BILL ANALYSIS

C.S.H.B. 620
By: Eiland
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties report that preferred provider organization (PPO) networks, which are used by preferred provider benefit plans, health maintenance organizations, and other entities to assemble and credential providers and to negotiate discounts with certain providers in their networks, are subject to insufficient regulation in Texas. Those parties assert that, consequently, a large portion of the Texas health care system is not sufficiently regulated.

The parties further note that the number of intermediary entities involved in the health care claims payment process is increasing dramatically. While the discounter profits from discounting the appropriate payment to a provider, little, if any, information regarding the discounter's actions is shared with the provider or patient. It has been reported that without this information, individual providers find it extremely difficult to determine how much and by whom they will be paid for a particular service, and patients have an equally difficult time determining their share of the cost of their medical care.

C.S.H.B. 620 seeks to better regulate PPO networks and increase the transparency of PPO provider reimbursement practices by establishing criteria for network and discount access and contract termination; setting out contracting entity rights and responsibilities; providing for registration of unlicensed contracting entities; and providing remedies when a contract is taken without a contractual basis.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 620 amends the Insurance Code to require a person who enters into a direct contract with a provider for the delivery of health care services to covered individuals and who establishes a provider network or networks for access by another party in the ordinary course of business to register with the Texas Department of Insurance (TDI) as a contracting entity not later than the 30th day after the date on which the person begins acting in that capacity in Texas. The bill establishes an exception to this registration requirement for a contracting entity that holds a certificate of authority issued by TDI to engage in the business of insurance in Texas or operates a health maintenance organization under the Texas Health Maintenance Organization Act. The bill requires a contracting entity that holds such a certificate of authority or that is a health maintenance organization to file with the commissioner of insurance an application for exemption from registration under which the contracting entity's affiliates are authorized to access the contracting entity's network, requires the applicaton to be accompanied by a list of such affiliates, and requires the contracting entity to update that list with the commissioner on an annual basis. The bill establishes that the list of affiliates is public information and not exempt from disclosure under public information law. The bill requires the commissioner to grant such affiliates an exemption from registration requirements if the commissioner determines that an affiliate is not subject to a disclaimer of affiliation under provisions relating to insurance holding

company systems and if the relationships between the person who holds a certificate of authority and all affiliates of that person are disclosed and clearly defined. The bill applies this exemption only to registration and specifies that an entity granted an exemption is otherwise subject to the bill's provisions.

C.S.H.B. 620 requires a person required to register with TDI as a contracting entity to disclose all names used by the contracting entity, certain contact information for the entity, and any other information required by the commissioner by rule. The bill requires such disclosure to include a description or copy of the applicant's basic organizational structure documents and a copy of organization charts and lists that show both the relationships between the contracting entity and any of its affiliates and the internal organizational structure of the contracting entity's management. The bill requires such information to be submitted in a written or electronic format adopted by the commissioner of insurance by rule, authorizes TDI to collect a reasonable fee set by the commissioner as necessary to administer the registration process, and requires such fees to be deposited in the TDI operating fund.

C.S.H.B. 620 prohibits a contracting entity from selling, leasing, or otherwise transferring information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior adequate notification of the provider. The bill requires the provider network contract to require that on the request of the provider, the contracting entity will provide the information necessary to determine whether a particular person has been authorized to access the provider's health care services and contractual discounts. The bill requires a provider network contract, including the lines of business specified by the bill, to also specify a separate fee schedule for each such line of business in order to be enforceable against a provider. The bill authorizes the separate fee schedule to describe specific services or procedures that the provider will deliver along with a corresponding payment, to describe a methodology for calculating payment based on a published fee schedule, or to describe payment in any other reasonable manner that specifies a definite payment for services. The bill authorizes the fee information to be provided by any reasonable method, including electronically. The bill authorizes the commissioner by rule to add additional lines of business for which express authority is required.

C.S.H.B. 620 prohibits a contracting entity from providing a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the person is required to comply with all applicable terms, limitations, and conditions of the provider network contract. The bill requires a contracting entity, for the purposes of contract access, to permit reasonable access, including electronic access, to the provider during business hours for the review of the provider network contract. The bill restricts use or disclosure of that information to purposes of complying with the terms of the contract or state law.

