BILL ANALYSIS

Senate Research Center
83R3884 JRR-F

S.B. 822
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State Affairs
4/4/2013
As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Many health plans use third-party entities to assemble and credential physicians and other health care providers, to negotiate physician and provider discounts, and to access secondary or rental networks to make their primary networks more robust. The influence of intermediaries or third parties paying health care claims today on behalf of employers is increasing. They may inappropriately tap into those same health plan networks and access discounts they are not authorized to use.

Unfortunately, some third-party entities today profit from inappropriately accessing network contracts while inappropriately discounting physician or other health care provider payments. They do this without the physicians' or providers' permission or agreement. Little information is known about the extent of these third parties' presence in the market or their interactions, if any, with the patient, physician, or other health care provider. Without this information, it becomes extremely difficult for the physician and health care providers to detect and/or identify who has access to their discounts, or if that access was agreed upon. More importantly, it is difficult for patients to determine if or when a physician or provider is actually in their network or to determine the patient's portion of the expense for medical care.

The bill amends Subtitle F (Physicians and Health Care Providers), Title 8, Insurance Code, by creating a new Chapter 1458 (Provider Network Contract Arrangements) that will regulate provider network contract arrangements.

S.B. 822 establishes the criteria for network and discount access and contract termination, the rights and responsibilities of contracting entities, and the disclosure to contracting entities about any third-party access to the providers' discounts.

S.B. 822 provides registration requirements of currently unlicensed contracting entities and remedies for physicians, hospitals, and other health care providers when a discount is taken without a contractual basis.

As proposed, S.B. 822 amends current law relating to the regulation of certain health care provider network contract arrangements.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1458.052 and 1458.053, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1458, as follows:

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. Defines "affiliate," "contracting entity," "covered individual," "direct notification," "health care services," "person," "provider," "provider network contract," and "third party" in this chapter.

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) Defines "health benefit plan" in this chapter.

(b) Provides that "health benefit plan" does not include one or more or any combination of certain coverage or insurance.

(c) Provides that "health benefit plan" does not include certain benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage.

(d) Provides that "health benefit plan" does not include coverage limited to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if the coverage is provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor.

Sec. 1458.003. EXEMPTIONS. Provides that this chapter does not apply to a provider network contract for services provided to a beneficiary under the Medicaid program, the Medicare program, or the state child health plan established under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the comparable plan under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code; under circumstances in which access to the provider network is granted to an entity that operates under the same brand licensee program as the contracting entity; or to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001 (Definitions).

[Reserves Sections 1458.004-1458.050 for expansion.]

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Requires a person, unless the person holds a certificate of authority issued by the Texas Department of Insurance (TDI) to engage in the business of insurance in this state or operates a health maintenance organization under Chapter 843 (Health Maintenance Organizations), to register with TDI not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

(b) Requires a contracting entity that holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is a health maintenance organization, notwithstanding Subsection (a), under Section 1458.055, to file with the commissioner of insurance (commissioner) an application for exemption from registration under which the affiliates may access the contracting entity's network.

(c) Requires that an application for an exemption filed under Subsection (b) be accompanied by a list of the contracting entity's affiliates. Requires the contracting entity to update the list with the commissioner on an annual basis.

(d) Provides that a list of affiliates filed with the commissioner under Subsection (c) is public information and is not exempt from disclosure under Chapter 552 (Public Information), Government Code.

Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) Requires a person required to register under Section 1458.051 to disclose all names used by the contracting entity, including any name under which the contracting entity intends to engage or has engaged in business in this state; the mailing address and main telephone number of the contracting entity's headquarters; the name and telephone number of the contracting entity's primary contact for TDI; and any other information required by the commissioner by rule.

(b) Requires that the disclosure made under Subsection (a) include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks and the internal organizational structure of the contracting entity's management.

Sec. 1458.053. SUBMISSION OF INFORMATION. Requires that information required under this subchapter be submitted in a written or electronic format adopted by the commissioner by rule.

Sec. 1458.054. FEES. Authorizes TDI to collect a reasonable fee set by the commissioner as necessary to administer the registration process. Requires that fees collected under this chapter be deposited in the TDI operating fund.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) Requires the commissioner to grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that the affiliate is not subject to a disclaimer of affiliation under Chapter 823 (Insurance Holding Company Systems) and the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

(b) Provides that an exemption granted under this section applies only to registration. Provides that an entity granted an exemption is otherwise subject to this chapter.

(c) Requires the commissioner to establish a reasonable fee as necessary to administer the exemption process.

[Reserves Sections 1458.056-1458.100 for expansion.]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. Prohibits a contracting entity from providing a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the contracting entity is authorized to contract with a third party to provide access to the contracting entity's rights and responsibilities under a provider network contract and the third party is required to comply with all applicable terms, limitations, and conditions of the provider network contract.

Sec. 1458.102. DUTIES OF CONTRACTING ENTITY. (a) Requires a contracting entity that has granted access to health care services and contractual discounts under a provider network contract to notify each provider of the identity of, and contact information for, each third party that has or may obtain access to the provider's health care services and contractual discounts; provide each third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract; require each third party to disclose the identity of the contracting entity and the existence of a provider network contract on each remittance advice or explanation of payment

form; and notify each third party of the termination of the provider network contract not later than the 30th day after the effective date of the contract termination.

(b) Requires the contracting entity, if a contracting entity knows that a third party is making claims under a terminated contract, to take reasonable steps to cause the third party to cease making claims under the provider network contract. Requires the contracting entity, if the steps taken by the contracting entity are unsuccessful and the third party continues to make claims under the terminated provider network contract, to terminate the contracting entity's contract with the third party, or notify the commissioner, if termination of the contract is not feasible.

(c) Requires that any notice provided by a contracting entity to a third party under Subsection (b) include a statement regarding the third party's potential liability under this chapter for using a provider's contractual discount for services provided after the termination date of the provider network contract.

(d) Requires that the notice required under Subsection (a)(1) is required to be provided by providing for a subscription to receive the notice by e-mail, or posting the information on an Internet website at least once each calendar quarter; and is required to include a separate prominent section that lists each third party that the contracting entity knows will have access to a discounted fee of the provider in the succeeding calendar quarter and the effective date and termination or renewal dates, if any, of the third party's contract to access the network.

(e) Authorizes the e-mail notice described by Subsection (d) to contain a link to an Internet web page that contains a list of third parties that complies with this section.

(f) Provides that the notice described by Subsection (a)(1) is not required to include information regarding payors who are not insurers or health maintenance organizations.

Sec. 1458.103. EFFECT OF CONTRACT TERMINATION. Provides that, subject to continuity of care requirements, agreements, or contractual provisions:

(1) a third party is prohibited from accessing health care services and contractual discounts after the date the provider network contract terminates;

(2) claims for health care services performed after the termination date are prohibited from being processed or paid under the provider network contract after the termination; and

(3) claims for health care services performed before the termination date and processed after the termination date are authorized to be processed and paid under the provider network contract after the date of termination.

Sec. 1458.104. AVAILABILITY OF CODING GUIDELINES. (a) Requires that a contract between a contracting entity and a provider provide that the provider is authorized to request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the provider will receive under the contract; the contracting entity or the contracting entity's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the contracting entity receives the request; the contracting entity or the contracting entity's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and if the requested information indicates a reduction in payment to the provider from the amounts agreed to on the effective date of the contract, the contract is authorized to be terminated by the provider on written notice to the contracting entity on or before the 30th day after

the date the provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) Authorizes a provider who receives information under Subsection (a) to only use or disclose the information for the purpose of practice management, billing activities, and other business operations, and disclose the information to a governmental agency involved in the regulation of health care or insurance.

(c) Requires the contracting entity to, on request of the provider, provide the name, edition, and model version of the software that the contracting entity uses to determine bundling and unbundling of claims.

(d) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

(e) Requires the contracting entity, if a contracting entity is unable to provide the information described by Subsection (a)(1) (relating to requiring that a contract between a contracting entity and a provider provide that the provider is authorized to request a description and copy of certain coding guidelines), (a)(3) (relating to requiring that a contract between a contracting entity and a provider provide that the contracting entity or the contracting entity's agent will provide notice of certain changes), or (c), to by telephone provide a readily available medium in which providers may obtain the information, which may include an Internet website.

[Reserves Sections 1458.105-1458.150 for expansion.]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY

Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. Requires a third party that leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount to another party, who is not a covered individual, to comply with the responsibilities of a contracting entity under Subchapters C and E.

Sec. 1458.152. DISCLOSURE BY THIRD PARTY. (a) Requires a third party to disclose, to the contracting entity and providers under the provider network contract, the identity of a person, who is not a covered individual, to whom the third party leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount through an electronic notification that complies with Section 1458.102 and includes a link to the Internet website described by Section 1458.102(d).

(b) Requires a third party that uses an Internet website under this section to update the website on a quarterly basis. Requires a contracting entity, on request, to disclose the information by telephone or through direct notification.

[Reserves Sections 1458.153-1458.200 for expansion.]

SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS

Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT. (a) Provides that a person who knowingly accesses or uses a provider's contractual discount under a provider network contract without a contractual relationship established under this chapter commits an unfair or deceptive act in the business of insurance that violates Subchapter B (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined), Chapter 541. Provides that the remedies available for a violation of Subchapter B, Chapter 541, under this subsection do not include a private cause of action under Subchapter D (Private Action for Damages), Chapter 541, or a class action under Subchapter F (Class Actions by Attorney General or Private Individual), Chapter 541.

(b) Requires a contracting entity or third party to comply with the disclosure requirements under Sections 1458.102 and 1458.152 concerning the services listed on a remittance advice or explanation of payment. Authorizes a provider to refuse a discount taken without a contract under this chapter or in violation of those sections.

(c) Provides that, notwithstanding Subsection (b), an error in the remittance advice or explanation of payment may be corrected by a contracting entity or third party not later than the 30th day after the date the provider notifies in writing the contracting entity or third party of the error.

Sec. 1458.202. ACCESS TO THIRD PARTY. Prohibits a contracting entity from providing a third party access to a provider network contract unless the third party is a payor or person who administers or processes claims on behalf of the payor; a preferred provider benefit plan issuer or preferred provider network, including a physician-hospital organization; or a person who transports claims electronically between the contracting entity and the payor and does not provide access to the provider's services and discounts to any other third party.

[Reserves Sections 1458.203-1458.250 for expansion.]

SUBCHAPTER F. ENFORCEMENT

Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) Provides that a contracting entity that violates this chapter commits an unfair claim settlement practice under Subchapter A (Unfair Claim Settlement Practices), Chapter 542, and is subject to sanctions under that subchapter as if the contracting entity were an insurer.

(b) Authorizes a provider who is adversely affected by a violation of this chapter to make a complaint under Subchapter A, Chapter 542.

Sec. 1458.252. REMEDIES NOT EXCLUSIVE. Provides that the remedies provided by this subchapter are in addition to any other defense, remedy, or procedure provided by law, including common law.

SECTION 2. Makes application of this Act prospective to January 1, 2014.

SECTION 3. Effective date: September 1, 2013.