BILL ANALYSIS

Senate Research Center

H.B. 574
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Business & Commerce
5/8/2015
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Interested parties note that some insurance carriers have intimidated physicians into referring patients only to in-network providers. The parties assert that some physicians who have referred patients to specific out-of-network providers have then received a letter from the insurer canceling their contract for not utilizing the network, which is commonly referred to as "de-listing," and in many cases, a de-listed physician must follow a course of legal action to seek reinstatement. The parties contend that clear statutory guidance would discourage insurance carriers from this practice and allow physicians to serve their patients by occasionally referring them out-of-network without the threat of harm to their professional livelihood. H.B. 574 seeks to discourage the practice of "de-listing."

H.B. 574 amends current law relating to the operation of certain managed care plans with respect to certain physicians and health care providers and amends provisions subject to a criminal penalty.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 843, Insurance Code, by adding Section 843.010, as follows:

> Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Provides that Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the health benefits plan for children under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code, or a Medicaid program, including a Medicaid managed care program operated under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code.

SECTION 2. Amends Section 843.306, Insurance Code, by adding Subsection (f) to prohibit a health maintenance organization from terminating participation of a physician or provider solely because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers.

SECTION 3. Amends Section 843.363, Insurance Code, by amending Subsection (a) and adding Subsection (a-1), as follows:

> (a) Adds information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition to the information a health maintenance organization, as a condition of a contract with a physician, dentist, or provider, or in any other manner, is may not prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with

a current, prospective, or former patient, or a person designated by the patient. Makes nonsubstantive changes.

(a-1) Prohibits a health maintenance organization from, as a condition of payment with a physician, dentist, or provider, or in any other manner, requiring a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

SECTION 4. Amends Section 1301.001, Insurance Code, by adding Subdivision (5-a) to define "out-of-network provider."

SECTION 5. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.0057 and 1301.0058, as follows:

Sec. 1301.0057. ACCESS TO OUT-OF-NETWORK PROVIDERS. Prohibits an insurer from terminating, or threatening to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider.

Sec. 1301.0058. PROTECTED COMMUNICATIONS BY PREFERRED PROVIDERS. (a) Prohibits an insurer from in any manner prohibiting, attempting to prohibit, penalizing, terminating, or otherwise restricting a preferred provider from communicating with an insured about the availability of out-of-network providers for the provision of the insured's medical or health care services.

(b) Prohibits an insurer from terminating the contract of or otherwise penalizing a preferred provider solely because the provider's patients use out-of-network providers for medical or health care services.

(c) Authorizes an insurer's contract with a preferred provider to require that, except in a case of a medical emergency as determined by the preferred provider, before the provider is authorized to make an out-of-network referral for an insured, the preferred provider inform the insured of information relating to out-of-network providers as set forth.

SECTION 6. Amends Section 1301.057(d), Insurance Code, as follows:

(d) Requires an insurer, on request, to provide to a practitioner whose participation in a preferred provider benefit plan is being terminated an expedited review conducted in accordance with a process that complies with rules established by the commissioner of insurance (commissioner) and 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 provider is measured, and the statistics underlying the profile and standards. Makes nonsubstantive changes.

Deletes existing text requiring an insurer to, on request, make an expedited review available to a practitioner whose participation in a preferred provider benefit plan is being terminated and requiring that the expedited review process comply with rules established by the commissioner.

SECTION 7. Amends Section 1301.067, Insurance Code, by adding Subsection (a-1), as follows:

(a-1) Prohibits an insurer from, as a condition of payment with a physician or health care provider or in any other manner, requiring a physician or health care provider to provide a notification form stating that the physician or health care provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

SECTION 8. (a) Makes application of this Act prospective to January 1, 2016, except as provided by this section.

(b) Makes application of Sections 843.306, 843.363, and 1301.057(d), Insurance Code, as amended by this Act, and Section 1301.0058, Insurance Code, as added by this Act, prospective.

SECTION 9. Effective date: September 1, 2015.