.

(b) 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. Each of the following persons present at a hearing conducted under this chapter may examine or cross-examine any witness testifying at the hearing in person, telephonically, or electronically through the Internet or otherwise:

(1) the physician or, at the physician's option, the physician's counsel, but not both;

(2) the representative of the health benefit plan issuer, as designated by the issuer; and

(3) the members of the hearing panel.

Sec. 1460.059. BURDEN OF PROOF; DECISION. (a) The health benefit plan issuer must prove, by a preponderance of evidence,

that:

(1) 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

(2) 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) The decision of the hearing panel is binding.

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

(d) If the hearing panel's decision is that the health benefit plan issuer has not met its burden of proof, the panel shall 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) 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, the health benefit plan issuer shall 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) Each Internet web page displaying comparison, rating, tier, classification, measurement, or ranking information must 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. Subtitle D, Title 8, Insurance Code, is amended by adding Chapter 1302 to read as follows:

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1302.001. DEFINITIONS. In this chapter:

(1) "Contracting agent" means any entity engaged, for monetary or other consideration, in disclosing or transferring a contracted discounted fee of a physician or health care provider.

(2) "Health care provider" means a hospital, a physician-hospital organization, or an ambulatory surgical center.

(3) "Payor" means a fully self-insured health plan, a health benefit plan, an insurer, or another entity that assumes the risk for payment of claims by, or reimbursement for health care services provided by, physicians and health care providers.

(4) "Physician" means:

(A) an individual licensed to practice medicine in this state under the authority of Subtitle B, Title 3,

Occupations Code;

(B) a professional entity organized in conformity with Title 7, Business Organizations Code, and permitted to practice medicine under Subtitle B, Title 3, Occupations Code;

(C) a partnership organized in conformity with Title 4, Business Organizations Code, comprised entirely by individuals licensed to practice medicine under Subtitle B, Title 3, Occupations Code;

(D) an approved nonprofit health corporation certified under Chapter 162, Occupations Code;

(E) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.501, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(F) any other person wholly owned by individuals licensed to practice medicine under Subtitle B, Title 3, Occupations Code.

(5) "Transfer" means to lease, sell, aggregate, assign, or otherwise convey a contracted discounted fee of a physician or health care provider.

Sec. 1302.002. EXEMPTIONS. This chapter does not apply to:

(1) the activities of:

(A) a health maintenance organization's network that are subject to Subchapter J, Chapter 843; or

(B) an insurer's preferred provider network that

are subject to Subchapters C and C-1, Chapter 1301; or

(2) any aspect of the administration or operation of:

(A) the state child health plan; or

(B) any medical assistance program using a managed care organization or managed care principal, including the state Medicaid managed care program under Chapter 533, Government Code.

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

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

Sec. 1302.004. RETALIATION PROHIBITED. A contracting agent may not engage in any retaliatory action against a physician or health care provider because the physician or provider has:

(1) filed a complaint against the contracting agent; or

(2) appealed a decision of the contracting agent.

[Sections 1302.005-1302.050 reserved for expansion]

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

Sec. 1302.051. REGISTRATION REQUIRED. (a) Except as provided by Subsection (b), each contracting agent that does not hold a certificate of authority or license otherwise issued by the

department under this code must register with the department in the manner prescribed by the commissioner before engaging in business in this state.

(b) 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. The commissioner shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement and administer this chapter.

Sec. 1302.053. REGISTRATION APPLICATION. Each application for registration as a contracting agent must include:

(1) a description or a copy of the applicant's basic organizational structure documents and a copy of other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) 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) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(6) 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

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

Sec. 1302.053A. IMMEDIATE REGISTRATION. (a) 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 the department an affidavit, signed by an officer with sufficient authority to bind the contracting agent, that:

(A) attests to the existence of the conditions described in Subsections (a)(1) and (2);

(B) 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

(C) contains basic identifying information as the commissioner may require; and

(4) files with the department, 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) The commissioner may adopt rules or issue orders as necessary to implement this section.

(c) This section expires September 1, 2010.

[Sections 1302.054-1302.100 reserved for expansion]

SUBCHAPTER C. PROHIBITION OF CERTAIN TRANSFERS; NOTICE REQUIREMENTS

Sec. 1302.101. PROHIBITION OF CERTAIN TRANSFERS. (a) A contracting agent may not transfer 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) This section does not affect the authority of the commissioner of insurance or the commissioner of workers' compensation under this code or Title 5, Labor Code, to request and

obtain information.

Sec. 1302.102. IDENTIFICATION OF PAYORS; TERMINATION OF CONTRACT. (a) A contracting agent shall 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. The notice requirement under this subsection does not apply to an employer authorized to access a discounted fee through a contracting agent.

(b) The notice required under Subsection (a) must:

(1) be provided, at least every calendar quarter, through:

(A) electronic mail, after provision by the affected physician or health care provider of a current electronic mail address; and

(B) posting of a list on a secure Internet website; and

(2) include a separate prominent section that lists:

(A) 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

(B) the effective date of any applicable contract and the termination date of the contract.

(c) The electronic mail notice under Subsection (b)(1)(A) may contain a link to a secure Internet website that contains a list of payors that complies with this section.

(d) The identity of a 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) must be included in the subsequent notice.

(e) 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 to a discounted fee, other than a payor that is an employer that is a self-insured health plan, the physician or health care provider may 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). Termination of a contract under this subsection is subject to applicable continuity of care requirements under Section 843.362 and Subchapter D, Chapter 1301.

