AN ACT

relating to the operation of certain managed care plans with respect to certain physicians and health care providers; amending provisions subject to a criminal penalty.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter A, Chapter 843, Insurance Code, is amended by adding Section 843.010 to read as follows:

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 533, Government Code.

SECTION 2. Section 843.306, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) A health maintenance organization may not terminate 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 3. Section 843.363, Insurance Code, is amended by amending Subsection (a) and adding Subsection (a-1) to read as

follows:

(a) A health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage 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:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the terms, requirements, or services of the health care plan as they relate to the medical needs of the patient; [~~or~~]

(3) the termination of the physician's, dentist's, or provider's contract with the health care plan or the fact that the physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan; or

(4) information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition.

(a-1) A health maintenance organization may not, as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the

form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

SECTION 4. Section 1301.001, Insurance Code, is amended by adding Subdivision (5-a) to read as follows:

(5-a) "Out-of-network provider" means a physician or health care provider who is not a preferred provider.

SECTION 5. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Sections 1301.0057 and 1301.0058 to read as follows:

Sec. 1301.0057. ACCESS TO OUT-OF-NETWORK PROVIDERS. An insurer may not terminate, or threaten to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider.

Sec. 1301.0058. PROTECTED COMMUNICATIONS BY PREFERRED PROVIDERS. (a) An insurer may not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict 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.

(b) An insurer may not terminate the contract of or otherwise penalize a preferred provider solely because the provider's patients use out-of-network providers for medical or health care services.

(c) An insurer's contract with a preferred provider may require that, except in a case of a 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:

(A) the insured may choose a preferred provider or an out-of-network provider; and

(B) 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 6. Section 1301.057(d), Insurance Code, is amended to read as follows:

(d) On request, an insurer shall provide [~~make an expedited review available~~] to a practitioner whose participation in a preferred provider benefit plan is being terminated:

(1) an [~~. The~~] expedited review conducted in accordance with a process that complies [~~must comply~~] with rules established by the commissioner; and

(2) 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.

SECTION 7. Section 1301.067, Insurance Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) An insurer may not, as a condition of payment with a physician or health care provider or in any other manner, require a physician or health care provider to provide a notification form stating that the physician or health care provider is an

out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

SECTION 8. (a) Except as provided by this section, the changes in law made by this Act apply only to an insurance policy, insurance or health maintenance organization contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2016. A policy, contract, or evidence of coverage delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) Sections 843.306, 843.363, and 1301.057(d), Insurance Code, as amended by this Act, and Section 1301.0058, Insurance Code, as added by this Act, apply only to a contract between a health maintenance organization or insurer and a physician or health care provider that is entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 9. This Act takes effect September 1, 2015.

President of the Senate

Speaker of the House

I certify that H.B. No. 574 was passed by the House on May 1, 2015, by the following vote: Yeas 139, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 574 was passed by the Senate on May 20, 2015, by the following vote: Yeas 29, Nays 1.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor