BILL ANALYSIS

Senate Research Center
83R12799 SCL-F

C.S.S.B. 822
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State Affairs
4/9/2013
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Many health plans use third-party entities to assemble and credential physicians and other health care providers, to negotiate physician and provider discounts, and to access secondary or rental networks to make their primary networks more robust. The influence of intermediaries or third parties paying health care claims today on behalf of employers is increasing. They may inappropriately tap into those same health plan networks and access discounts they are not authorized to use.

Unfortunately, some third-party entities today profit from inappropriately accessing network contracts while inappropriately discounting physician or other health care provider payments. They do this without the physicians' or providers' permission or agreement. Little information is known about the extent of these third parties' presence in the market or their interactions, if any, with the patient, physician, or other health care provider. Without this information, it becomes extremely difficult for the physician and health care providers to detect and/or identify who has access to their discounts, or if that access was agreed upon. More importantly, it is difficult for patients to determine if or when a physician or provider is actually in their network or to determine the patient's portion of the expense for medical care.

The bill amends Subtitle F (Physicians and Health Care Providers), Title 8, Insurance Code, by creating a new Chapter 1458 (Provider Network Contract Arrangements) that will regulate provider network contract arrangements.

C.S.S.B. 822 establishes the criteria for network and discount access and contract termination, the rights and responsibilities of contracting entities, and the disclosure to contracting entities about any third-party access to the providers' discounts.

C.S.S.B. 822 provides registration requirements of currently unlicensed contracting entities and remedies for physicians, hospitals, and other health care providers when a discount is taken without a contractual basis.

C.S.S.B. 822 amends current law relating to the regulation of certain health care provider network contract arrangements, provides an administrative penalty, and authorizes a fee.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1458.004 and 1458.101, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1458, as follows:

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. Defines "affiliate," "contracting entity," "covered individual," "express authority," "health care services," "person," "provider," and "provider network contract" in this chapter.

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) Defines "health benefit plan" in this chapter.

(b) Provides that "health benefit plan" does not include one or more or any combination of certain coverage, insurance, or arrangements.

(c) Provides that "health benefit plan" does not include certain benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage.

(d) Provides that "health benefit plan" does not include coverage limited to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if the coverage is provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor.

Sec. 1458.003. EXEMPTIONS. Provides that this chapter does not apply under circumstances in which access to the provider network is granted to an entity that operates under the same brand licensee program as the contracting entity, or to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001 (Definitions).

Sec. 1458.004. RULEMAKING AUTHORITY. Authorizes the commissioner to adopt rules to implement this chapter.

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Requires a person, unless the person holds a certificate of authority issued by the Texas Department of Insurance (TDI) to engage in the business of insurance in this state or operates a health maintenance organization under Chapter 843 (Health Maintenance Organizations), to register with TDI not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

(b) Requires a contracting entity that holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is a health maintenance organization, notwithstanding Subsection (a), under Section 1458.055, to file with the commissioner of insurance (commissioner) an application for exemption from registration under which the affiliates may access the contracting entity's network.

(c) Requires that an application for an exemption filed under Subsection (b) be accompanied by a list of the contracting entity's affiliates. Requires the contracting entity to update the list with the commissioner on an annual basis.

(d) Provides that a list of affiliates filed with the commissioner under Subsection (c) is public information and is not exempt from disclosure under Chapter 552 (Public Information), Government Code.

Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) Requires a person required to register under Section 1458.051 to disclose all names used by the contracting entity, including any name under which the contracting entity intends to engage or has engaged in business in this state; the mailing address and main telephone number of the

contracting entity's headquarters; the name and telephone number of the contracting entity's primary contact for TDI; and any other information required by the commissioner by rule.

(b) Requires that the disclosure made under Subsection (a) include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks and the internal organizational structure of the contracting entity's management.

Sec. 1458.053. SUBMISSION OF INFORMATION. Requires that information required under this subchapter be submitted in a written or electronic format adopted by the commissioner by rule.

Sec. 1458.054. FEES. Authorizes TDI to collect a reasonable fee set by the commissioner as necessary to administer the registration process. Requires that fees collected under this chapter be deposited in the TDI operating fund.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) Requires the commissioner to grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that the affiliate is not subject to a disclaimer of affiliation under Chapter 823 (Insurance Holding Company Systems) and the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

(b) Provides that an exemption granted under this section applies only to registration. Provides that an entity granted an exemption is otherwise subject to this chapter.

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. (a) Provides that, 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 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the comparable plan under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code.

(b) Prohibits a contracting entity from selling, leasing, or otherwise transferring information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior adequate notification of the provider.

(c) Requires that the provider network contract 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.

(d) Requires that a provider network contract, including the lines of business described by Subsection (a) and (e), to be enforceable against a provider, also specify a separate fee schedule for each such line of business. Authorizes the separate fee schedule to describe specific services or procedures that the provider will deliver along with a corresponding payment, to describe a methodology for calculating payment based on a published fee schedule, or to describe payment for services. Authorizes the fee information to be provided by any reasonable method, including electronically.

(e) Authorizes the commissioner, by rule, to add additional lines of business for which express authority is required.

Sec. 1458.102. CONTRACT ACCESS. (a) Prohibits a contracting entity from providing a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the person is required to comply with all applicable terms, limitations, and conditions of the provider network contract.

(b) Requires a contracting entity, for the purposes of this section, to permit reasonable access, including electronic access, to the provider during business hours for the review of the provider network contract. Authorizes the information to be used or disclosed only for the purposes of complying with the terms of the contract or state law.

Sec. 1458.103. ENFORCEMENT. Authorizes the commissioner to impose a sanction under Chapter 82 (Sanctions) or assess an administrative penalty under Chapter 84 (Administrative Penalties) on a contracting entity that violates this chapter or a rule adopted to implement this chapter.

SECTION 2. (a) Provides that the change in law made by this Act applies only to a provider network contract entered into or renewed on or after September 1, 2013. Provides that a provider network contract entered into or renewed before September 1, 2013, 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) Provides that, for the purposes of compliance with Section 1458.101, Insurance Code, as added by this Act, a provider's express authority is presumed if:

(1) the provider network contract is in existence before September 1, 2013;

(2) on the first renewal after September 1, 2013, the contracting entity sends a written renewal notice by United States mail to the provider;

(3) the notice described by Subdivision (2) of this subsection:

(A) contains a statement that failure to timely respond serves as assent to the renewal;

(B) contains separate signature lines for each line of business applicable to the contract; and

(C) specifies the separate fee schedule for each line of business applicable to the contract, described in any reasonable manner and which is authorized to be provided electronically; and

(4) the provider fails to respond within 60 days of receipt of the notice and has not objected to the renewal.

SECTION 3. Effective date: September 1, 2013.