BILL ANALYSIS

S.B. 1738
By: Duncan
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Current Texas law is unclear regarding whether facilities are allowed to waive co-payments and lacks the appropriate regulatory structure to sanction offending facilities. Providers can freely balance bill patients for out-of-network services. Consumers often have little knowledge regarding the real cost of health care services, and the disclosure of such information would help patients to make health care choices based on cost.

Currently, if a person receives services from an out-of-network physician (often, a physician who has contracted to work within a network facility), that out-of-network physician will bill the patient for the difference between billed charges and the out-of-network payment from the health plan. Some facilities in the state are waiving the utilization control measures of health plans to entice patients to use their out-of-network services.

The bill requires facilities and facility-based physicians to provide patients with specific information regarding health care costs and authorizes them to only have one charge master. It requires facilities and health plans to inform patients that while they may receive services in an in-network facility, some physicians within the facility are out-of-network, and could hold patients liable for paying the balance of the procedures by those providers.

The bill provides for patient rights and complaint procedures for reasonable charges at facilities.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 2 (Section 322.002, Health and Safety Code) and to the Commissioner of Insurance in SECTION 5 (Section 1456.007, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. SHORT TITLE. Authorizes this Act to be cited at the Consumer Right to Know Act.

SECTION 2. Amends Subtitle G, Title 4, Health and Safety Code, by adding Chapter 322, as follows:

CHAPTER 322. CONSUMER ACCESS TO HEALTH CARE INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 322.001. DEFINITIONS. (a) Defines "Billed charge," "Charge master," "Consumer," "Department," "Executive commissioner, "Facility," and "Health benefit plan."

[Bill as drafted does not contain Subsection (b).]

Sec. 322.002. RULES. Authorizes the executive commissioner of the Health and Human Services Commission to adopt and enforce rules to further the purposes of this chapter.

[Reserves Sections 322.003-322.050 for expansion.]

SUBCHAPTER B. BILLING CHARGES

See. 322.051. NOTICE TO CONSUMER. Requires a facility, before any nonemergency treatment or service is performed, to provide notice to a consumer before or on admission to a facility of the consumer's right to receive a free copy of facility's common procedure charge list, a notice regarding availability of the common procedure charge information on the Consumer Guide to Health Care website, and a free written estimate of charges.

See. 322.052. CHARGE MASTER. A facility may have only one current charge master, which must include an initial effective date.

Sec. 322.053. CREATION OF FACILITY COMMON PROCEDURES LIST. (a) Requires the Department of State Health Services (DSHS) to identify 50 common inpatient procedures and 50 common outpatient procedures performed on patients by facilities in this state. A procedure may be a single health care service or supply, or a group of services and supplies most commonly provided as a unit to patients.

(b) Requires a facility to provide a list of the 50 common inpatient procedures and 50 common outpatient procedures performed for patients of the facility in this state to DSHS in a format developed by DSHS. Requires DSHS to use the lists provided by facilities to develop the common procedures list described in Subsection (a).

(c) Requires DSHS to update the most common procedures list at least every two years.

Sec. 322.054. FACILITY COMMON PROCEDURE CHARGE LIST. (a) Requires a facility to establish and maintain a list of the average charges for each procedure identified in the common procedure list created by DSHS under Section 322.053 if the procedure is performed within the facility.

(b) Requires the average charge for each procedure in a facility's procedure charge list to be based on the charges listed for individual services and supplies in the facility's current charge master at the time the list was compiled.

(c) Requires the facility to have only one current procedure charge list, which must be updated their procedure charge list on a semi-annual basis to reflect any changes made to the facility's charge master.

(d) Requires a facility to follow specific guidelines regarding identifying effective dates, retaining versions of, and posting the charge master. Requires the facility to provide notices to a consumer requesting the charge list that actual charges will vary based on a specific medical condition and that the range of charges for a procedure may differ from the amount paid by the consumer or the consumer's health plan.

(e) Requires the facility to provide to a consumer on request, a free copy of any version of the procedure charge list retained under Subsection (d) and to inform the consumer that the current procedure charge list is posted on the facility's Internet website, if any, with the Internet website address.

Sec. 322.055. CONSUMER GUIDE TO HEALTH CARE. (a) Requires a facility to file with DSHS the procedure charge list created under Section 322.054.

(b) Requires DSHS to make available on its Internet website a consumer guide to health care. The guide must include the procedure charge list for each facility that submits the list required under Subsection (a).

(c) Authorizes DSHS to accept gifts and grants to fund the consumer guide to health care.