[Sections 1302.103-1302.150 reserved for expansion]

SUBCHAPTER D. RESTRICTIONS ON TRANSFERS

Sec. 1302.151. RESTRICTIONS ON TRANSFERS; EXCEPTION. (a) In this section, "line of business" includes noninsurance plans, fully self-insured health plans, Medicare Advantage plans, and personal injury protection under an automobile insurance policy.

(b) Except as provided by Subsection (d), a contract between a contracting agent and a physician or health care provider may not require 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) A contract between a contracting agent and a physician or health care provider must 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) Notwithstanding Subsection (b)(1):

(1) a contracting agent may offer, but may not require, 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:

(i) by which all claims for services submitted by or on behalf of the physician or health care provider will be computed and paid; or

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

[Sections 1302.152-1302.200 reserved for expansion]

SUBCHAPTER E. DISCLOSURE REQUIREMENTS

Sec. 1302.201. IDENTIFICATION OF CONTRACTING AGENT. An explanation of payment or remittance advice in an electronic or paper format must 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. A payor or representative of a payor that processes claims or claims payments must clearly identify in an electronic or paper format on the explanation of payment or

remittance advice the identity of:

(1) the payor that assumes the risk for payment of claims or reimbursement for services; and

(2) the contracting agent through which the payment rate and any discount are claimed.

Sec. 1302.203. INFORMATION ON IDENTIFICATION CARDS. If a contracting agent or payor issues member or subscriber identification cards, the identification cards must identify, in a clear and legible manner, any third-party entity, including any contracting agent:

(1) who is responsible for paying claims; and

(2) through whom the payment rate and any discount are claimed.

[Sections 1302.204-1302.250 reserved for expansion]

SUBCHAPTER F. ENFORCEMENT

Sec. 1302.251. PENALTIES. (a) 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.

(b) 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, Chapter 17, Business & Commerce Code.

SECTION 6.002. Sections 1301.001(4) and (6), Insurance Code, are amended to read as follows:

(4) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility

that provides care for the sick or injured or other care that may be covered in a health insurance policy. The term includes an ambulatory surgical center.

(6) "Physician" means:

(A) an individual [~~a person~~] licensed to practice medicine in this state under the authority of Title 3, Subtitle B, Occupations Code;

(B) a professional entity organized in conformity with Title 7, Business Organizations Code, and permitted to practice medicine under Subtitle B, Title 3, Occupations Code;

(C) a partnership organized in conformity with Title 4, Business Organizations Code, comprised entirely by individuals licensed to practice medicine under Subtitle B, Title 3, Occupations Code;

(D) an approved nonprofit health corporation certified under Chapter 162, Occupations Code;

(E) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.501, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(F) any other person wholly owned by individuals licensed to practice medicine under Subtitle B, Title 3, Occupations Code.

SECTION 6.003. Section 1301.056, Insurance Code, is amended to read as follows:

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurer, [~~or~~] third-party administrator, or other entity may not reimburse 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:

(1) the insurer, [~~or~~] third-party administrator, or other entity has contracted with either:

(A) the physician or other practitioner, institutional provider, or organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the physician or other practitioner, institutional provider, or organization of physicians and health care providers;

(2) the physician or other practitioner, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer, [~~or~~] third-party administrator, or other entity has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, assign, aggregate, disclose, or otherwise transfer the discounted fee, or any other information regarding the discount, payment, or reimbursement terms of the contract without the express

authority of and [~~prior~~] adequate notification to the other contracting parties. This subsection does not:

(1) prohibit a payor from disclosing any information, including fees, to an insured; or

(2) affect the authority of the commissioner of insurance or the commissioner of workers' compensation under this code or Title 5, Labor Code, to request and obtain information.

(c) An insurer, third-party administrator, or other entity may not access 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. 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) The notice required under Subsection (c) must:

(1) be provided, at least every calendar quarter, through:

(A) electronic mail, after provision by the affected physician or health care provider of a current electronic mail address; and

(B) posting of a list on a secure Internet website; and

(2) include a separate prominent section that lists:

(A) 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

(B) the effective date of any applicable contract and the termination date of the contract.

(e) The electronic mail notice under Subsection (d)(1)(A) may contain a link to a secure Internet website that contains a list of payors that complies with this section.

(f) 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) must be included in the subsequent notice.

(g) If, after receipt of the notice required under Subsection (c), a 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, the physician or other practitioner, institutional provider, or organization of physicians and health care providers may 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) An insurer, third-party administrator, or other entity that processes claims or claims payments shall clearly identify in an electronic or paper format on the explanation of payment or remittance advice:

(1) the identity of the party responsible for administering the claims; and

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

(j) An insurer, [~~or~~] third-party administrator, or other entity that holds a certificate of authority or license under this code who violates this section:

(1) commits an unfair settlement practice in violation of Chapter 541;

(2) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542; and

(3) [~~(2)~~] is subject to administrative penalties under Chapters 82 and 84.

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

SECTION 6.004. The change in law made by this article applies only to a cause of action that accrues on or after the effective date of this article. A cause of action that accrues before that date 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 6.005. The commissioner of insurance shall adopt rules as necessary to implement Chapter 1302, Insurance Code, as added by this article, not later than December 1, 2009.

SECTION 6.006. This article applies only to a contract entered into or renewed on or after January 1, 2010. 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. 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) Except as provided by Subsections (b) and (c) of this section, this article takes effect September 1, 2009.

(b) Subchapter E, Chapter 1302, Insurance Code, as added by this article, takes effect January 1, 2010.

(c) Subchapter F, Chapter 1302, Insurance Code, as added by this article, takes effect September 1, 2010.

ARTICLE 7. EFFECTIVE DATE

SECTION 7.001. Except as otherwise provided by this Act, this Act takes effect immediately if it receives a vote of

two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.