By: Bonnen of Galveston H.B. No. 2359

Substitute the following for H.B. No. 2359:

By: Bonnen of Galveston C.S.H.B. No. 2359

A BILL TO BE ENTITLED

AN ACT

relating to health care compensation under certain health benefit or managed care plans.

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

SECTION 1. Section 1451.153(a), Insurance Code, is amended to read as follows:

(a) A managed care plan may not:

(1) discriminate against a health care practitioner because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(2) restrict or discourage a plan participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(3) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the optometrist, therapeutic optometrist, or ophthalmologist does not have medical staff privileges at a hospital or at a particular hospital;

(4) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the services or procedures provided by the optometrist, therapeutic optometrist, or ophthalmologist may be provided by

another type of health care practitioner; [~~or~~]

(5) as a condition for a therapeutic optometrist or ophthalmologist to be included in one or more of the plan's medical panels, require the therapeutic optometrist or ophthalmologist to be included in, or to accept the terms of payment under or for, a particular vision panel in which the therapeutic optometrist or ophthalmologist does not otherwise wish to be included;

(6) use different contractual terms and conditions or administrative procedures for an optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(7) use, within a geographic area, different contractual fee schedules or reimbursement amounts for an optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist; or

(8) use different claim adjudication methodologies or procedures for an optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist.

SECTION 2. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1470 to read as follows:

CHAPTER 1470. DISCLOSURE OF PAYMENT AND COMPENSATION METHODOLOGY

Sec. 1470.001. DEFINITIONS. In this chapter, unless the context otherwise requires:

(1) "Edit" means a practice or procedure under which an adjustment is made regarding procedure codes that results in:

(A) payment for some, but not all, of the health care procedures performed under a procedure code;

(B) payment made under a different procedure code;

(C) a reduced payment as a result of services provided to a patient that are claimed under more than one procedure code on the same service date;

(D) a reduced payment related to a modifier used with a procedure code; or

(E) a reduced payment based on multiple units of the same procedure code billed for a single date of service.

(2) "Health benefit plan issuer" means:

(A) an insurance company, association, organization, group hospital service corporation, health maintenance organization, or pharmacy benefit manager that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits and includes:

(i) a life, health, or accident insurance company operating under Chapter 841 or 982;

(ii) a general casualty insurance company operating under Chapter 861;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a mutual life insurance company operating under Chapter 882;

(v) a local mutual aid association operating under Chapter 886;

(vi) a statewide mutual assessment company operating under Chapter 881;

(vii) a mutual assessment company or mutual assessment life, health, and accident association operating under Chapter 887;

(viii) a mutual insurance company operating under Chapter 883 that writes coverage other than life insurance;

(ix) a Lloyd's plan operating under Chapter 941;

(x) a reciprocal exchange operating under Chapter 942;

(xi) a stipulated premium insurance company operating under Chapter 884;

(xii) an exchange operating under Chapter 942;

(xiii) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss(g)(1));

(xiv) a health maintenance organization operating under Chapter 843;

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

(xvi) an approved nonprofit health corporation that holds a certificate of authority under Chapter

844; and

(B) a nongovernmental entity issuing or administering medical benefits provided under a workers' compensation insurance policy or otherwise under Title 5, Labor Code, but excluding benefits provided through self-insurance.

(3) "Health care contract" means a contract entered into or renewed between a health care contractor and a physician or health care provider for the delivery of health care services to others.

(4) "Health care contractor" means an individual or entity that has as a business purpose contracting with physicians or health care providers for the delivery of health care services. The term includes a health benefit plan issuer, an administrator regulated under Chapter 4151, and a pharmacy benefit manager that administers or manages prescription drug benefits.

(5) "Health care provider" means an individual or entity that furnishes goods or services under a license, certificate, registration, or other authority issued by this state to diagnose, prevent, alleviate, or cure a human illness or injury. The term includes a physician or a hospital, ambulatory surgical center, outpatient imaging facility, or other health care facility.