C.S.H.B. 620 authorizes the commissioner to adopt rules to implement the bill's provisions on provider network contract arrangements. The bill authorizes the commissioner to impose a sanction or assess an administrative penalty on a contracting entity that violates any provisions governing provider network contract arrangements as added by the bill or a rule adopted to implement those provisions.

C.S.H.B. 620 establishes that, for purposes of complying with the requirements prescribed by the bill for a provider network contract, a provider's express authority is presumed if the provider network contract is in existence before September 1, 2013; if, on the first renewal after September 1, 2013, the contracting entity sends a written renewal notice by mail to the provider that conforms to certain specified requirements; and if the provider fails to respond within 60 days of receipt of the notice and has not objected to the renewal.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 620 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:	SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:
CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS	CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS
SUBCHAPTER A. GENERAL PROVISIONS	SUBCHAPTER A. GENERAL PROVISIONS
Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:	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.	(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 who:	(2) "Contracting entity" means a person who:
(A) enters into a direct contract with a provider for the delivery of health care services to covered individuals; and	(A) enters into a direct contract with a provider for the delivery of health care services to covered individuals; and
(B) in the ordinary course of business establishes a provider network or networks for access by another party.	(B) in the ordinary course of business establishes a provider network or networks for access by another party.
(3) "Covered individual" means an individual who is covered under a health benefit plan.	(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.	(4) "Express authority" means a provider's consent that is obtained through separate signature lines for each line of business.
(5) "Health care services" means services provided for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.	(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.	(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	(7)(A) "Provider" means: (i) an advanced practice nurse; (ii) an optometrist; (iii) a therapeutic optometrist; (iv) a physician; (v) a professional association composed solely of physicians, optometrists, or therapeutic optometrists; (vi) a single legal entity authorized to practice medicine owned by two or more

provider to facilitate the provider's participation in health care contracts, or an institution that is licensed under Chapter 241, Health and Safety Code. The term does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to a third party.	physicians; (vii) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code; (viii) a partnership composed solely of physicians, optometrists, or therapeutic optometrists; (ix) a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts; or (x) an institution that is licensed under Chapter 241, Health and Safety Code. (B) "Provider" does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to another 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.	(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 another 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) a discount health care program, as defined by Section 7001.001; (7) coverage for on-site medical clinics; (8) automobile medical payment insurance;	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) a discount health care program, as defined by Section 7001.001; (7) coverage for on-site medical clinics; (8) automobile medical payment insurance;

or

(9) 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

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

(10) 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) 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) to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001.

[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 operates 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 shall file with the commissioner an application for exemption from registration under which the affiliates may access the contracting entity's network.

(c) An application for an exemption filed under Subsection (b) must be accompanied by a list of the contracting entity's affiliates. The contracting entity shall update the list with the commissioner on an annual basis.

(d) A list of affiliates filed with the commissioner under Subsection (c) is public information and is not exempt from disclosure under Chapter 552, Government Code.

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.

program as the contracting entity; or

(2) to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001.

Sec. 1458.004. RULEMAKING AUTHORITY. The commissioner may adopt rules to implement this chapter.

SUBCHAPTER B. REGISTRATION REQUIREMENTS

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(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 shall 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) the affiliate is not subject to a disclaimer of affiliation under Chapter 823; and

(2) 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.

(c) The commissioner shall establish a reasonable fee as necessary to administer the exemption process.

[Sections 1458.056-1458.100 reserved for expansion]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS.

(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 shall 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) the affiliate is not subject to a disclaimer of affiliation under Chapter 823; and

(2) 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.

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. (a) In this section, the following are each considered a single separate line of business:

(1) preferred provider benefit plans

covering individuals and groups;

(2) exclusive provider benefit plans covering individuals and groups;

(3) health maintenance organization plans covering individuals and groups;

(4) Medicare Advantage or similar plans issued in connection with a contract with the Centers for Medicare and Medicaid Services;

(5) Medicaid managed care; and

(6) the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code.

(b) A contracting entity may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior adequate notification of the provider.

(c) The provider network contract must require that on the request of the provider, the contracting entity will provide information necessary to determine whether a particular person has been authorized to access the provider's health care services and contractual discounts.

(d) To be enforceable against a provider, a provider network contract, including the lines of business described by Subsections (a) and (e), must also specify a separate fee schedule for each such line of business. The separate fee schedule may describe specific services or procedures that the provider will deliver along with a corresponding payment, may describe a methodology for calculating payment based on a published fee schedule, or may describe payment in any other reasonable manner that specifies a definite payment for services. The fee information may be provided by any reasonable method, including electronically.

