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A BILL TO BE ENTITLED

AN ACT

relating to regulation of certain health care provider network contract arrangements.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Contracting entity" means a person that enters into a direct contract with a provider for the delivery of health care services in the ordinary course of business.

(3) "Covered individual" means an individual who is covered under a health benefit plan.

(4) "Direct notification" means a written or electronic communication from a contracting entity to a physician or other health care provider documenting third party access to a provider network.

(5) "Health care services" means services provided for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

(6) "Person" has the meaning assigned by Section 823.002.

(7) "Provider" means a physician, a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, a partnership composed solely of physicians, a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts, a health care practitioner, or an institutional provider or other person or organization that furnishes health care services that is licensed or otherwise authorized to practice in this state. The term does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to a third party.

(8) "Provider network contract" means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual.

(9) "Third party" means a person that contracts with a contracting entity or third party to gain access to a provider network contract.

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means:

(1) a hospital and medical expense incurred policy;

(2) a nonprofit health care service plan contract;

(3) a health maintenance organization subscriber contract; or

(4) any other health care plan or arrangement that pays for or furnishes medical or health care services.

(b) "Health benefit plan" does not include one or more or any combination of the following:

(1) coverage only for accident or disability income insurance or any combination of those coverages;

(2) credit-only insurance;

(3) coverage issued as a supplement to liability insurance;

(4) liability insurance, including general liability insurance and automobile liability insurance;

(5) workers' compensation or similar insurance;

(6) coverage for on-site medical clinics;

(7) automobile medical payment insurance; or

(8) other similar insurance coverage, as specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:

(1) dental or vision benefits;

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits;

(3) other similar, limited benefits, including benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or

(4) a Medicare supplement benefit plan described by Section 1652.002.

(d) "Health benefit plan" does not include coverage limited to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if:

(1) the coverage is provided under a separate policy, certificate, or contract of insurance;

(2) there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and

(3) the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor.

Sec. 1458.003. EXEMPTIONS. This chapter does not apply:

(1) to a provider network contract for services provided to a beneficiary under the Medicaid program, the Medicare program, or the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code;

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

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

[Sections 1458.004-1458.050 reserved for expansion]

SUBCHAPTER B. REGISTRATION REQUIREMENTS

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

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

Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) A person required to register under Section 1458.051 must disclose:

(1) all names used by the contracting entity, including any name under which the contracting entity intends to engage or has engaged in business in this state;

(2) the mailing address and main telephone number of the contracting entity's headquarters;

(3) the name and telephone number of the contracting entity's primary contact for the department; and

(4) any other information required by the commissioner by rule.

(b) The disclosure made under Subsection (a) must include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show:

(1) the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks; and

(2) the internal organizational structure of the contracting entity's management.

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

Sec. 1458.054. FEES. The department may collect a reasonable fee set by the commissioner as necessary to administer the registration process. Fees collected under this chapter shall be deposited in the Texas Department of Insurance operating fund.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) The commissioner may grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that:

(1) multiple registrations would require the filing of duplicative information or would be wasteful of state resources;

(2) the affiliate is not subject to a disclaimer of

affiliation under Chapter 823; and

(3) the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

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

Sec. 1458.056. RULES CONCERNING EXEMPTIONS FROM REGISTRATION REQUIREMENTS. The commissioner by rule:

(1) shall prescribe the form for filing for an exemption under Section 1458.055;

(2) shall establish the circumstances under which an exemption is required to be amended or a new exemption filed;

(3) shall establish the time frames and manner for filing initial, amended, and renewal exemptions;

(4) shall establish the period for which an initial, amended, or renewal exemption is valid;

(5) shall establish a reasonable fee as necessary to administer the exemption process; and

(6) may require disclosure of any information necessary to implement and administer Section 1458.055.

