By: Klick H.B. No. 1905
Substitute the following for H.B. No. 1905:
By: Lucio III C.S.H.B. No. 1905

A BILL TO BE ENTITLED
AN ACT
relating to the relationship between physicians or health care providers and health maintenance organizations or preferred provider benefit plans.

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

SECTION 1. Section 843.306, Insurance Code, is amended by amending Subsections (a), (b), and (e) and adding Subsections (a-1), (a-2), (b-1), (b-2), (b-3), and (g) to read as follows:

(a) Before terminating a contract with a physician or provider, a health maintenance organization shall provide to the physician or provider:

(1) written notice of:

(A) the health maintenance organization's intent to terminate the physician's or provider's contract;

(B) the physician's or provider's right to request a review under Subsection (b); and

(C) the physician's or provider's right to request the review be expedited under Section 843.307; and

(2) a written explanation of the reasons for termination.

(a-1) In a case involving fraud or malfeasance by a provider, the written notice required by Subsection (a) must include notice of the health maintenance organization's right to suspend the provider's participation in the health maintenance
organization network during the review process as provided by Subsection (b-1).

(a-2) If a health maintenance organization terminates a contract with a physician or provider, the health maintenance organization shall, on request of the physician or provider, provide to the physician or provider a written copy of all information on which the health maintenance organization wholly or partly based the termination, including the economic profile of the physician or provider, the standards by which the physician or provider is measured, and the statistics underlying the profile and standards.

(b) On request, before the effective date of the termination and within a period not to exceed 60 days, a physician or provider is entitled to a review by an advisory review panel of the health maintenance organization's proposed termination, except in a case involving:

(1) imminent harm to patient health;

(2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(3) fraud or malfeasance by a physician.

(b-1) If a provider requests a review under Subsection (b) in a case involving fraud or malfeasance by the provider, the health maintenance organization may suspend the provider's participation in the health maintenance organization network:
(1) beginning not earlier than the date notice is
provided under Subsection (a); and

(2) ending on the earlier of:

(A) the 60th day after the date the provider
requests the review;

(B) the 30th day after the date the provider
requests the review be expedited under Section 843.307, if
applicable; or

(C) the date the health maintenance organization
makes a final determination under Subsection (b-2).

(b-2) If a health maintenance organization suspends a
provider's participation in the health maintenance organization
network under Subsection (b-1), the health maintenance
organization shall make a final determination to terminate or
resume the provider's participation not later than three business
days after the date the health maintenance organization receives
the recommendation of the advisory review panel. The health
maintenance organization shall immediately notify the provider of
the determination.

(b-3) Review under Subsection (b) must provide an
opportunity for the physician or provider to present evidence to
the advisory review panel before the panel makes a recommendation.

(e) The health maintenance organization [on request] shall
provide to the affected physician or provider a copy of the
recommendation of the advisory review panel and the health
maintenance organization's determination.

(g) A health maintenance organization may not terminate a
provider's contract unless the provider fails to comply with a material term of the contract.

SECTION 2. Section 843.308, Insurance Code, is amended to read as follows:

Sec. 843.308. NOTIFICATION OF PATIENTS OF DESELECTED OR TERMINATED PHYSICIAN OR PROVIDER. (a) Except as provided by Subsection (b), if a physician or provider is deselected or terminated for a reason other than the request of the physician or provider, a health maintenance organization may not notify patients of the deselection or termination until the later of the effective date of the deselection or termination, or, if a review is requested, the date the advisory review panel makes a formal recommendation.

(b) If the contract of a physician or provider is deselected or terminated for a reason related to imminent harm, a health maintenance organization may notify patients immediately.

SECTION 3. Section 843.309, Insurance Code, is amended to read as follows:

Sec. 843.309. CONTRACTS WITH PHYSICIANS OR PROVIDERS: NOTICE TO CERTAIN ENROLLEES OF TERMINATION OF PHYSICIAN OR PROVIDER PARTICIPATION IN PLAN. Subject to Section 843.308, a [A] contract between a health maintenance organization and a physician or provider must provide that reasonable advance notice shall be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee.

