By: Frank H.B. No. 4051

A BILL TO BE ENTITLED

AN ACT

relating to method of payment for certain medical care and contract arrangements.

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

SECTION 1. Chapter 1204, Insurance Code, is amended by adding Subchapter G to read as follows:

SUBCHAPTER G. AUTHORIZED PAYMENT BY ENROLLEES IN LIEU OF CLAIM FOR BENEFITS

Sec. 1204.301. DEFINITIONS. In this subchapter:

(1) "Enrollee" means an individual who is enrolled in a health care plan or entitled to coverage under a health benefit plan.

(2) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services.

(3) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United State.

(4) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care

provider.

(5) "Physician" means an individual licensed to practice medicine in this or another state of the United States.

Sec. 1204.302. APPLICABILITY TO CERTAIN PLANS. In addition to the health benefit plans described by Section 1204.301, notwithstanding any other law, this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) a plan providing basic coverage under Chapter 1601.

Sec. 1204.303. AUTHORIZED PAYMENT IN LIEU OF CLAIM FOR BENEFITS. (a) A physician or health care provider may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim to the enrollee's health benefit plan.

(b) Notwithstanding Insurance Code Section 552.003 or any other law, the charge for a health care service for which a physician or health care provider accepts a payment as described Subsection (a) may not exceed the lowest contract rate for the health care service allowable under any health benefit plan with respect to which the physician or health care provider is a contracted, preferred, or participating provider.

SECTION 2. Section 1458.001 , Insurance Code, is amended to read as follows:

Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Contracting entity" means a person who:

(A) enters into a direct contract with a provider for the delivery of health care services to covered individuals; and

(B) in the ordinary course of business establishes a provider network or networks for access by another party.

(3) "Covered individual" means an individual who is covered under a health benefit plan.

(4) "Express authority" means a provider's consent that is obtained through separate signature lines for each line of business.

(5) "Health care services" means services provided for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

(5-1) "Most favored nation clause" means a provision in a provider network contract that:

(A) Prohibits or grants an option to prohibit:

(i) a provider from contracting with another contracting entity to provide healthcare services at a lower price; or

(ii) a contracting entity from contracting with another provider to provide healthcare services at a higher price;

(B) Requires or grants an option to require:

(i) a provider to accept a lower payment in the event the provider agrees to provide healthcare services to another contracting entity at a lower price; or

(ii) a contracting entity to pay at a higher rate in the event the contracting entity agrees to pay another provider at a higher rate;

(C) Requires or grants an option to require termination or renegotiation of an existing provider network contract if:

(i) a provider agrees to provide healthcare services to another contracting entity at a lower price; or

(ii) a contracting entity agrees to pay another provider at a higher rate;

(D) Requires a provider to disclose the provider's contractual reimbursement rates with other contracting entities or a contracting entity to disclose the contracting entity's contractual reimbursement rates with other providers.

(6) "Person" has the meaning assigned by Section 823.002.

(7)(A) "Provider" means:

(i) an advanced practice nurse;

(ii) an optometrist;

(iii) a therapeutic optometrist;

(iv) a physician;

(v) a physician assistant;

(vi) a professional association composed

solely of physicians, optometrists, or therapeutic optometrists;

(vii) a single legal entity authorized to practice medicine owned by two or more physicians;

(viii) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code;

(ix) a partnership composed solely of physicians, optometrists, or therapeutic optometrists;

(x) a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts; or

(xi) an institution that is licensed under Chapter 241, Health and Safety Code.

(B) "Provider" does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to another party.

(8) "Provider network contract" means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual.

SECTION 3. Section 1458.101, Insurance Code is amended to read as follows:

Sec. 1458.101. CONTRACT REQUIREMENTS. (a) In this section, the following are each considered a single separate line of business:

(1) preferred provider benefit plans covering individuals and groups;

(2) exclusive provider benefit plans covering

individuals and groups;

(3) health maintenance organization plans covering individuals and groups;

(4) Medicare Advantage or similar plans issued in connection with a contract with the Centers for Medicare and Medicaid Services;

(5) Medicaid managed care; and

(6) the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code.

(b) A contracting entity may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior adequate notification to the provider. The prior adequate notification may be provided in the written format specified by a provider network contract subject to this chapter.

(c) A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the contracting entity may contract with a person to provide access to the contracting entity's rights and responsibilities under the provider network contract.

(d) The provider network contract must require that on the request of the provider, the contracting entity will provide information necessary to determine whether a particular person has been authorized to access the provider's health care services and contractual discounts.

(e) To be enforceable against a provider, a provider network contract, including the lines of business described by Subsections (a) and (f), must also specify or reference a separate fee schedule for each such line of business. The separate fee schedule may describe specific services or procedures that the provider will deliver along with a corresponding payment, may describe a methodology for calculating payment based on a published fee schedule, or may describe payment in any other reasonable manner that specifies a definite payment for services. The fee information may be provided by any reasonable method, including electronically.

(f) The commissioner may, by rule, add additional lines of business for which express authority is required.

(g) A contracting entity shall not:

(1) Offer to a provider a provider network contract that includes a most favored nation clause;

(2) Enter into a provider network contract that includes a most favored nation clause; or

(3) Amend or renew an existing provider network contract previously entered into with a provider so that the contract as amended or renewed adds or continues to include a most favored nation clause.

The change in law made by this Act to Chapter 552, Insurance Code, does not apply to an offense committed before the effective date of this Act. An offense committed before the effective date of this Act is governed by the law as it existed on the date the offense was committed, and the former law is continued in effect for that

purpose. For purposes of this section, an offense was committed before the effective date of this Act if any element of the offense occurred before that date.

SECTION 4. This Act takes effect September 1, 2021.