By: Moody, Raymond, Guillen, Oliverson H.B. No. 1914

A BILL TO BE ENTITLED

AN ACT

relating to the relationship between health maintenance organizations and preferred provider benefit plans and physicians and health care providers, including prompt payment of the claims of certain physicians and health care providers.

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 843.351, Insurance Code, is amended to read as follows:

Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. (a) The provisions of this subchapter relating to prompt payment by a health maintenance organization of a physician or provider, including Section 843.342, and to verification of health care services apply to a physician or provider who:

(1) is not included in the health maintenance organization delivery network; and

(2) provides to an enrollee:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other health care services at the request of the health maintenance organization or a physician or provider who is included in the health maintenance organization delivery network because the services are not reasonably available within the network.

(b) For purposes of calculating a penalty under Section 843.342 related to a claim by a physician or provider described by Subsection (a), the contracted rate for the health care service provided by the physician or provider is the usual and customary rate for the service in the geographic area in which the service is

provided.

SECTION 6. 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 recommendation.

SECTION 7. Section 1301.057, Insurance Code, is amended to read as follows:

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW PROCESS. (a) Before terminating a contract with a preferred provider, an insurer shall:

(1) provide written notice of:

(A) the insurer's intent to terminate the preferred provider's contract;

(B) the preferred provider's right to request a review under this section; and

(C) the preferred provider's right to request the review be expedited under Subsection (d);

(2) provide written reasons for the termination; and

(3) [~~(2) if the affected provider is a practitioner,~~] provide, on request, a reasonable review mechanism, except in a case involving:

(A) imminent harm to a patient's health;

(B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the physician's or health care provider's [~~practitioner's~~] ability to practice medicine, dentistry, or another profession; or

(C) fraud or malfeasance by a physician.

(a-1) In a case involving fraud or malfeasance by a health care provider, the written notice required by Subsection (a) must include notice of the insurer's right to suspend the health care 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) [~~(a)(2)~~] 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 [~~practitioner~~]:

(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 [~~practitioner~~] 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 8. Section 1301.069, Insurance Code, is amended to read as follows:

Sec. 1301.069. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH CARE PROVIDERS. (a) The provisions of this chapter relating

to prompt payment by an insurer of a physician or health care provider, including Section 1301.137, and to verification of medical care or health care services apply to a physician or provider who:

(1) is not a preferred provider included in the preferred provider network; and

(2) provides to an insured:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network.

(b) For purposes of calculating a penalty under Section 1301.137 related to a claim by a physician or health care provider described by Subsection (a) or Section 1301.0053, the contracted rate for the health care service provided by the physician or provider is the usual and customary rate for the service in the geographic area in which the service is provided.

SECTION 9. 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 10. (a) Except as provided by Subsection (b) of this section, 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.

(b) Sections 843.351 and 1301.069, Insurance Code, as amended by this Act, apply only to a claim filed on or after the effective date of this Act.

SECTION 11. This Act takes effect September 1, 2019.