By: Duncan S.B. No. 2332

A BILL TO BE ENTITLED

AN ACT

relating to the regulation of preferred provider benefit plans regarding network adequacy, contracting and reimbursement activities.

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

SECTION 1. Section 1301.001, Insurance Code, is amended by adding Subdivision (3-a) to read as follows:

(3-a) "Hospital-based physician" includes a radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, and any other category of physician as determined appropriate by the commissioner:

(A) to whom the hospital has granted clinical privileges; and

(B) who provides services to patients of the hospital under those clinical privileges.

SECTION 2. Section 1301.005, Insurance Code, is amended by adding Subsections (a-1), (a-2), and (d) to read as follows:

(a-1) The commissioner shall adopt rules to establish network adequacy requirements and related marketing requirements for preferred provider benefits for hospital-based physician services furnished at a hospital that is a preferred provider for an insurer offering a preferred provider benefit plan.

(a-2) The rules adopted by the Commissioner pursuant to Subsection (a-1) shall require that an insurer fully comply with

the network adequacy requirements established under such rules no later than September 1, 2011.

(d) Subsection (b) does not excuse an insurer's duty to comply with network adequacy and health care availability and accessibility requirements for preferred provider benefits as established by this chapter and as required by the commissioner by rules adopted pursuant to Subsection (a-1).

SECTION 3. Section 1301.007, Insurance Code, is amended to read as follows:

Sec. 1301.007. RULES. (a) The commissioner shall adopt rules as necessary to:

(1) implement this chapter; and

(2) ensure reasonable accessibility and availability of preferred provider services to residents of this state, including rules to establish network adequacy requirements for preferred provider benefits for hospital-based physician services furnished at a hospital that is a preferred provider for an insurer offering a preferred provider benefit plan.

(b) In adopting rules to establish hospital-based physician network adequacy requirements, the commissioner shall consider an insurer's good faith negotiations with hospital-based physicians in creating and maintaining the insurer's preferred provider network.

(1) Presumption of good faith. There shall be a presumption that an insurer has engaged in good faith negotiations as required in this subsection if:

(A) fewer than five per cent of an insurer's

hospital-based physician claims are out-of-network claims; or

(B) the insurer has offered prospective hospital-based physicians an amount at least equal to the insurer's average contracted rate for those hospital-based physician services.

(2) Other factors. The commissioner shall consider additional factors with respect to whether an insurer has engaged in good faith negotiations with hospital-based physicians, including:

(A) the length of time the insurer has been trying to negotiate a contract with the out-of-network hospital-based physicians;

(B) the in-network payment rates the insurer has offered to the hospital-based physicians;

(C) the other, non-financial contractual terms the insurer has offered to the out-of-network hospital-based physicians, including those relating to prior authorization and other utilization management policies and procedures;

(D) the insurer's history with respect to claims payment timeliness, overturned claims denials, and physician and provider complaints;

(E) the insurer's solvency status;

(F) the out-of-network hospital-based physicians' reasons for not contracting with the insurer; and

(G) any additional information the commissioner determines relevant to determine whether an insurer has undertaken good faith negotiations.

SECTION 4. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Sections 1301.070 and 1301.071 to read as follows:

Sec. 1301.070. TRANSACTION IMPROVEMENT PROCESS. An insurer offering a preferred provider benefit plan shall, in consultation with preferred providers, establish a transaction improvement process focused on decreasing difficulties for insureds.

Sec. 1301.071. CONTRACT PROVISIONS REQUIRED FOR USE WITH HOSPITALS. A preferred provider contract with a hospital shall include the following provisions:

(1) hospital contracts with hospital-based physicians or groups of hospital-based physicians shall not grant exclusive practice privileges unless the physicians or groups of physicians agree not to bill the insureds covered by the insurer's preferred provider benefit plan, other than for co-payments and deductibles, for the balance of the physician's fee for service received by the insured from the physician that is not fully reimbursed by the insurer;

(2) hospitals that have at least one day of notice that hospital-based physician services will be required for an insured covered by the insurer's preferred provider benefit plan shall coordinate with the hospital-based physician or group of hospital-based physicians likely to furnish the services to supply a good faith estimate to the insured and insurer of the cost of the hospital-based physician services if the hospital-based physician services are likely to be provided by an out-of-network physician;

(3) in scheduling hospital-based physician services

for an insured covered by a preferred provider benefit plan, hospitals shall assign hospital-based physicians that are preferred providers with an insurer's preferred provider benefit plan to furnish services except in extraordinary circumstances;

(4) except in extraordinary circumstances, hospitals shall provide notice of the pending termination of a hospital-based physician group contract with the hospital to an insurer with whom the hospital is a preferred provider at least 60 days prior to the effective date of the termination; and

(5) if the hospital is unable to furnish notice as required in Subdivision (4) due to extraordinary circumstances, the hospital shall provide the notice as soon as is reasonably practicable.

