# BILL ANALYSIS

C.S.H.B. 574
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Insurance
Committee Report (Substituted)

## BACKGROUND AND PURPOSE

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. C.S.H.B. 574 seeks to discourage the practice of "de-listing."

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

## ANALYSIS

C.S.H.B. 574 amends the Insurance Code to prohibit a health maintenance organization (HMO) from terminating participation of a physician or provider solely because the physician or provider informs an individual who is enrolled in a health care plan, including covered dependents, of the full range of physicians and providers available to the enrollee, including out-of-network providers. The bill prohibits an HMO, as a condition of a contract with a physician, dentist, or provider, or in any other manner, from prohibiting, attempting to prohibit, or discouraging such health care providers from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition. The bill exempts from these provisions coverage under the child health plan program, the health benefits plan for certain alien children, or a Medicaid program, including a Medicaid managed care program.

C.S.H.B. 574 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. This prohibition applies only to an insurance policy, insurance or HMO contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2016.

C.S.H.B. 574 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. The bill 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. The bill 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 may make an out-of-network referral for an insured, the preferred provider inform the insured whether the preferred provider has a financial interest in the out-of-network provider, that the insured may choose a preferred provider or an out-of-network provider, and that if the insured chooses the out-of-network provider the insured may incur higher out-of-pocket expenses.

C.S.H.B. 574 requires an insurer, on request, to provide to a practitioner whose participation in a preferred provider benefit plan is being terminated, in addition to the expedited review required by law, all information on which the insurer wholly or partly based the termination.

**EFFECTIVE DATE**

September 1, 2015.

**COMPARISON OF ORIGINAL AND SUBSTITUTE**

While C.S.H.B. 574 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

| INTRODUCED | HOUSE COMMITTEE SUBSTITUTE |
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| No equivalent provision. | SECTION 1. Subchapter A, Chapter 843, Insurance Code, is amended by adding Section 843.010 to read as follows:<br>Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:<br>(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or<br>(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 533, Government Code. |
| SECTION 1. Section 843.306, Insurance Code, is amended. | SECTION 2. Same as introduced version. |
| SECTION 2. Section 843.363(a), Insurance Code, is amended. | SECTION 3. Same as introduced version. |
| SECTION 3. Section 1301.001, Insurance Code, is amended. | SECTION 4. Same as introduced version. |

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| SECTION 4. Subchapter A, Chapter 1301, Insurance Code, is amended. | SECTION 5. Same as introduced version. |
| SECTION 5. Section 1301.057(d), Insurance Code, is amended. | SECTION 6. Same as introduced version. |
| SECTION 6. (a) Except as provided by this section, the changes in law made by this Act apply only to an insurance policy, insurance or health maintenance organization contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2016. A policy, contract, or evidence of coverage delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.<br>(b) 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, apply only to a contract between a health maintenance organization or insurer and a physician or health care provider that is entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before the effective date of this Act 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. | SECTION 7. Same as introduced version. |
| SECTION 7. This Act takes effect September 1, 2015. | SECTION 8. Same as introduced version. |