

BILL ANALYSIS

C.S.H.B. 2929
By: Bonnen
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Despite state law providing for claim payments, audits, appeals, and remedies for health care providers, it has been argued that there may be significant gaps in the law, leaving providers vulnerable in vital areas. Providers are on the front line of ensuring care, and without the means to do so, they will fall short on these efforts. C.S.H.B. 2929 seeks to address these gaps by changing the regulation and implementation of health insurance preferred provider benefit plans in Texas.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 4 of this bill.

ANALYSIS

C.S.H.B. 2929 amends the Insurance Code to set out provisions relating to the conduct of insurers providing preferred provider benefit plans with respect to physician and health care provider contracts and claims.

C.S.H.B. 2929 specifies that, for purposes of the prohibition against an insurer engaging in any retaliatory action against a physician or health care provider because the physician or provider has reasonably filed a complaint against the insurer on behalf of an insured or has appealed a decision of the insurer, a retaliatory action includes the following:

- implementing measurable penalties in the contract negotiation process;
- engaging in an unfair or deceptive practice, including not listing the physician or provider in the network directory or requiring the physician or provider to submit medical records with each claim;
- arbitrarily reducing the physician's or provider's fees on the insurer's fee schedule; and
- otherwise making changes to material contractual terms that are adverse to the physician or provider.

C.S.H.B. 2929 requires an insurer that determines all or a portion of a clean claim that a preferred provider submits electronically is not payable to provide the requisite notice of that determination electronically. The bill replaces the authorization for an insurer to notify a preferred provider who does not supply information reasonably requested by the insurer in connection with a claim audit that the provider must provide the information by a certain deadline or forfeit the amount of the claim and, if the provider does not provide the information, to recover the amount of the claim with a requirement for the insurer to do so. The bill requires

an insurer to make such a request and provide certain information relating to an audited claim electronically if the preferred provider's claim was electronically submitted.

C.S.H.B. 2929 prohibits an insurer from recovering a payment on an audited claim until a final audit is completed. The bill requires an insurer to provide written notice to the preferred provider of the insurer's failure to timely complete an audit not later than the 15th day after the date on which the insurer is required to complete the audit.

C.S.H.B. 2929 requires an insurer to provide a reasonable mechanism for an appeal requested by a preferred provider who disagrees with a refund request made by the insurer based on a claim audit and for an appeal requested by a physician or health care provider who disagrees with a request for recovery of an overpayment. The bill does the following:

- requires the review mechanisms to incorporate a review panel in an advisory role only;
- requires such a review panel to be composed of at least three preferred provider representatives of the same or similar specialty as the affected preferred provider selected by the insurer from a list of preferred providers;
- requires the preferred providers contracting with the insurer in the applicable service area to provide the list of preferred provider representatives to the insurer; and
- requires the insurer, on request, to provide to the affected preferred provider the panel's composition and recommendation and, if the insurer's determination is contrary to the panel's recommendation, a written explanation of that determination.

C.S.H.B. 2929 requires the commissioner of insurance by rule to establish procedures for a preferred provider to submit a request for the Texas Department of Insurance (TDI) to review a claim audit conducted by an insurer. The TDI review of an audit is a contested case under the Administrative Procedure Act. The bill requires TDI to award compensatory damages to the preferred provider incurred as a result of the audit and order the insurer to pay to TDI the costs incurred by TDI in reviewing the audit if TDI determines that the audit, as follows:

- resulted in unreasonable costs for the preferred provider;
- unnecessarily delayed or prevented payment of a claim; or
- otherwise violated applicable statutory provisions relating to prompt payment of claims or rules adopted under such provisions.

C.S.H.B. 2929 applies to a claim for payment made on or after the bill's effective date unless the claim is made under a contract that was entered into before the bill's effective date and that, at the time the claim is made, has not been renewed or was last renewed before the bill's effective date.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2929 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute changes the original's prohibition against an insurer engaging in an unfair or deceptive contract negotiation practice against a physician or health care provider to a prohibition against engaging, generally, in an unfair or deceptive practice against such a provider.

The substitute includes the following, which were not in the original, as prohibited retaliatory actions by an insurer against a physician or health care provider:

- not listing the physician or provider in the network directory or requiring the physician or

- provider to submit medical records with each claim;
- arbitrarily reducing the physician's or provider's fees on the insurer's fee schedule; and
- otherwise making changes to material contractual terms that are adverse to the physician or provider.

The substitute includes a specification that was not in the original that the three preferred provider representatives who must be on the review panel for an appeal relating to a disagreement on a refund request made by the insurer based on a claim audit and for an appeal relating to a disagreement on a request for recovery of an overpayment must be provider representatives of the same or similar specialty as the affected preferred provider.