BILL ANALYSIS

C.S.H.B. 3270
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Health insurance is typically provided under a network in which insurers contract with health care providers, including physicians and hospitals, to provide care to the insurers' policyholders according to a set of established terms, conditions, and charges. These types of insurance agreements and networks are commonly referred to as preferred provider organizations. Policyholders using in-network providers in a preferred provider organization are generally responsible for a relatively low copayment, and providers in the network agree not to charge the policyholders more than the provider has agreed to accept from the insurer under the network agreement.

However, these network plans can include higher copayments for out-of-network care, and non-network providers often charge more than network providers because there is no agreement between the provider and the insurer regarding payment. If the insurer does not pay the full billed charge, the non-network provider may "balance bill" the policyholder for the difference between the amount the insurer pays and the billed amount. Interested parties note that a policyholder generally understands the ramifications if the policyholder knowingly chooses an out-of-network provider, but problems arise when the policyholder unknowingly receives treatment from an out-of-network provider, which is usually by a facility-based provider at an in-network hospital. Because the insurer does not have a contract with the facility-based provider, balance billing may occur and higher out of pocket costs to the policyholder may result.

Recently enacted legislation required the Texas Department of Insurance (TDI) to adopt certain network adequacy standards applicable to preferred provider organizations and established exclusive provider organizations, which resemble preferred provider organizations but contain more stringent out-of-network requirements. Interested parties report that TDI implemented procedures to provide health care insurance to insureds through preferred and exclusive provider benefit plans that ensure the availability of, and accessibility to, a full range of contracted physicians and health care providers. Interested parties assert that the procedures implemented by TDI established a high standard for insurers with respect to their network adequacy requirements, requiring such insurers to pay usual and customary charges to providers and, if necessary, to protect policyholders from balance billing issues when a complete network solution is unavailable. C.S.H.B. 3270 seeks to ensure full implementation of the rules adopted by TDI for the protection of consumers in Texas by clarifying how preferred and exclusive provider benefit plans should be regulated.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 1 and 6 of this bill.

ANALYSIS

C.S.H.B. 3270 amends the Insurance Code to require a preferred provider benefit plan to include a health care service delivery network that complies with statutory provisions governing

preferred provider benefit plans and local market access adequacy requirements established by commissioner of insurance rule. The bill sets out elements required to be included in such adequacy requirements within the insurer's designated service area. The bill authorizes a preferred benefit plan to have one or more contiguous or noncontiguous service areas, provided that a service area that is not statewide must comply with geographic parameters established by the commissioner rule.

C.S.H.B. 3270 requires an insurer to monitor on an ongoing basis, and take corrective action to maintain compliance with, the network requirements imposed by the bill and as adopted by commissioner rule, but authorizes the commissioner to waive one or more adequacy standards for the insurer's network on a showing of good cause. The bill authorizes the commissioner to find good cause to grant a waiver if the insurer demonstrates that physicians or health care providers necessary for an adequate local market access network are not available for contract or have refused to contract with the insurer on any terms and, if such physicians or health care providers are available within the relevant service area, sets out the information required to be included in an insurer's request for a waiver. The bill requires an insurer's request for a waiver to state whether any physician or health care provider is available within the service area for the covered service or services in the waiver request and authorizes a physician or health care provider, not later than the 30th day after the date an insurer files a request for a waiver, to file a response to the request in the manner prescribed by commissioner rule. The bill requires the Texas Department of Insurance (TDI) to post on its Internet website information relevant to the grant of a waiver and specifies the information to be included. The bill authorizes an insurer to apply annually for renewal of a granted waiver and requires an application for renewal of a waiver to be filed in a manner prescribed by commissioner rule not less than the 30th day before the anniversary of the date the commissioner granted the waiver. The bill establishes that a waiver of network adequacy standards expires on the anniversary of the date the commissioner granted the waiver if an insurer fails to timely request renewal or if TDI denies the insurer's renewal request.

C.S.H.B. 3270 requires an insurer, not later than the 30th day after the date an insurer's network fails to comply with the network adequacy requirements for a specific service area, to establish a local market access plan and to request a waiver of network adequacy standards seeking approval of that plan. The bill requires an insurer to file the plan with the waiver request and requires the local access plan to be provided to TDI on request. The bill prescribes the contents of a local market access plan for each service area that does not meet the network adequacy requirements. The bill requires an insurer to establish and implement procedures for use in each service area for which a local market access plan is submitted and specifies elements to be included in the procedures. The bill authorizes a local market access plan to include a process for negotiating with a nonpreferred provider before the provider provides a health care service.