(6) "Physician" means:

(A) an individual licensed to engage in the practice of medicine in this state; or

(B) an entity organized under Subchapter B, Chapter 162, Occupations Code.

(7) "Procedure code" means an alphanumeric code used

to identify a specific health procedure performed by a health care provider. The term includes:

(A) the American Medical Association's Current Procedural Terminology code, also known as the "CPT code";

(B) the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System; and

(C) other analogous codes published by national organizations and recognized by the commissioner.

(8) "Same service" means health care procedures performed or billed under the same procedure code.

Sec. 1470.002. DEFINITION OF MATERIAL CHANGE. For purposes of this chapter, "material change" means a change to a contract that decreases the health care provider's payment or compensation.

Sec. 1470.003. APPLICABILITY OF CHAPTER. (a) This chapter does not apply to an employment contract or arrangement between health care providers.

(b) Notwithstanding Subsection (a), this chapter applies to contracts for health care services between a medical group and other medical groups.

Sec. 1470.004. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of this chapter.

Sec. 1470.005. DISCLOSURE TO DEPARTMENT. A health care contract may not preclude the use of the contract or disclosure of the contract to the department to enforce this chapter or other state law. The information is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena, except

to the extent necessary to enable the commissioner to enforce this chapter or other state law.

Sec. 1470.006. REQUIRED DISCLOSURE AND PERMISSIBLE RANGE OF PAYMENT AND COMPENSATION. (a) Each health care contract must include a disclosure form that states, in plain language, payment and compensation terms. The form must include information sufficient for a health care provider to determine the compensation or payment for the provider's services.

(b) The disclosure form under Subsection (a) must include:

(1) the manner of payment, such as fee-for-service, capitation, or risk sharing;

(2) the effect of edits, if any, on payment or compensation; and

(3) a fee schedule that shows:

(A) the compensation or payments to the health care provider for procedure codes reasonably expected to be billed by the health care provider for services provided under all contracts used by the health care contractor; and

(B) the range of compensation or payments to different health care providers performing the same service for procedure codes reasonably expected to be billed by the health care provider for services provided under all contracts used by the health care contractor and, on request, the range of compensation or payments for other procedure codes used by, or which may be used by, the health care provider.

(c) A health care contractor may not pay an amount of compensation or payments to a health care provider that is less than

85 percent of the amount paid for the same service to another health care provider that holds the same license, certificate, or other authority, regardless of the location of the health care providers and of whether the health care providers are performing services under the same contract.

(d) A health care contractor may satisfy the requirement under Subsection (b)(2) regarding the effect of edits by providing a clearly understandable, readily available mechanism that allows a health care provider to determine the effect of an edit on payment or compensation before a service is provided or a claim is submitted.

(e) The fee schedule described by Subsection (b)(3) must include, as applicable, service or procedure codes and the associated payment or compensation for each code. The fee schedule may be provided electronically.

(f) A health care contractor shall provide the fee schedule described by Subsection (b)(3) to an affected health care provider when a material change related to payment or compensation occurs. Additionally, a health care provider may request that a written fee schedule be provided up to twice annually, and the health care contractor must provide the written fee schedule promptly.

(g) If applicable, a health care contractor, in the disclosure form described by Subsection (a), shall inform an affected health care provider of the prohibited payment and contracting practices described by Sections 1451.153(a)(6), (7), and (8).

Sec. 1470.007. ENFORCEMENT. (a) The commissioner shall

adopt rules as necessary to enforce the provisions of this chapter.

(b) A violation of Section 1470.006 is a deceptive act or practice in insurance under Subchapter B, Chapter 541.

Sec. 1470.008. WAIVER OF FEDERAL LAW. If the commissioner determines that a waiver of federal law or other federal authorization would facilitate implementation of this chapter, the commissioner may request the waiver or authorization.

SECTION 3. Section 1451.153(a), Insurance Code, as amended by this Act, and Chapter 1470, Insurance Code, as added by this Act, apply only to a health care contract that is entered into or renewed on or after January 1, 2014. A health care contract entered into before January 1, 2014, 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 4. This Act takes effect September 1, 2013.