BILL ANALYSIS

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S.B. 1197
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas Legislature has considered balance billing issues for the last three legislative sessions. S.B. 1731, 80th Legislature, Regular Session, 2007, required greater transparency by health plans, hospitals, and hospital based providers. H.B. 2256, 81st Legislature, Regular Session, 2009, created a new mediation process for consumers facing balancing billing when services are provided by out of network hospital based providers. H.B. 2256 also required the Texas Department of Insurance (TDI) to establish network adequacy rules. H.B. 1772, 82nd Legislature, Regular Session, 2011 created a new exclusive provider organization health plan option similar to that used by national employers where benefits are limited to network providers except in cases of an emergency or when no network provider is available.

In crafting and adopting rules for exclusive provider organization and preferred provider organization regulation, interested parties contend that TDI overreached its authority with regard to H.B. 2256 and H.B. 1772, ignoring the objections of bill authors and legislative intent. The concerns of the health plan industry, captured in multiple rounds of formal comments, were also ignored. This wilful disregard of legislative intent and statutory language resulted in rules, effective July 2013, that intentionally create policy on topics the legislature determined to be the jurisdiction of the private marketplace.

S.B. 1197 seeks to reinforce legislation passed in previous legislative sessions by clarifying exclusive provider and preferred provider organization benefit plans that otherwise will be significantly altered by the recently adopted TDI rules.

As proposed, S.B. 1197 amends current law relating to requirements of exclusive provider and preferred provider benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 5 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1301.001, Insurance Code, by adding Subdivisions (9-a) and (9-b) to define "procedure code" and "same service."

SECTION 2. Amends Section 1301.0041(b), Insurance Code, as follows:

> (b) Prohibits the commissioner of insurance (commissioner) from imposing a requirement for an exclusive provider benefit plan that is different from a requirement for a preferred provider benefit plan unless otherwise specified in this chapter (Preferred Provider Benefit Plans). Deletes existing text providing that an exclusive provider benefit plan, unless otherwise specified, is subject to this chapter in the same manner as a preferred provider benefit plan. Prohibits the commissioner, except as provided by this chapter, from imposing additional requirements for an exclusive provider benefit plan, including requirements based on:
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> (1) an annual network adequacy report;

(2) a complaint process or record;

(3) a document not related to network adequacy;

(4) a filing of a network provider contract with the commissioner;

(5) a filing of a description of information systems with the commissioner;

(6) a network certification; and

(7) a qualifying examination.

SECTION 3. Amends Section 1301.005, Insurance Code, by amending Subsection (b) and adding Subsections (d) and (e), as follows:

(b) Requires an insurer, if services are not available through a preferred provider within a designated service area or through a facility-based physician providing services at a network health care facility under a preferred provider benefit plan or an exclusive provider benefit plan, to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(d) Provides that a preferred provider benefit plan is not required to provide coverage, including credit to applicable deductibles or out-of-pocket maximums, for the excess amount the physician or health care provider who is not a preferred provider charges over the allowable amount covered under the preferred provider benefit plan.

(e) Requires that each insurance policy, certificate, and outline of coverage disclose how reimbursement for services provided by a physician or health care provider who is not a preferred provider is calculated. Requires that the reimbursements be calculated pursuant to appropriate reasonable and objective methodologies, including the median amount negotiated with preferred providers for the same service, published claims data, or a percentage of the published rate allowed by the Centers for Medicare and Medicaid Services for the same or similar service within the geographic market.

SECTION 4. Amends Section 1301.0055, Insurance Code, as follows:

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) Creates this subsection from existing text and makes no further change to this subsection.

(b) Provides that a preferred provider benefit plan issuer is not required to obtain the commissioner's approval for a departure from local market network adequacy standards, and the standards are not violated, if there is not a licensed provider of a particular specialty located within the service area. Requires a preferred provider plan issuer to list the areas in which a health care provider of a particular specialty is not available on the issuer's Internet website.

SECTION 5. (a) Requires the commissioner, as soon as practicable after the effective date of this Act, to adopt revised rules to implement the change in law made by this Act.

(b) Makes application of the change in law made by this Act prospective.

SECTION 6. Effective date: upon passage or September 1, 2013.