# BILL ANALYSIS

Senate Research Center

C.S.S.B. 383
By: Cain
Economic Development
3-3-97
Committee Report (Substituted)

## DIGEST

Currently, in Texas, insurers which sponsor preferred provider plans are regulated under Chapter 3 of the Insurance Code. However, the code does not provide adequate quality of care standards and consumer protections for these plans. This bill will provide for the regulation of preferred provider benefit plans offered by health insurance providers.

## PURPOSE

As proposed, C.S.S.B. 383 provides regulations for preferred provider benefit plans offered by health insurance plans.

## RULEMAKING AUTHORITY

Rulemaking authority is granted to the commissioner of insurance in SECTION 1 (Article 3.70-3C(9), Insurance Code) of this bill.

## SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 3, Insurance Code, by adding Article 3.70-3C, as follows:

ARTICLE 3.70-3C. PREFERRED PROVIDER BENEFIT PLANS

Sec. 1. DEFINITIONS. Defines "emergency care," "health insurance policy," "health care provider" or "provider," "hospital," "institutional provider," "insurer," "life threatening," "physician," "practitioner," "preferred provider," "prospective insured," "quality assessment," and "service area."

Sec. 2. APPLICATION. Provides that this article applies to any preferred provider benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage which is different from the basic level of coverage provided by the health insurance policy if the insured uses a preferred provider. Provides that this article does not apply to provisions for dental care benefits in any health insurance policy.

Sec. 3. CONTRACTING REQUIREMENTS. Sets forth the requirements for contracts between health insurance providers and physicians, practitioners, institutional providers, or health care providers.

Sec. 4. CONTINUITY OF CARE. Requires the insurer to establish reasonable procedures for assuring a transition of insureds to physicians or health care providers and for continuity of treatment. Requires the insurers to provide, subject to Section 6(e) of this article, reasonable advance notice to the insured of the impending termination from the plan of a physician or health care provider who is currently treating the insured. Requires insurers, in the event of termination of a preferred provider's participation in the plan, to make available to the insured a current listing of preferred providers. Sets forth contract requirements to insure continuing treatment of the insured if a preferred provider's participation in the plan is terminated. Defines "special circumstances." Requires contracts between an insurer, physicians, and health care providers to include procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. Provides that this section

does not extend the obligation of the insurer to reimburse, at the preferred provider level of coverage, the terminated physician or health care provider or, if applicable, the insured for ongoing treatment of an insured after the 90th day from the effective date of the termination. Provides that, however, the obligation of the insurer to reimburse, at the preferred provider level of coverage, the terminated physician or health care provider or, if applicable, the insured who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate post-partum care, and the follow-up checkup within the first six weeks of delivery.

Sec. 5. EMERGENCY CARE PROVISIONS. Requires an insurer, if the insured cannot reasonably reach a preferred provider, to provide reimbursement for certain emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider.

Sec. 6. MANDATORY DISCLOSURE REQUIREMENTS. Requires all health insurance policies, health benefit plan certificates, endorsements, amendments, applications, or riders to be written in plain language, be in a readable and understandable format, and comply with all applicable requirements relating to minimum readability requirements. Requires the insurer to provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms and conditions of the policy to allow the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. Sets forth requirements for the written description. Requires a current list of preferred providers to be provided to all insureds no less than annually. Prohibits any insurer, or agent or representative of an insurer, from causing or permitting the use or distribution of prospective insured information which is untrue or misleading. Prohibits an insurer, if a physician or practitioner is terminated for reasons other than at the preferred provider's request, from notifying enrollees of the termination until the effective date of the termination or at such time as a review panel makes a formal recommendation regarding the termination, whichever is later. Requires a physician or provider, if the physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, to provide reasonable notice to enrollees under the physician's or provider's care. Requires the insurer to provide assistance to the physician or provider in assuring that the notice requirements of this subdivision are met. Authorizes an insurer, if a physician or practitioner is terminated for reasons related to imminent harm, to notify enrollees immediately.

Sec. 7. PROHIBITED PRACTICES. Prohibits an insurer from engaging in any retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured, or a person acting on behalf of the insured, has filed a complaint against the insurer or against a preferred provider or has appealed a decision of the insurer. Prohibits an insurer from engaging in any retaliatory action against a physician or health care provider, including termination of or refusal to renew a contract, because the physician or provider has, on behalf of an insured, reasonably filed a complaint against the insurer or has appealed a decision of the insurer. Prohibits an insurer, as a condition of a contract with a physician or health care provider or in any other manner, from prohibiting, attempting to prohibit, or discouraging a physician or provider from discussing with or communicating certain information or opinions. Prohibits an insurer from penalizing, terminating, or refusing to compensate for covered services a physician or provider for discussing or communicating with a current, prospective, or former patient, or a party designated by a patient, pursuant to this section. Prohibits an insurer from using any financial incentive or making payment to a physician or health care provider which acts directly or indirectly as an inducement to limit medically necessary services.

Sec. 8. AVAILABILITY OF PREFERRED PROVIDERS. Requires any insurer offering a preferred provider benefit plan to ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. Requires, if services are not available through preferred providers within the service area, nonpreferred providers to be reimbursed at the same percentage level of reimbursement as the preferred providers would have been reimbursed had the insured been treated by them.

Provides that nothing in this subsection requires reimbursement at a preferred level or coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience.

Sec. 9. RULEMAKING AUTHORITY. Requires the commissioner of insurance to adopt rules as necessary to implement the provisions of this article and to ensure reasonable accessibility and availability of preferred provider and basic level benefits to Texas citizens.

SECTION 2. Makes application of this Act prospective.

SECTION 3. Emergency clause.
Effective date: upon passage.

**SUMMARY OF COMMITTEE CHANGES**

Amends SECTION 1, Section 1, Article 3.70-3C, V.T.C.S., to redefine "emergency care" and "health care provider," and to define "life threatening" and "prospective insured."

Amends SECTION 1, Section 3, Article 3.70-3C, V.T.C.S., to prohibit certain health insurance policies from being considered unjust, unfair discrimination, or violating certain laws, if the policies meet the requirements of this section. Deletes proposed Subsection (k) relating to preferred providers contracting with other health insurance organizations or preferred providers. Requires an insurer and all preferred provider insurance benefit plans to meet the requirements of this article, rather than section. Redesignates Subsections (l) and (m) as Subsections (k) and (l).

Amends SECTION 1, Section 4, Article 3.70-3C, V.T.C.S., to require an insurer to continue to reimburse a terminated physician or health care provider at the level of preferred provider coverage for a certain time period, if at the time of termination the insured is past the 24th week of pregnancy. Makes nonsubstantive changes.

Amends SECTION 1, Section 6, Article 3.70-3C, V.T.C.S., to require notification to insureds if a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer. Requires the insurer to aid the physician or provider in notifying insureds.

Amends SECTION 1, Section 7, Article 3.70-3C, V.T.C.S., to delete a reference to "other health care services" in the prohibition on restricting the ability of a physician or health care provider to discuss a patient's health care options with that patient.

Amends SECTION 1, Section 8, Article 3.70-3C, V.T.C.S., to provide that an insurer does not have to reimburse a nonpreferred provider at a preferred level of coverage solely because an insured lives outside of the service area and, for reasons of convenience, chooses to receive services from a provider other than a preferred provider.