SUBJECT: Requiring provider approval to transfer Medicaid fee schedules

COMMITTEE: Insurance — favorable, without amendment

VOTE: 6 ayes — Smithee, G. Bonnen, Morrison, Muñoz, Sheets, Taylor

0 nays

3 absent — Eiland, Creighton, C. Turner

SENATE VOTE: On final passage, April 25 — 30-0, on Local and Uncontested Calendar

WITNESSES: For — Patricia Kolodzey, Texas Medical Association; Pati McCandless, Blue Cross & Blue Shield of Texas; (*Registered, but did not testify:* BJ Avery, Texas Optometric Association; Charles Bailey, Texas Hospital Association; Jennifer Cawley, Texas Association of Life and Health Insurers)

Against — None

On — (*Registered, but did not testify:* Doug Danzeiser, Texas Department of Insurance)

DIGEST: SB 1221 would prohibit an insurance company, health maintenance organization (HMO), or preferred provider organization (PPO) in the Medicaid or children's health insurance program (CHIP) from requiring that a contracted provider allow access to or transfer their name and discounted fee to other HMO and PPO benefit plans.

The bill would allow such transfers only if the provider signed on a separate signature line near a written notice from the insurance company, HMO, or PPO that included in conspicuous, boldface type a statement similar to the following: “By signing on this line, you may be agreeing to apply this company's Medicaid or CHIP fee schedule to services you provide to commercial insurance or HMO enrollees.”

SB 1221 would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take

effect September 1, 2013 and would apply only to contracts entered into or renewed on or after that date.