BILL ANALYSIS

Senate Research Center
77R11497 DLF-F

H.B. 1913
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Business & Commerce
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Engrossed

DIGEST AND PURPOSE

Current law requires a preferred provider organization (PPO) or health maintenance organization (HMO) to provide due process to a provider through the use of an advisory panel of physicians selected by the PPO or HMO before the provider is deselected from the PPO's or HMO's health plan. Since the panel's decision is of an advisory nature only, a provider who brings a case before the panel may still be deselected from the health plan without good cause. Providers may seek legal redress if they feel their deselection from a plan is unwarranted, but may not be able to pursue the action due to time constraints, cost concerns, and the improbability of prevailing in the suit. H.B. 1913 strengthens the peer review process by requiring the process to meet certain federal guidelines regarding good faith professional review activities if a contributing cause of the termination of a contract is based on utilization review, quality review, or any action reported to the National Practitioner Data Bank and authorizing aggrieved parties to bring an action for failure to follow procedures.

RULEMAKING AUTHORITY

This bill does not expressly 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, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by amending Subsection (g) and adding Subsections (o) and (p), as follows:

(g) Requires the insurer, before terminating a contract with a preferred provider, to provide written reasons for the termination. Requires the insurer, on request and, except as provided by this subsection, prior to termination of a physician or practitioner, but within a period not to exceed 60 days, to provide, rather than request, a reasonable review mechanism that incorporates, in an advisory role, a review panel selected in the manner described in Subsection (b)(3) of this section. Requires the review, if a contributing cause of the termination is based on utilization review, quality review, or any action reported to the National Practitioner Data Bank, to be a peer review process that meets the requirements of 42 U.S.C. Section 11101 et seq., as amended, and to be conducted before the preferred provider organization files any complaint, as provided under state law or 42 U.S.C. Section 11101 et seq., as amended, with the Texas State Board of Medical Examiners. Requires the peer review process, in cases in which there is imminent harm to a patient's health or an action by a state medical or other physician licensing board or other government agency that effectively impairs a physician's or practitioner's ability to practice medicine or in cases of fraud or malfeasance, to be initiated simultaneously with the termination or suspension. Requires an insurer determination contrary to any recommendation of the panel to be for good cause shown, and a written explanation of the insurer's determination to also be provided to the affected physician or practitioner.

(o) Authorizes a preferred provider who is injured by an insurer's failure to follow the procedures required under Subsection (g) of this section to bring an action against the

insurer to recover certain costs.

(p) Authorizes a preferred provider to bring an action under Subsection (o) of this section on the person's own behalf and on behalf of others similarly situated.

SECTION 2. Amends Section 18A, Texas Health Maintenance Organization Act (Article 20A.18A, V.T.C.S.), as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, by amending Subsection (b) and adding Subsections (k) and (l), as follows:

(b) Requires a physician or provider, on request and, except as provided by this subsection, before the effective date of the termination, but within a period not to exceed 60 days, to be entitled to a review of the health maintenance organization's proposed termination by an advisory review panel. Requires the decision of the advisory review panel to be considered and provides that it is binding on the health maintenance organization, except for good cause shown. Makes conforming changes.

(k) Makes conforming changes.

(l) Authorizes a physician or provider to bring an action under Subsection (k) of this section on the person's own behalf and on behalf of others similarly situated.

SECTION 3. Makes application of this Act prospective.

SECTION 4. Effective date: upon passage or September 1, 2001.