

- SUBJECT:** Ability of physicians to refer patients to out-of-network providers
- COMMITTEE:** Insurance — committee substitute recommended
- VOTE:** 8 ayes — Frullo, Muñoz, G. Bonnen, Guerra, Meyer, Paul, Sheets, Workman
- 0 nays
- 1 absent — Vo
- WITNESSES:** For — Dan Chepkaukas, Patient Choice Coalition of Texas; Fiaz Zaman, TASCs; Vim Head; (*Registered, but did not testify:* Wayne Chan and Karen Yates, Altus Infusion; Lee Loftis, Independent Insurance Agents of Texas; Dianne Wheeler, League of Women Voters of Texas; Jaime Capelo, MEDNAX Medical Group, Texas Chapter American College of Cardiology; Kyle Frazier, Patient Choice Coalition of Texas; Bill Pewitt, Texas Association for Home Care and Hospice;; Anjanette Wyatt, Texas Pharmacy Association, Alliance of Independent Pharmacists, Texas Association of Independent Pharmacy Owners; Mark Hanna, Texas Podiatric Medical Association; Vilingh Nguyen, Texas Southern University College of Pharmacy; Amy Kyle, TXASCS; and 10 individuals)
- Against — None
- On — Debra Diaz-Lara, Texas Department of Insurance
- DIGEST:** CSHB 574 would prohibit a health maintenance organization (HMO) from terminating the participation of physician or a provider in an HMO’s network solely because the physician or provider informed an enrollee of the full range of available physicians and providers, including out-of-network providers. The bill would define an “out-of-network provider” to mean a physician or health care provider who is not a preferred provider.
- Under the bill, an HMO could not contractually prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing or

communicating in good faith with a patient or patient's designee the availability of in-network and out-of-network facilities for the treatment of a patient's medical condition.

These prohibitions would not apply to the state's Children's Health Insurance Program, the state's health insurance program for qualified alien (legal immigrant) children, or a Medicaid program, including a Medicaid managed care program operated under Government Code, ch. 533, which governs implementation of Medicaid managed care programs.

The bill also would prohibit an insurer from terminating or threatening to terminate an insured person's participation in a preferred provider benefit plan solely because the person used an out-of-network provider. The bill would specify that an insurer could not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict a preferred provider from communicating with an insured person about the availability of out-of-network providers for the provision of the person's medical or health care services. An insurer could not terminate a preferred provider's contract or otherwise penalize the provider solely because the provider's patients used out-of-network providers for medical or health care services.

Except in the case of a medical emergency, an insurer could contractually require a preferred provider to disclose the following information to the insured person before the provider could make an out-of-network referral:

- that the insured person could choose a preferred provider or an out-of-network provider;
- if the insured person chose the out-of-network provider, the person could incur higher out-of-pocket expenses; and
- whether the preferred provider had a financial interest in the out-of-network provider.

In addition to the expedited review already required under existing statute to be provided to a practitioner whose participation in a preferred provider benefit plan was terminated, the bill would require an insurer to provide to the terminated practitioner all information on which the insurer wholly or

partly based the termination. This information would include the economic profile of the preferred provider, the standards by which the provider was measured, and the statistics underlying the profile and standards.

The provisions in the bill would apply to an insurance policy, insurance or HMO contract, or evidence of coverage delivered, issued for delivery, or renewed starting January 1, 2016. All provisions in the bill would apply only to a HMO contract entered into or renewed starting September 1, 2015, except those provisions exempting certain health insurance plans, defining an out-of-network provider, and prohibiting an insurer from terminating or threatening to terminate an insured person's participation in a preferred provider benefit plan solely because the insured person used an out-of network provider.

The bill would take effect September 1, 2015.

**SUPPORTERS
SAY:**

Health insurance plans currently can cancel a physician's contract with an insurer for referring a patient to a specific out-of-network health care provider. CSHB 574 would give clear guidance in statute to discourage health insurance carriers from this practice and would allow physicians to serve their patients by occasionally sending them to an out-of-network provider as needed without the threat of harm to a physician's professional livelihood. The bill also would protect a patient's contractual right to seek medical treatment with any health care provider of the patient's choice.

Terminating or threatening to terminate a physician's contract for referring a patient to an out-of-network provider is overly punitive and reduces access to health care and continuity of care for the terminated physician's patients. Health insurance plans already have incentives for patients to stay in-network; terminating a physician's contract for simply referring a patient to an out-of-network provider is not necessary.

**OPPONENTS
SAY:**

One of the ways health insurance plans reduce costs is by restricting a patient's choice of providers. CSHB 574 could increase costs of a health

insurance plan by reducing an insurer's ability to penalize providers who referred patients insured under a certain plan to out-of-network providers.