SECTION 5. Section 1301.1591 is amended by adding Subsection (b-1) to read as follows:

(b-1) Notwithstanding Subsection (b), the insurer shall update an Internet site subject to this section that lists hospital-based physicians that are preferred providers with the insurer's preferred provider benefit plan at a hospital that is a preferred provider with insurer's preferred provider benefit plan within five days of the insurer's receipt of notice from the hospital that the status of a hospital-based physician group as hospital-based providers at the hospital has terminated or will terminate on a date certain.

SECTION 6. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.1592 to read as follows:

Sec. 1301.1592. SPECIAL REQUIREMENT CONCERNING TERMINATION

OF HOSPITAL-BASED PHYSICIANS. (a) On receipt of notice from a hospital that is a preferred provider with an insurer that the status of a hospital-based physician group as hospital-based providers at the hospital has terminated or will terminate on a date certain, the insurer shall provide written notice to insureds of the change.

(b) The insurer shall establish procedures to enable the insurer to provide the notice required in Subsection (a) to insureds within 10 days of the insurer's receipt of notice from a hospital.

(c) If a hospital-based physician group's participation in a preferred provider benefit plan is terminated at the hospital-based physician group's request, the insurer shall provide written notice to insureds no later than 10 days after the effective date of the termination.

SECTION 7. Section 1301.160, Insurance Code, is amended by amending Subsections (a) to read as follows:

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request or by reason of the termination of the practitioner's status as a hospital-based provider at a hospital, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal recommendation regarding the termination.

SECTION 8. Chapter 1301, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. OUT-OF-NETWORK REIMBURSEMENT OF HOSPITAL-BASED PHYSICIANS.

Sec. 1301.251. APPLICABILITY. (a) This subchapter applies only to claims submitted on or after September 1, 2012, or a later date as determined by the commissioner by rule, by hospital-based physicians to an insurer for services provided to an insured at a hospital that is a preferred provider under a preferred provider benefit plan.

Sec. 1301.252. REIMBURSEMENT OF OUT-OF-NETWORK HOSPITAL-BASED PHYSICIAN SERVICES. (a) If a preferred provider hospital or a hospital-based physician notifies an insurer offering a preferred provider benefit plan at least five days prior to provision of covered health care services to an insured that the service is likely to be provided by a hospital-based physician that is not a preferred provider with the insurer's preferred provider benefit plan and furnishes a good-faith estimate of the hospital-based physician's charges for the anticipated services, the insurer must attempt in good faith to reach an agreed reimbursement rate for the services before the services are furnished.

(b) If the insurer and hospital-based physician do not agree to a reimbursement rate for covered services as described in Subsection (a), the insurer will furnish to the insured, in advance of the procedure, a written statement containing the following information:

(1) a statement of the reimbursement offer made by the insurer to the hospital-based physician and the basis for the offer;

(2) a statement of the hospital-based physician's counteroffer to the insurer concerning reimbursement, if any, and the provider's estimated billed charge; and

(3) a statement of the amount for which the patient might be billed after reimbursement by the insurer.

(c) On receipt of a claim for covered services from a hospital-based physician that is not a preferred provider with the insurer's preferred provider benefit plan, the insurer must pay the hospital-based physician's billed charges if:

(1) the hospital-based physician, in coordination with the preferred provider hospital, furnished to the insurer a good faith estimate of charges for services as described in Subsection (a); and

(2) the hospital-based physician participates in an annually-published survey of billed charges for commonly used services as approved the commissioner or as collected and published by the department.

(d) On receipt of a claim for covered services from a hospital-based physician that is not a preferred provider with the insurer's preferred provider benefit plan, and for which the hospital-based physician did not furnish a good faith estimate of charges for the anticipated services as described in Subsection (a), the insurer may reimburse the hospital-based physician at the same percentage level of reimbursement as a preferred provider

would have been reimbursed had the insured been treated by a preferred provider, provided the insurer offers to pay for binding arbitration with the hospital-based physician with respect to the remainder of the hospital-based physician's billed charges, excepting amounts attributable to copayments and deductibles.

(e) This section does not preclude application of Subchapter C with respect to claims subject to that subchapter.

SECTION 9. Not later than May 1, 2010, the commissioner of insurance shall adopt rules as necessary to implement Chapter 1301, as amended by this Act.

SECTION 10. This Act applies to an insurance policy, certificate, or contract delivered, issued for delivery, or renewed on or after the effective date of this Act. A policy, certificate, or contract delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 11. With respect to a contract entered into between an insurer and a hospital that is a preferred provider with the insurer's preferred provider benefit plan, the changes in law made by this Act apply only to a contract entered into or renewed on or after the effective date of this Act. Such a contract entered into or renewed before the effective date of this Act 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.

SECTION 12. With respect to the payment for medical care or health care services furnished, but not furnished under a contract

entered into between an insurer and a physician or group of physicians, the changes in law made by this Act apply only to medical care or health care services for which claims are submitted to the insurer on or after September 1, 2012.

SECTION 13. (a) Except as provided by Subsection (b) of this section, this Act takes effect September 1, 2009.

(b) Section 8 of this Act takes effect on September 1, 2012.