(e) The commissioner may, by rule, add additional lines of business for which express authority is required.

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

Sec. 1458.102. CONTRACT ACCESS. (a) 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 the person must comply with all applicable terms, limitations, and conditions of the provider network contract.

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

(b) For the purposes of this section, a contracting entity shall permit reasonable access, including electronic access, to the provider during business hours for the review of the provider network contract. The information may be used or disclosed only for the purposes of complying with the terms of the contract or state law.

Sec. 1458.103. ENFORCEMENT. The commissioner may impose a sanction under Chapter 82 or assess an administrative penalty under Chapter 84 on a contracting entity that violates this chapter or a rule adopted to implement this chapter.

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) provide each third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of 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 provider network contract not later than the 30th day after the effective date of the contract termination.

(b) If a contracting entity knows that a third party is making claims under a terminated contract, the contracting entity must take reasonable steps to cause the third party to cease making claims under the provider network contract. If the steps taken by the contracting entity are unsuccessful and the third party continues to make claims under the terminated provider network contract, the contracting entity must:

(1) terminate the contracting entity's contract with the third party; or

(2) notify the commissioner, if termination

No equivalent provision.

of the contract is not feasible.

(c) Any notice provided by a contracting entity to a third party under Subsection (b) must include a statement regarding the third party's potential liability under this chapter for using a provider's contractual discount for services provided after the termination date of the provider network contract.

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

(1) must be provided by:

(A) providing for a subscription to receive the notice by e-mail; or

(B) posting the information on an Internet website at least once each calendar quarter; 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.

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

(f) The notice described by Subsection (a)(1) is not required to include information regarding payors who are not insurers or health maintenance organizations.

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.

No equivalent provision.

Sec. 1458.104. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a contracting entity and a provider

No equivalent provision.

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) if the requested information indicates a reduction in payment to the provider from the amounts agreed to on the effective date of the contract, the contract may be terminated by the provider on written notice to the contracting entity 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.

(e) If a contracting entity is unable to provide the information described by Subsection (a)(1), (a)(3), or (c), the contracting entity shall by telephone provide a readily available medium in which providers may obtain the information, which may include an Internet website.

[Sections 1458.105-1458.150 reserved for expansion]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY	No equivalent provision.
Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. A third party that leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount to another party, who is not a covered individual, must comply with the responsibilities of a contracting entity under Subchapters C and E.	No equivalent provision.
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, who is not a covered individual, to whom the third party leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount through an electronic notification that complies with Section 1458.102 and includes a link to the Internet website described by Section 1458.102(d). (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.	No equivalent provision.
[Sections 1458.153-1458.200 reserved for expansion]	
SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS	No equivalent provision.
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 Sections 1458.102 and 1458.152	No equivalent provision.

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.	No equivalent provision.
[Sections 1458.203-1458.250 reserved for expansion]	
SUBCHAPTER F. ENFORCEMENT	No equivalent provision.
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.	No equivalent provision.
Sec. 1458.252. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are in addition to any other defense, remedy, or procedure provided by law, including common law.	No equivalent provision.
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, 2014. A provider network contract entered into or renewed before January 1, 2014, is governed by the law as it	SECTION 2. (a) The change in law made by this Act applies only to a provider network contract entered into or renewed on or after September 1, 2013. A provider network contract entered into or renewed before September 1, 2013, is governed by

existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) For the purposes of compliance with Section 1458.101, Insurance Code, as added by this Act, a provider's express authority is presumed if:

(1) the provider network contract is in existence before September 1, 2013;

(2) on the first renewal after September 1, 2013, the contracting entity sends a written renewal notice by United States mail to the provider;

(3) the notice described by Subdivision (2) of this subsection:

(A) contains a statement that failure to timely respond serves as assent to the renewal;

(B) contains separate signature lines for each line of business applicable to the contract; and

(C) specifies the separate fee schedule for each line of business applicable to the contract, described in any reasonable manner and which may be provided electronically; and

(4) the provider fails to respond within 60 days of receipt of the notice and has not objected to the renewal.

SECTION 3. This Act takes effect September 1, 2013.

SECTION 3. Same as introduced version.