

By: Carona

S.B. No. 521

A BILL TO BE ENTITLED

AN ACT

relating to the operation of certain managed care plans with respect to health care providers.

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

SECTION 1. Section 843.306, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) A health maintenance organization may not terminate participation of a physician or provider solely because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers.

SECTION 2. Section 843.363(a), Insurance Code, is amended to read as follows:

(a) A health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the terms, requirements, or services of the health care plan as they relate to

1 the medical needs of the patient; [~~or~~]

2 (3) the termination of the physician's, dentist's, or  
3 provider's contract with the health care plan or the fact that the  
4 physician, dentist, or provider will otherwise no longer be  
5 providing medical care, dental care, or health care services under  
6 the health care plan; or

7 (4) information regarding the availability of  
8 facilities, both in-network and out-of-network, for the treatment  
9 of the patient's medical condition.

10 SECTION 3. Section 1301.001, Insurance Code, is amended by  
11 adding Subdivision (5-a) to read as follows:

12 (5-a) "Out-of-network provider" means a physician or  
13 health care provider who is not a preferred provider.

14 SECTION 4. Subchapter A, Chapter 1301, Insurance Code, is  
15 amended by adding Sections 1301.0051 and 1301.0052 to read as  
16 follows:

17 Sec. 1301.0051. ACCESS TO OUT-OF-NETWORK PROVIDERS. An  
18 insurer may not terminate, or threaten to terminate, an insured's  
19 participation in a preferred provider benefit plan solely because  
20 the insured uses an out-of-network provider.

21 Sec. 1301.0052. PROTECTED COMMUNICATIONS BY PREFERRED  
22 PROVIDERS. (a) An insurer may not in any manner prohibit, attempt  
23 to prohibit, penalize, terminate, or otherwise restrict a preferred  
24 provider from communicating with an insured about the availability  
25 of out-of-network providers for the provision of the insured's  
26 medical or health care services.

27 (b) An insurer may not terminate the contract of or

1 otherwise penalize a preferred provider solely because the  
2 provider's patients use out-of-network providers for medical or  
3 health care services.

4 (c) An insurer's contract with a preferred provider may  
5 require that, except in a case of a medical emergency as determined  
6 by the preferred provider, before the provider may make an  
7 out-of-network referral for an insured, the preferred provider  
8 inform the insured:

9 (1) that:

10 (A) the insured may choose a preferred provider  
11 or an out-of-network provider; and

12 (B) if the insured chooses the out-of-network  
13 provider the insured may incur higher out-of-pocket expenses; and

14 (2) whether the preferred provider has a financial  
15 interest in the out-of-network provider.

16 SECTION 5. Section 1301.057(d), Insurance Code, is amended  
17 to read as follows:

18 (d) On request, an insurer shall provide [~~make an expedited~~  
19 ~~review available~~] to a practitioner whose participation in a  
20 preferred provider benefit plan is being terminated:

21 (1) an [~~.—The~~] expedited review conducted in  
22 accordance with a process that complies [~~must comply~~] with rules  
23 established by the commissioner; and

24 (2) all information on which the insurer wholly or  
25 partly based the termination, including the economic profile of the  
26 preferred provider, the standards by which the provider is  
27 measured, and the statistics underlying the profile and standards.

1           SECTION 6. (a) Except as provided by this section, the  
2 changes in law made by this Act apply only to an insurance policy,  
3 insurance or health maintenance organization contract, or evidence  
4 of coverage delivered, issued for delivery, or renewed on or after  
5 January 1, 2012. A policy, contract, or evidence of coverage issued  
6 before that date is governed by the law in effect immediately before  
7 the effective date of this Act, and that law is continued in effect  
8 for that purpose.

9           (b) Sections 843.306, 843.363, and 1301.057(d), Insurance  
10 Code, as amended by this Act, and Section 1301.0052, Insurance  
11 Code, as added by this Act, apply only to a contract between a  
12 health maintenance organization or preferred provider benefit plan  
13 issuer and a physician or health care provider that is entered into  
14 or renewed on or after the effective date of this Act. A contract  
15 entered into or renewed before the effective date of this Act is  
16 governed by the law in effect immediately before the effective date  
17 of this Act, and that law is continued in effect for that purpose.

18           SECTION 7. This Act takes effect September 1, 2011.