C.S.H.B. 3270 sets out provisions requiring an insurer other than an exclusive provider benefit plan to pay claims if services are provided by a nonpreferred provider when a preferred provider is not reasonably available to an insured and establishes requirements relating to the payment of those claims. The bill prescribes the methodology by which an insurer is required to calculate the reimbursement of a nonpreferred provider for a covered service. The bill requires an insurer to pay all covered basic benefits for services obtained from physicians or health care providers at a level not less than the preferred benefit plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan, and prohibits an insurer from denying a claim because the services were provided by physicians or health care providers outside that area. The bill requires an insurer, if a nonpreferred facility-based physician provides a service to an insured and the difference between the allowed amount and the billed charge is at least $1,000, to include a notice on the explanation of benefits that the insured may have the right to request mediation of the claim of an uncontracted facility-based provider and may obtain information at TDI's Internet website.

C.S.H.B. 3270 requires an insurer to file a network adequacy report with TDI before marketing a

preferred provider benefit plan in a new service area and not less frequently than annually on a date prescribed by commissioner rule and prescribes the information required to be specified in the report. The bill requires the report to be submitted as required by commissioner rule and requires an insurer to submit its local market access plan as a part of its annual network adequacy report.

C.S.H.B. 3270 authorizes the commissioner to impose sanctions or to issue a cease and desist order upon determining, after notice and opportunity for hearing, that the insurer's network and any local market access plan supporting the network are inadequate to ensure the availability and accessibility of preferred provider benefits, of all medical and health care services and items covered under a preferred provider benefit plan, or of adequate personnel, specialty care, and facilities. The bill authorizes the commissioner, in exercising that enforcement authority, to order an insurer to reduce a service area of a preferred provider benefit plan, to stop marketing a preferred provider benefit plan in all or part of the state, or to withdraw from the preferred provider benefit plan market. The bill clarifies that its provisions relating to commissioner enforcement do not limit the commissioner's authority to order any other appropriate corrective action, sanction, or penalty.

C.S.H.B. 3270 sets out content and format requirements relating to mandatory disclosures for an application for a health insurance policy that provides preferred provider benefits and an endorsement, amendment, or rider to the policy and for a description of the policy terms that allows the insured to make comparisons and informed decisions about selecting a health care plan. The bill requires the copy of the written description of policy terms to be filed with TDI on the date of the initial filing of the preferred provider benefit plan and not later than the 60th day after the date of a material change to a policy term. The bill requires a preferred provider benefit plan and all related promotional, solicitation, and advertising material to clearly describe the distinction between preferred and nonpreferred providers and requires an illustration of preferred provider benefits to be in proximity to an equally prominent description of basic benefits. The bill requires an insurer that maintains an Internet website providing information about the insurer or the health insurance policies it offers to provide certain Internet-based provider information and a statement of whether a provider's network meets the network adequacy requirements as prescribed by the bill and by commissioner rule.

C.S.H.B. 3270 requires an insurer to provide a notice and outlines of the coverage in all health insurance policies that provide preferred provider benefits and in all health insurance policies that provide exclusive provider benefits and prescribes the form and content of those notices. The bill requires an insurer, not less frequently than annually, to provide notice to all insureds describing the manner by which an insured may access a current list of all preferred providers on a cost-free basis and may obtain assistance by telephone at a specified telephone number during regular business hours to identify available preferred providers.

C.S.H.B. 3270 requires an insurer to update not less than quarterly all electronic or nonelectronic listings of preferred providers made available to insureds and requires an insurer that does not maintain a preferred provider listing that an insured can access in order to identify current preferred providers to distribute a current preferred provider listing to all insureds not less than annually by mail or other method as agreed by the insured. The bill requires preferred provider information and listings to include a method by which an insured may identify hospitals that have contractually agreed to exercise good faith efforts to accommodate a request from an insured to use a preferred provider and to provide in a timely manner as prescribed by commissioner rule information sufficient to enable the insured to determine whether an assigned facility-based physician or physician group is a preferred provider. The bill sets out the preferred provider information required in a provider disclosure. The bill requires an insurer, if applicable, on issuance of a policy or not less than 30 days before the date of policy renewal, to provide notice that the preferred provider benefit plan relies on a local market access plan as specified by commissioner rule, the contents of which are required to be determined by commissioner rule.

C.S.H.B. 3270 sets out the circumstances under which disclosure for each insurance policy and in each outline of coverage is required with respect to reimbursement rates for nonpreferred providers relating to basic benefit services. The bill prohibits an insurer from causing or permitting the use or distribution of information related to a preferred provider benefit plan that is untrue or misleading. The bill requires an insurer to pay a claim for services provided by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that the insured reasonably relied on a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information and that the statement was obtained from the insurer, the insurer's Internet website, or the Internet website of a third party designated by the insurer not more than 30 days before the date of service to provide the listing for use by the insured.

C.S.H.B. 3270 sets out provisions regarding consumer protections applicable only to exclusive provider benefit plans requiring a determination of compliance with the bill's provisions and commissioner approval of an insurer's exclusive provider network in the relevant service area before the insurer offers, delivers, or issues for delivery an exclusive provider plan in Texas. The bill provides for the network approval process specifying information required in an application for approval and requiring qualifying examinations at a designated physical address. The bill sets out requirements relating to TDI approval of a modification to a network that affects the adequacy of the network, expands or reduces an existing service area, or adds a new service area and requirements relating to the revision or supplementation of an application for approval of a network or for network modification during the review process.

