

By: Bonnen

H.B. No. 3195

A BILL TO BE ENTITLED

AN ACT

relating to conduct of insurers providing preferred provider benefit plans with respect to physician and health care provider contracts and claims.

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

SECTION 1. Sections 1301.066 and 1301.103, Insurance Code, are amended to read as follows:

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. (a) An insurer may not engage in any retaliatory action against a physician or health care provider [~~, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract,~~] because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer.

(b) A retaliatory action under Subsection (a) includes:

(1) terminating the physician's or provider's participation in the preferred provider benefit plan;

(2) refusing to renew the physician's or provider's contract;

(3) implementing measurable penalties in the contract negotiation process;

(4) engaging in an unfair or deceptive practice,

1 including not listing the physician or provider in the network  
2 directory or requiring the physician or provider to submit medical  
3 records with each claim;

4 (5) arbitrarily reducing the physician's or provider's  
5 fees on the insurer's fee schedule; and

6 (6) otherwise making changes to material contractual  
7 terms that are adverse to the physician or provider.

8 (c) Subsections (b)(3)-(6) do not apply to a freestanding  
9 emergency medical care facility.

10 Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. (a)  
11 Except as provided by Sections 1301.104 and 1301.1054, not later  
12 than the 45th day after the date an insurer receives a clean claim  
13 from a preferred provider in a nonelectronic format or the 30th day  
14 after the date an insurer receives a clean claim from a preferred  
15 provider that is electronically submitted, the insurer shall make a  
16 determination of whether the claim is payable and:

17 (1) if the insurer determines the entire claim is  
18 payable, pay the total amount of the claim in accordance with the  
19 contract between the preferred provider and the insurer;

20 (2) if the insurer determines a portion of the claim is  
21 payable, pay the portion of the claim that is not in dispute and  
22 notify the preferred provider in writing why the remaining portion  
23 of the claim will not be paid; or

24 (3) if the insurer determines that the claim is not  
25 payable, notify the preferred provider in writing why the claim  
26 will not be paid.

27 (b) An insurer shall provide notice under Subsection (a)

1 electronically if the preferred provider's clean claim was  
2 electronically submitted and the provider is not a freestanding  
3 emergency medical care facility.

4 SECTION 2. Section 1301.105, Insurance Code, is amended by  
5 amending Subsection (d) and adding Subsection (e) to read as  
6 follows:

7 (d) If the preferred provider does not supply information  
8 reasonably requested by the insurer in connection with the audit,  
9 the insurer shall or, if the provider is a freestanding emergency  
10 medical care facility, may:

11 (1) notify the provider in writing that the provider  
12 must provide the information not later than the 45th day after the  
13 date of the notice or forfeit the amount of the claim; and

14 (2) if the provider does not provide the information  
15 required by this section, recover the amount of the claim.

16 (e) An insurer shall make a request or provide information  
17 under this section electronically if the preferred provider's clean  
18 claim was electronically submitted and the provider is not a  
19 freestanding emergency medical care facility.

20 SECTION 3. Sections 1301.1051 and 1301.1052, Insurance  
21 Code, are amended to read as follows:

22 Sec. 1301.1051. COMPLETION OF AUDIT. (a) The insurer must  
23 complete an audit under Section 1301.105 on or before the 180th day  
24 after the date the clean claim is received by the insurer, and any  
25 additional payment due a preferred provider or any refund due the  
26 insurer shall be made not later than the 30th day after the  
27 completion of the audit.

1       (b) An insurer may not recover a payment on an audited claim  
2 until a final audit is completed if the claim was submitted by a  
3 preferred provider other than a freestanding emergency medical care  
4 facility.

5       (c) An insurer shall provide written notice to the preferred  
6 provider, other than a freestanding emergency medical care  
7 facility, of the insurer's failure to complete an audit in the time  
8 required by Subsection (a) not later than the 15th day after the  
9 date on which the insurer is required to complete the audit under  
10 that subsection.

