By: Taylor S.B. No. 1197

A BILL TO BE ENTITLED

AN ACT

relating to requirements of exclusive provider and preferred provider benefit plans.

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

SECTION 1. Section 1301.001, Insurance Code, is amended by adding Subdivisions (9-a) and (9-b) to read as follows:

(9-a) "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.

(9-b) "Same service" means a health care service under the same procedure code as another health care service.

SECTION 2. Section 1301.0041(b), Insurance Code, is amended to read as follows:

(b) The commissioner may not impose a requirement for an exclusive provider benefit plan that is different from a requirement for a preferred provider benefit plan unless [~~Unless~~] otherwise specified in this chapter[~~, an exclusive provider benefit plan is subject to this chapter in the same manner as a preferred~~

~~provider benefit plan~~]. Except as provided by this chapter, the commissioner may not impose additional requirements for an exclusive provider benefit plan, including requirements based on:

(1) an annual network adequacy report;

(2) a complaint process or record;

(3) a document not related to network adequacy;

(4) a filing of a network provider contract with the commissioner;

(5) a filing of a description of information systems with the commissioner;

(6) a network certification; and

(7) a qualifying examination.

SECTION 3. Section 1301.005, Insurance Code, is amended by amending Subsection (b) and adding Subsections (d) and (e) to read as follows:

(b) If services are not available through a preferred provider within a designated service area or through a facility-based physician providing services at a network health care facility under a preferred provider benefit plan or an exclusive provider benefit plan, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(d) A preferred provider benefit plan is not required to provide coverage, including credit to applicable deductibles or out-of-pocket maximums, for the excess amount the physician or

health care provider who is not a preferred provider charges over the allowable amount covered under the preferred provider benefit plan.

(e) Each insurance policy, certificate, and outline of coverage must disclose how reimbursement for services provided by a physician or health care provider who is not a preferred provider is calculated. The reimbursements must be calculated pursuant to appropriate reasonable and objective methodologies, including the median amount negotiated with preferred providers for the same service, published claims data, or a percentage of the published rate allowed by the Centers for Medicare and Medicaid Services for the same or similar service within the geographic market.

SECTION 4. Section 1301.0055, Insurance Code, is amended to read as follows:

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) The commissioner shall by rule adopt network adequacy standards that:

(1) are adapted to local markets in which an insurer offering a preferred provider benefit plan operates;

(2) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health care services to insureds; and

(3) on good cause shown, may allow departure from local market network adequacy standards if the commissioner posts on the department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

(b) A preferred provider benefit plan issuer is not required

to obtain the commissioner's approval for a departure from local market network adequacy standards, and the standards are not violated, if there is not a licensed provider of a particular specialty located within the service area. A preferred provider plan issuer shall list the areas in which a health care provider of a particular specialty is not available on the issuer's Internet website.

SECTION 5. (a) As soon as practicable after the effective date of this Act, the commissioner of insurance shall adopt revised rules to implement the change in law made by this Act.

(b) The change in law made by this Act applies to an insurance policy delivered, issued for delivery, or renewed on or after the effective date of this Act. A policy delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 6. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2013.