[Sections 1458.057-1458.100 reserved for expansion]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the

provider network contract specifically states that:

(1) the contracting entity may contract with a third party to provide access to the contracting entity's rights and responsibilities under a provider network contract; and

(2) the third party must comply with all applicable terms, limitations, and conditions of the provider network contract.

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

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

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

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

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

(b) The notice required under Subsection (a)(1):

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

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

(B) posting of the information on an Internet website; and

(2) must include a separate prominent section that lists:

(A) each third party that the contracting entity knows will have access to a discounted fee of the provider in the succeeding calendar quarter; and

(B) the effective date and termination or renewal dates, if any, of the third party's contract to access the network.

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

Sec. 1458.103. EFFECT OF CONTRACT TERMINATION. Subject to continuity of care requirements, agreements, or contractual provisions:

(1) a third party may not access health care services and contractual discounts after the date the provider network contract terminates;

(2) claims for health care services performed after the termination date may not be processed or paid under the provider network contract after the termination; and

(3) claims for health care services performed before the termination date and processed after the termination date may

be processed and paid under the provider network contract after the date of termination.

Sec. 1458.104. OFFER FOR DIRECT CONTRACT BY CONTRACTING ENTITY. (a) In this section, "line of business" has the meaning assigned by commissioner rule. The term includes noninsurance plans.

(b) Except as provided by Subsection (c), a contract between a contracting entity and a provider may not require the provider to consent to access to, or transfer of, the provider's name and contracted discounted fee for use with more than one line of business.

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

Sec. 1458.105. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a contracting entity and a provider must provide that:

(1) the provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the provider will receive under the contract;

(2) the contracting entity or the contracting entity's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the contracting entity receives the request;

(3) the contracting entity or the contracting entity's

agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) the contract may be terminated by the provider on or before the 30th day after the date the provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A provider who receives information under Subsection (a) may only:

(1) use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

(2) disclose the information to a governmental agency involved in the regulation of health care or insurance.

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

(d) The provisions of this section may not be waived, voided, or nullified by contract.

[Sections 1458.106-1458.150 reserved for expansion]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY

Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. (a) A third party that grants access to a provider's health care

services and contractual discounts to another third party must comply with the responsibilities of a contracting entity under Subchapters C and E.

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

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

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

[Sections 1458.153-1458.200 reserved for expansion]

SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS

Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT. (a) A person who knowingly accesses or uses a provider's contractual discount under a provider network contract without a contractual relationship established under this chapter commits an unfair or deceptive act in the business of insurance that violates Subchapter B, Chapter 541. The remedies available for a violation of Subchapter B, Chapter 541, under this subsection do not include a private cause of action under Subchapter D, Chapter 541, or a class

action under Subchapter F, Chapter 541.

(b) A contracting entity or third party must comply with the disclosure requirements under Section 1458.052(a)(2) or 1458.152 concerning the services listed on a remittance advice or explanation of payment. A provider may refuse a discount taken without a contract under this chapter or in violation of those sections.

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

Sec. 1458.202. ACCESS TO THIRD PARTY. A contracting entity may not provide a third party access to a provider network contract unless the third party is:

(1) a payor or person who administers or processes claims on behalf of the payor;

(2) a preferred provider benefit plan issuer or preferred provider network, including a physician-hospital organization; or

(3) a person who transports claims electronically between the contracting entity and the payor and does not provide access to the provider's services and discounts to any other third party.

[Sections 1458.203-1458.250 reserved for expansion]

SUBCHAPTER F. ENFORCEMENT

Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) A

contracting entity that violates this chapter commits an unfair claim settlement practice under Subchapter A, Chapter 542, and is subject to sanctions under that subchapter as if the contracting entity were an insurer.

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

Sec. 1458.252. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are:

(1) not exclusive; and

(2) in addition to any other remedy or procedure provided by another law or at common law.

SECTION 2. The change in law made by this Act applies only to a provider network contract entered into or renewed on or after January 1, 2012. A provider network contract entered into or renewed before January 1, 2012, 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 3. This Act takes effect September 1, 2011.