11       Sec. 1301.1052. PREFERRED PROVIDER APPEAL AFTER AUDIT. (a)  
12 If a preferred provider disagrees with a refund request made by an  
13 insurer based on an audit under Section [1301.105](#), the insurer shall  
14 provide the provider with an opportunity to appeal in accordance  
15 with this section, and the insurer may not attempt to recover the  
16 payment until all appeal rights are exhausted.

17       (b) An insurer shall provide a reasonable mechanism for an  
18 appeal requested under Subsection (a) by a preferred provider other  
19 than a freestanding emergency medical care facility. The review  
20 mechanism must incorporate, in an advisory role only, a review  
21 panel.

22       (c) A review panel described by Subsection (b) must be  
23 composed of at least three preferred provider representatives of  
24 the same or similar specialty as the affected preferred provider  
25 selected by the insurer from a list of preferred providers. The  
26 preferred providers contracting with the insurer in the applicable  
27 service area shall provide the list of preferred provider

1 representatives to the insurer.

2 (d) On request and if applicable, the insurer shall provide  
3 to the affected preferred provider:

4 (1) the panel's composition and recommendation; and

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

8 SECTION 4. Subchapter C, Chapter 1301, Insurance Code, is  
9 amended by adding Section 1301.10525 to read as follows:

10 Sec. 1301.10525. DEPARTMENT REVIEW OF AUDITS. (a) The  
11 commissioner by rule shall establish procedures for a preferred  
12 provider, other than a freestanding emergency medical care  
13 facility, to submit a request for the department to review an audit  
14 conducted by an insurer under this subchapter. The department  
15 review of an audit is a contested case under Chapter 2001,  
16 Government Code.

17 (b) If the department determines that an audit for which a  
18 preferred provider requested review under Subsection (a) resulted  
19 in unreasonable costs for the preferred provider, unnecessarily  
20 delayed or prevented payment of a claim, or otherwise violated this  
21 subchapter or rules adopted under this subchapter, the department  
22 shall:

23 (1) award compensatory damages to the preferred  
24 provider incurred as a result of the audit; and

25 (2) order the insurer to pay to the department the  
26 costs incurred by the department in reviewing the audit.

27 SECTION 5. Section 1301.132, Insurance Code, is amended by

1 adding Subsections (c), (d), and (e) to read as follows:

2 (c) An insurer shall provide a reasonable mechanism for an  
3 appeal requested under Subsection (b) by a physician or health care  
4 provider other than a freestanding emergency medical care facility.  
5 The review mechanism must incorporate, in an advisory role only, a  
6 review panel.

7 (d) A review panel described by Subsection (c) must be  
8 composed of at least three preferred provider representatives of  
9 the same or similar specialty as the affected preferred provider  
10 selected by the insurer from a list of preferred providers. The  
11 preferred providers contracting with the insurer in the applicable  
12 service area shall provide the list of preferred provider  
13 representatives to the insurer.

14 (e) On request and if applicable, the insurer shall provide  
15 to the affected preferred provider:

- 16 (1) the panel's composition and recommendation; and  
17 (2) a written explanation of the insurer's  
18 determination, if that determination is contrary to the panel's  
19 recommendation.

20 SECTION 6. (a) The changes in law made by this Act apply to  
21 a claim for payment made on or after the effective date of this Act  
22 unless the claim is made under a contract that was entered into  
23 before the effective date of this Act and that, at the time the  
24 claim is made, has not been renewed or was last renewed before the  
25 effective date of this Act.

26 (b) A claim made before the effective date of this Act or  
27 made on or after the effective date of this Act under a contract

1 described by Subsection (a) of this section is governed by the law  
2 as it existed immediately before the effective date of this Act, and  
3 that law is continued in effect for that purpose.

4 SECTION 7. This Act takes effect September 1, 2023.