BILL ANALYSIS

C.S.H.B. 2397
By: Muñoz, Jr.
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties contend that the law under which an insurer provides notice to a preferred provider and conducts a reasonable review mechanism when the insurer seeks to terminate a provider's contract should better protect a provider against false allegations of fraud or malfeasance. C.S.H.B. 2397 seeks to provide this protection.

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. 2397 amends the Insurance Code to remove the exception for a case involving fraud or malfeasance to the requirement that an insurer provide, on request and before terminating a contract with a preferred provider, a reasonable review mechanism to the affected provider who is a practitioner. The bill authorizes an insurer that provides written notice of termination of a contract with a preferred provider and provides such a reasonable review mechanism to suspend the affected practitioner's participation in the preferred provider benefit plan beginning not earlier than the date the notice is provided and ending on the date the insurer makes a final determination under the bill's provisions. The bill requires such an insurer to include written notice of the suspension, if applicable, with the required notice of termination. The bill requires an insurer that suspends a practitioner's participation in the preferred provider benefit plan to make a final determination to terminate or resume the provider's participation in the preferred provider benefit plan not later than three business days after the date the insurer receives the recommendation of the review panel that is incorporated in the review mechanism. The bill requires the insurer to immediately send to the practitioner written notice of the insurer's determination.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2397 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
No equivalent provision.	SECTION 1. The heading to Section 1301.057, Insurance Code, is amended to read as follows: Sec. 1301.057. TERMINATION OR SUSPENSION OF PARTICIPATION; EXPEDITED REVIEW PROCESS.
SECTION 1. Section 1301.057(a), Insurance Code, is amended to read as follows: (a) Before terminating a contract with a preferred provider, an insurer shall: (1) provide written reasons for the termination; and (2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving: (A) imminent harm to a patient's health; (B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine; or (C) fraud or malfeasance committed by the practitioner against the insurer, as determined by a final, unappealable judgment of a court.	SECTION 2. Section 1301.057, Insurance Code, is amended by amending Subsection (a) and adding Subsections (a-1) and (a-2) to read as follows: (a) Before terminating a contract with a preferred provider, an insurer shall: (1) provide written reasons for the termination; and (2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving: (A) imminent harm to a patient's health; or (B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine[; or [~~(C) fraud or malfeasance~~].
	(a-1) If an insurer provides notice and review under Subsection (a) in a case involving fraud or malfeasance by the affected practitioner, the insurer: (1) may suspend the affected practitioner's participation in the preferred provider benefit plan: (A) beginning not earlier than the date the notice is provided under Subsection (a); and (B) ending on the date the insurer makes a final determination under Subsection (a-2); and (2) must include written notice of the suspension, if applicable, with the notice required under Subsection (a). (a-2) If an insurer suspends a practitioner's participation in the preferred provider benefit plan under Subsection (a-1), the insurer shall make a final determination to terminate or resume the provider's participation in the preferred provider benefit plan not later than three business days after the date the insurer receives the recommendation of the review panel

	described by Subsection (b). The insurer shall immediately send to the practitioner written notice of the insurer's determination.
SECTION 2. The change in law made by this Act applies only to a contract 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 3. Same as introduced version.
SECTION 3. This Act takes effect September 1, 2017.	SECTION 4. Same as introduced version.