SECTION 4. Subchapter I, Chapter 843, Insurance Code, is amended by adding Section 843.3095 to read as follows:
Sec. 843.3095. WAIVER OF CERTAIN PROVISIONS PROHIBITED.

The provisions of this subchapter related to deselection or termination of a contract with a physician or provider may not be waived, voided, or nullified by contract.

SECTION 5. Section 1301.053, Insurance Code, is amended to read as follows:

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED PROVIDER. (a) An insurer that does not designate a physician or health care provider [practitioner] as a preferred provider shall provide a reasonable mechanism for reviewing that action. The review mechanism must incorporate, in an advisory role only, a review panel.

(b) A review panel must be composed of at least three individuals selected by the insurer from a list of participating physicians or health care providers [practitioners] and must include one member who is a physician or health care provider [practitioner] in the same or similar specialty as the affected physician or health care provider [practitioner], if available. The physicians or health care providers [practitioners] contracting with the insurer in the applicable service area shall provide the list of physicians or health care providers [practitioners] to the insurer.

(c) On request, the insurer shall provide to the affected physician or health care provider [practitioner]:

1. the panel's recommendation, if any; and
2. a written explanation of the insurer's determination, if that determination is contrary to the panel's
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provider's participation in the preferred provider benefit plan
during the review process as provided by Subsection (a-3).

(a-2) An insurer may not terminate a health care provider's
contract unless the provider fails to comply with a material term of
the contract.

(a-3) If a health care provider requests a review under
Subsection (a) in a case involving fraud or malfeasance by the
health care provider, the insurer may suspend the health care
provider's participation in the preferred provider benefit plan:

(1) beginning not earlier than the date notice is
provided under Subsection (a); and

(2) ending on the earlier of:

(A) the 60th day after the date the health care
provider requests the review;

(B) the 30th day after the date the health care
provider requests the review be expedited, if applicable; or

(C) the date the insurer makes a final
determination under Subsection (a-4).

(a-4) If an insurer suspends a health care provider's
participation in the preferred provider benefit plan under
Subsection (a-3), the insurer shall make a final determination to
terminate or resume the health care provider's participation not
later than three business days after the date the insurer receives
the recommendation of the review panel described by Subsection (b).
The insurer shall immediately notify the health care provider of
the insurer's determination.

(b) The review mechanism described by Subsection (a)(3)
must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days.

(b-1) Review under Subsection (a)(3) must provide an opportunity for the affected physician or health care provider to present evidence to the review panel before the panel makes a recommendation.

(c) The insurer shall provide to the affected physician or health care provider:

(1) the review panel's recommendation, if any; and

(2) on request, a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

(d) On request, an insurer shall provide to a physician or health care provider whose participation in a preferred provider benefit plan is being terminated:

(1) an expedited review conducted in accordance with a process that complies with rules established by the commissioner; and

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

(e) The provisions of this section may not be waived, voided, or nullified by contract.

SECTION 7. Section 1301.160, Insurance Code, is amended by
amending Subsections (a) and (c) and adding Subsection (d) to read
as follows:

(a) If a physician's or health care provider's [practitioner's] participation in a preferred provider benefit
plan is terminated for a reason other than at the physician's or
health care provider's [practitioner's] request, an insurer may not
notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) if a review is requested, the time at which a
review panel makes a formal recommendation regarding the
termination.

(c) If a physician's or health care provider's [practitioner's] participation in a preferred provider benefit
plan is terminated for reasons related to imminent harm, an insurer
may notify insureds immediately.

(d) The provisions of this section may not be waived,
voided, or nullified by contract.

SECTION 8. The changes in law made by this Act apply only to
a contract entered into, amended, or renewed on or after the
effective date of this Act. A contract entered into, amended, or
renewed before the effective date of this Act 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 9. This Act takes effect September 1, 2019.