Sec. 322.056. BILLING OF FACILITY SERVICES. (a) Requires each facility to develop, implement, and enforce specific written policies for billing of hospital services and supplies. The policies must include whether interest is charged on bill service not covered by a third party payor and the rate of interest, if any, a notice of the complaint procedure under Sections 322.101 and 311.0025, the consumer's right to file a complaint with the department, a disclosure of whether the facility is a participating provider under the consumer's third party payor's plan on the date of service and that physicians or other providers rendering services to the consumer while in the facility may not be participating providers in the consumer's third party payor's plan.

(b) Requires each facility to post in the general waiting area and in the waiting areas of any off-site or onsite registration, admission, or business office, a clear and conspicuous notice of the availability of the policies required by Subsection (a).

(c) Requires the facility to provide a written estimate of the charges for any procedure, service, or supply upon request before an elective admission or scheduling of nonemergency procedures or services. The written estimate must be provided within a reasonable time based on the number of charge estimates requested. The facility must advise the consumer that the request for a written estimate may result in a delay in scheduling and provision of the procedure, service or supply and that the consumer may be personally liable for payment of charges, depending on the consumer's health plan coverage.

(d) Requires the facility to provide a specific itemized statement of billed services upon the consumer's request, no later than the 30th business day after the date of the discharge. Specifies requirements for the itemized statement.

(e) Limits the time in which a consumer can request the statement to later than one year after the date on which the person is discharged from the facility. Requires the facility to provide the statement to the consumer not later than the 30th day after the statement is requested.

(f) Requires a facility to provide an itemized statement of billed services to a third party payor that is responsible or is paying all or part of the billed services provided and who has received a claim for payment of those services. The third party payor must request the statement from the facility and have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. Requires the facility to provide the statement to the payor not later than the 30th day after the date on which the payor requests the statement. If a third party payor receives a part, but not of the billed services, the third party payor may request an itemized statement for only the billed services for which payment is claimed or to which any deduction or copayment applies.

(g) Allows a facility to charge a reasonable fee for the third and subsequent copies if a consumer or third party payor requests more than two copies of the statement. The fee may not exceed the facility's cost to copy, process, and deliver the copy to the requesting party.

(h) If a consumer overpays a facility, the facility must refund the amount of the overpayment not later than the 30th day, upon determining that an overpayment has been made. Provides that this subsection does not apply to an overpayment covered by Chapter 1301, Insurance Code, or Section 843.350, Insurance Code.

Sec. 322.057. CONSUMER WAIVER PROHIBITED. Prohibits waiver, voiding or nullifying of the provisions of this subchapter by a contract or an agreement between a facility and a consumer.

[Reserves Sections 322.058-322.100 for expansion.]

SUBCHAPTER C. COMPLAINT RESOLUTION

Sec. 322.101. COMPLAINT PROCESS. (a) Requires a facility to have a procedure for handling complaints relating to the charges for health care services and supplies. Provides that if a consumer objects to the billed amount for a particular service or supply, the facility will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the objection cannot be resolved informally, requires the facility to advise the consumer that a complaint may be filed with DSHS and provide DSHS's mailing address and telephone number.

(b) Requires the facility to have a procedure for handling complaints by those third party payors relating to the charges for health care services and supplies, if a facility is not a participating provide with a third party payor. Provides that if a third party payor objects to the billed amount for a particular service or supply pursuant to this subsection, the facility will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. Requires the facility to advise the third party payor that a complaint may be filed with ESHS and provide DSHS's mailing address and the telephone number, if the objection cannot be resolved informally.

(c) Requires DSHS to complete an investigation of a complaint filed pursuant to this section not later than the 60th day upon receiving the complaint and all information necessary to make a determination concerning the validity of the complaint.

(d) Authorizes DSHS to extend the time necessary to complete an investigation, if certain situations arise.

(e) Authorizes DSHS to take disciplinary action as provided under Subchapter D, upon determining that a complaint regarding charges for healthcare services and supplies is valid.

[Reserves Section 322.102-322.150 for expansion.]

SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

Sec. 322.151. AUDIT AND INVESTIGATION. (a) Authorizes DSHS to audit, investigate, or take any other necessary action to reasonably ensure a facility, a facility vendor, or a health care provider is complying with Subchapter B or Subchapter C.

Sec. 322.152. DISCIPLINARY ACTION. (a) Provides that a facility that violates Subchapter B or Subchapter C is subject to disciplinary action by DSHS, as authorized by the applicable licensing law.

