BILL ANALYSIS

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S.B. 521
By: Carona, Deuell
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Under current law, insurers are not permitted to interfere with a health care provider's medical care decisions for an insured patient. This prohibition is usually recognized in insurer contracts with providers, including in preferred provider organization (PPO) and health maintenance organization (HMO) contracts; however, insurer contracts also often require that health care providers refer patients to other providers in the insurer's network of providers when possible. Although a provider may have compelling and legitimate reasons for referring a patient to an out-of-network provider or facility, insurers have been known to terminate, or threaten to terminate, a provider contract if the provider refers patients to out-of-network providers, sometimes even if there is only one such referral. Insurers have also been known to terminate an insured's coverage for using an out-of-network provider.

One of the key components of a PPO health insurance policy, which make up approximately 80 percent of the Texas health insurance market, is the option for the insured to seek care with an out-of-network physician or an out-of-network facility. PPO contracts are more expensive than HMO contracts, and, if an insured chooses to pay the increased cost for a PPO policy, then the insured should have access to PPO services. If physicians are prohibited or discouraged from referring patients to out-of-network providers or facilities, then the insured are paying PPO prices for HMO-level services.

S.B. 521 prohibits an HMO from terminating a physician or provider solely because the physician or provider informs the patient of the full range of physicians or providers available to the patient, including out-of-network providers. S.B. 521 prohibits an HMO from prohibiting, by contract, a provider from providing a patient with information regarding the availability of out-of-network facilities for the treatment of a patient's medical condition; from terminating or threatening to terminate an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider; from prohibiting a health care provider participating in a preferred provider benefit plan from communicating with a patient about the availability of out-of-network providers; or from terminating or penalizing a health care provider participating in a preferred provider plan solely because the provider's patient uses an out-of-network provider. S.B. 521 provides that a health care provider participating in a preferred provider benefit plan terminated by an insurer is entitled to all information on which the insurer based the decision to terminate. S.B. 521 authorizes an insurer's contract with a preferred provider to require the preferred provider, under certain conditions, to inform the insured that the insured is authorized to choose a preferred provider or an out-of-network provider and, if the insured chooses the out-of-network provider, that the insured may incur higher out-of-pocket expenses; and to inform the insured whether the preferred provider has a financial interest in the out-of-network provider.

As proposed, S.B. 521 amends current law relating to the operation of certain managed care plans with respect to health care providers.

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 843.306, Insurance Code, by adding Subsection (f), as follows:

> (f) Prohibits a health maintenance organization (HMO) from terminating participation of a physician or provider solely because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers.

SECTION 2. Amends Section 843.363(a), Insurance Code, to prohibit an HMO, as a condition of a contract with a physician, dentist, or provider, or in any other manner, from prohibiting, attempting to prohibit, or discouraging a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to certain information, including information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition. Makes nonsubstantive changes.

SECTION 3. Amends Section 1301.001, Insurance Code, by adding Subdivision (5-a) to define "out-of-network provider."

SECTION 4. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.0051 and 1301.0052, as follows:

> Sec. 1301.0051. ACCESS TO OUT-OF-NETWORK PROVIDERS. Prohibits an insurer from terminating, or threatening to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider.
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> Sec. 1301.0052. PROTECTED COMMUNICATIONS BY PREFERRED PROVIDERS. (a) Prohibits an insurer from in any manner prohibiting, attempting to prohibit, penalizing, terminating, or otherwise restricting a preferred provider from communicating with an insured about the availability of out-of-network providers for the provision of the insured's medical or health care services.
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> (b) Prohibits an insurer from terminating the contract of or otherwise penalizing a preferred provider solely because the provider's patients use out-of-network providers for medical or health care services.
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> (c) Authorizes an insurer's contract with a preferred provider to require that, except in a case of medical emergency as determined by the preferred provider, before the provider may make an out-of-network referral for an insured, the preferred provider inform the insured:
>
> (1) that the insured may choose a preferred provider or an out-of-network provider, and if the insured chooses the out-of-network provider the insured may incur higher out-of-pocket expenses; and
>
> (2) whether the preferred provider has a financial interest in the out-of-network provider.

SECTION 5. Amends Section 1301.057(d), Insurance Code, to require an insurer, on request, to provide, rather than make an expedited review available, to a practitioner whose participation in a preferred provider benefit plan is being terminated an expedited review conducted in accordance with a process that complies with rules established by the commissioner of insurance and all information on which the insurer wholly or partly based the termination, including the economic profile of the preferred provider, the standards by which the provider is measured, and the statistics underlying the profile and standards. Makes nonsubstantive changes.

SECTION 6. (a) Makes application of this Act, except as provided by this section, to an insurance policy, insurance or HMO contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2012, prospective.

(b) Makes application of Sections 843.306, 843.363, and 1301.057(d), Insurance Code, as amended by this Act, and Section 1301.0052, Insurance Code, as added by this Act, prospective.

SECTION 7. Effective date: September 1, 2011.