BILL ANALYSIS

Senate Research Center

S.B. 781
By: Madla
Economic Development
4/11/1999
As Filed

DIGEST

Currently, health care is often provided to enrollees of health insurance plans by practitioners who contract with health maintenance organizations (HMOs) and preferred provider organizations (PPOs). However, many of the provider contracts do not disclose all necessary information or provide protections for the provider. This bill would require HMO and PPO contracts to include certain safeguards for the providers.

PURPOSE

As proposed, S.B. 781 provides regulations on contracts between health care providers and health care plans.

RULEMAKING AUTHORITY

This bill does not grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 3, Article 3.70-3C, Insurance Code, by adding Subsections (n)-(z), as follows:

(n) Requires a preferred provider contract to include a complete fee schedule, all applicable treatment codes, and a complete explanation of the method of determining payment to the preferred provider.

(o) Requires a preferred provider contract to include a provision prohibiting the insurer from changing the fee schedule for a preferred provider except upon 90 days prior written notice to the preferred provider by certified mail. Requires the preferred provider contract, in such event, to include a provision that allows the preferred provider to terminate the preferred provider contract prior to the implementation of the revised fee schedule without penalty.

(p) Requires a preferred provider contract to include a provision prohibiting unilateral amendments to the contract, except as authorized by Subsection (o).

(q) Requires a preferred provider contract to include a provision prohibiting the insurer from assigning the contract to another entity and thereby causing the preferred provider to become a preferred or participating provider in another health care plan without the preferred provider's prior consent.

(r) Requires a preferred provider contract to include a provision giving the preferred provider not less than 90 days after the date of service to submit a claim.

(s) Requires a preferred provider contract to include a provision requiring the insurer to pay a properly submitted and complete claim to the preferred provider within 45 days. Requires a preferred provider contract to include a provision that requires the insurer to forfeit any applicable fee discount and to instead pay the preferred provider's usual and customary fee for such service if an insurer fails to pay a claim as required by this subsection.

(t) Requires a preferred provider contract to include a provision clearly enumerating all information that must be included on a claim form to be submitted by a preferred provider to render that claim full and an complete for payment purposes.

(u) Requires the preferred provider contract to include a provision that once eligibility and benefits have been properly verified by the preferred provider, the insurer may not deny a claim payment on the ground that the insurer is no longer eligible for coverage or that the benefits have changed.

(v) Requires a preferred provider contract to include a provision defining "medical necessity" as "the standard for health care services as determined by physicians and practitioners in accordance with the prevailing practices and standards of the medical profession and the community." Requires a preferred provider contract to include a provision that a preferred provider may appeal an adverse decision regarding "medical necessity" to a panel of preferred providers of the same specialty.

(w) Requires a preferred provider contract to include a provision clearly explaining the insurer's policy regarding global periods and payment methods for multiple surgical procedures that are performed during the same operation.

(x) Requires a preferred provider contract to include a provision prohibiting the insurer from denying or interfering with the preferred provider's right to render medical services and furnish durable medical equipment to patients in an office setting as is customary for preferred providers of the same medical specialty.

(y) Requires a preferred provider contract to include a provision which provides for the automatic annual renewal of the contract except upon 90 days prior written notice of termination to the other party which must state the cause for the termination.

(z) Requires a preferred provider contract to include a provision that all unresolved disputes between the insurer and a preferred provider are required to be resolved by binding arbitration upon the request of either party.

SECTION 2. Amends Section 18A, Article 20A.18A, Insurance Code (Texas Health Maintenance Organization Act), by adding Subsections (j) - (v), as follows:

(j) Requires a contract between a health maintenance organization and a physician or provider to include a complete fee schedule, all applicable treatment codes, and a complete explanation of the method of determining payment to the physician or provider.

(k) Requires a contract between a health maintenance organization and a physician or provider to include a provision prohibiting the health maintenance organization from changing the fee schedule for a physician or provider except upon 90 days prior written notice to the physician or provider by certified mail. Requires the contract, in such an event, to include a provision that allows the physician or provider to terminate the contract prior to the implementation of the revised fee schedule without a penalty.

(l) Requires a contract between a health maintenance organization and a physician or provider to include a provision prohibiting unilateral amendments to the contract, except as authorized by Subsection (k).

(m) Requires a contract between a health maintenance organization and a physician or provider to include a provision prohibiting the health maintenance organization from assigning the contract to another entity and thereby causing the physician or provider to become a preferred or participating physician or provider in another health care plan without the physician's or provider's prior consent.

(n) Requires a contract between a health maintenance organization and a physician or provider to include a provision giving the physician or provider not less than 90 days after the date of service to submit a claim for payment.

(o) Requires a contract between a health maintenance organization and a physician or provider to include a provision to require the health maintenance organization to pay a properly submitted and complete claim to the physician or provider within 45 days. Requires the contract to include a provision that requires the health maintenance organization to forfeit any applicable fee discount and to instead pay the physician's or provider's usual and customary fee for such service, in the

event the health maintenance organization fails to pay a claim as required by this subsection.

(p) Requires a contract between a health maintenance organization and a physician or provider to include a provision clearly enumerating all information that must be included on a claim form to be submitted by a physician or provider to render that claim full and complete for payment purposes.

(q) Requires a contract between a health maintenance organization and a physician or provider to include a provision that once eligibility and benefits have been properly verified by the physician or provider, the health maintenance organization may not deny a claim for payment on the ground that an enrollee is no longer eligible for coverage or that the benefits have changed.

(r) Requires a contract between a health maintenance organization and a physician or provider to include a provision defining "medical necessity" as "the standard for health care services as determined by physicians and providers in accordance with the prevailing practices and standards of the medical profession and the community." Requires a contract between a health maintenance organization and a physician or provider to include a provision that a physician or provider may appeal an adverse decision regarding "medical necessity" to a panel of physicians or providers of the same specialty.

(s) Requires a contract between a health maintenance organization and a physician or provider to include a provision clearly explaining the health maintenance organization's policy regarding global periods and payment methods for multiple surgical procedures that are performed during the same operation.

(t) Requires a contract between a health maintenance organization and a physician or provider to include a provision prohibiting the health maintenance organization from denying or interfering with the physician's or provider's right to render medical services and furnish durable medical equipment to patients in an office setting as is customary for physicians or providers of the same medical specialty.

(u) Requires a contract between a health maintenance organization and a physician or provider to include a provision which provides for the automatic annual renewal of the contract except upon 90 days prior written notice of termination to the other party which must state the cause for the termination.

(v) Requires a contract between a health maintenance organization and a physician or provider to include a provision that all unresolved disputes between the health maintenance organization and a physician or provider are required to be resolved by binding arbitration upon the request of either party.

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