C.S.H.B. 3270 requires the commissioner to conduct an examination relating to an exclusive provider benefit plan not less than once every five years and establishes procedures and requirements for such an examination. The bill requires an insurer to develop and maintain a quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of health care services provided under a benefit plan and to pursue opportunities for improvement and sets out the elements required to be included in such a program and the duties of an insurer's governing body with respect to the program. The bill requires an insurer's governing body to appoint a quality improvement committee to evaluate the overall effectiveness of the quality improvement program and provides for the committee's authority to delegate duties to subcommittees, the composition of the subcommittee, and the subcommittee's duties. The bill requires the quality improvement committee to use multidisciplinary teams as necessary to accomplish quality improvement program goals. The bill requires an insurer, before TDI grants approval of an application for expansion or reduction of a service area, to be in compliance with these provisions governing quality improvement programs, the duties of the governing bodies, and the duties of committees and subcommittees.

C.S.H.B. 3270 requires TDI, in a review of an insurer's quality improvement program, to presume the program complies with statutory and regulatory requirements if the insurer received nonconditional accreditation or certification in connection with quality improvement by the National Committee for Quality Assurance, the Joint Commission, the Utilization Review Accreditation Commission, or the Accreditation Association for Ambulatory Health Care, unless TDI determines that such accreditation or certification does not adequately address a material statutory or regulatory requirement of the state.

C.S.H.B. 3270 requires an insurer to fully reimburse a nonpreferred provider at the usual and customary rate, or at a rate agreed to by the nonpreferred provider for services provided before the date an insured can reasonably be transferred to a preferred provider, if the insured cannot reasonably reach a preferred provider for a medical screening examination or other legally required evaluation to determine whether a medical emergency condition exists to be provided in certain emergency medical facilities or if such an insured cannot reasonably reach a preferred provider for necessary emergency care services.

C.S.H.B. 3270 requires an insurer on the request of a provider and where medically necessary

covered services other than emergency care are not available through a preferred provider to approve a referral to a nonpreferred provider in a timely manner appropriate to the delivery of the services and condition of the patient, but not later than five business days after the date the insurer receives documentation relating to the referral. The bill prohibits the insurer in that circumstance from denying a referral until a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested has reviewed the referral. The bill authorizes an insurer to facilitate an insured's selection of a nonpreferred provider if medically necessary covered services, excluding emergency care, are unavailable through a preferred provider and an insured has received a referral from a preferred provider. The bill requires an insurer that facilitates an insured's selection to offer the insured a list of not less than three nonpreferred providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the insured.

C.S.H.B. 3270 requires an insurer reimbursing a nonpreferred provider to ensure that the insured is held harmless for any amounts in excess of the copayment and deductible amount and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider and requires such an insurer to issue payment to the nonpreferred provider at the usual and customary rate or at a rate agreed to by the nonpreferred provider. The bill requires such an insurer to pay any amounts that the nonpreferred provider bills the insured in excess of the amount paid by the insurer. The bill requires an insurer to provide with the payment an explanation of benefits to the insured and to request that the insured notify the insurer if the nonpreferred provider bills the insured for amounts in excess of the amount paid by the insurer. The bill requires an insurer, if the insured selects a nonpreferred provider that is not included in the list of nonpreferred providers, to pay the claim in accordance with the procedure prescribed by the bill for the payment of services provided to an insured by a nonpreferred provider because a preferred provider was not reasonably available to the insured.

C.S.H.B. 3270 authorizes an insurer to require that an insured request mediation under statutory provisions regulating out-of-network claim dispute resolution or under provisions adopted by the commissioner by rule but prohibits the insurer from penalizing the insured for failing to request mediation or from requiring the insured to participate in the mediation. The bill requires the insurer to notify the insured when mediation is available and to inform the insured of how to request mediation. The bill establishes that an insurer requesting the insured to initiate mediation is not responsible for any balance bill the insured receives from the nonpreferred provider until the insured requests mediation. The bill bases eligibility for mediation on the entire unpaid amount of the nonpreferred provider bills, less any applicable copayment, deductible, and coinsurance, and requires the insurer's payment to be based on the amount due resulting from the mediation process. The bill requires any methodology used by an insurer to calculate reimbursement of nonpreferred providers for services that are covered under an exclusive provider benefits plan to conform to requirements prescribed by the bill.

C.S.H.B. 3270 applies only to an insurance policy that is delivered, issued for delivery, or renewed on or after January 1, 2014.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 3270 differs from the original in minor or nonsubstantive ways to make technical corrections and by conforming to certain bill drafting conventions.