(b) Requires DSHS to provide certain opportunities and notices prior to taking any disciplinary action under Subsection (a).

SECTION 3. Amends Section 1271.055, Insurance Code, as effective April 1, 2005, by amending Subsection (b)(2), to require reimbursement of a non-network physician or provider at the usual and customary rate or at an agreed rate.

SECTION 4. Amends Section 1272.301, Insurance Code, as effective April 1, 2005, by amending Subsection (1), Subsection (a)(1)(B) to require reimbursement of a non-network physician or provider at the usual and customary rate or an agreed rate.

SECTION 5. Amends Subtitle F, Title 8, Insurance Code, as effective April 1, 2005, by adding Chapter 1456, as follows:

CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

Sec. 1456.001. DEFINITIONS. Adds definitions of "Balance billing," "Enrollee,"

"Facility-based physician," "Health care facility," "Health care practitioner," "Health care provider," and "Provider network."

Sec. 1456.002. APPLICABILITY OF CHAPTER. Sets forth the health benefit plans to which this chapter applies.

Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN. (a) Requires each health benefit plan that provides health care benefits through a provider network to provide notice to its enrollees that a facility-based physician or other health care provider may not be included in the health benefit plan's provider network and that such practitioner may balance bill for amounts not paid by the health benefit plan.

(b) Requires the health benefit plan to provide the disclosure, in writing, to each enrollee: in any material sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage; in an explanation of payment summary provided to an enrollee; in any other document that describes the enrollee's benefits under the plan; or conspicuously displayed on any website that an employee is reasonably expected to access.

Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY. (a) Requires each health care facility that has entered into a network contract with a health benefit plan to provide a notice to enrollees receiving health care services at the facility that a facility-based physician or other health care provider may not be included in the health benefit plan's provider network and that such practitioner may balance bill for amounts not paid by the health benefit plan.

(b) The facility must provide the written disclosure at the time the enrollee is first admitted to or first receives services at the facility.

SECTION 1456.005 REQUIRED DISCLOSURE: FACILITY-BASED PHYSICIANS. (a) Requires a facility-based physician that does not have a contract with a health benefit plan and bills a patient who is covered by that health benefit plan to send a billing statement that: contains an itemized listing of the services and supplies provided; contains a conspicuous, plain language explanation that the facility-based physician does not belong to the health benefit plan network and that the health benefit plan has paid the usual and customary rate as determined by the plan, which is below the facility-based physician billed amount; contains a telephone number to call to discuss the statement and for any explanations of the information on the statement or to discuss any payment issues; a notice that the patient may call to discuss alternate payment arrangements; a notice that the patient may file complaints with the Texas State Board of Medical Examiners, with the board's mailing address and complaint telephone number; and, for billing statements for more than $200 over any applicable copayments or deductibles, a plain language statement that, if the patient finalizes a payment plan agreement within 45 days of receiving the first billing statement and subsequently complies with that agreement, the facility-based physician may not furnish adverse information to a credit agency regarding the amount owed by the patient for one calendar year from the first statement date.

Sec. 1456.006. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTY. (a) Authorizes disciplinary action against a licensee or health care provider that violates this chapter.

(b) Provides that a violation of this chapter by a health care provider or facility-based physician is grounds for disciplinary action and imposition of an administrative penalty by the appropriate regulatory agency.

(c) Requires a regulatory agency to notify a health care provider or facility-based physician of any finding that the provider or physician is violating or has violated this chapter or rule adopted pursuant to the chapter and to provide the provider or physician with an opportunity to correct the violation.

(d) Provides that complaints brought under this section do not require a determination of medical competency and Section 154.058, Occupations Code, does not apply.

Sec. 1456.007. COMMISSIONER RULES; FORM OF DISCLOSURE. Authorizes the commissioner, by rule, to prescribe specific requirements for the disclosure required under Sections 1456.003 and 1456.004. Requires the form of the disclosure to be substantially similar to a specific notification.

SECTION 6. Amends Subchapter I, Chapter 843, Insurance Code, as effective April 1, 2005, by adding Section 843.321, as follows:

Sec. 843.321. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF HEALTH PLANS. (a) Defines "Commissioner" and "Health plan."
(b) Requires the commissioner of insurance (commissioner) to appoint an advisory committee to study facility-based provider network adequacy of health plans and its ability to contract on reasonable terms with facility-based physicians.

(c) Requires the committee to advise the commissioner periodically of its findings no later than December 2006.

(d) Sets forth requirements for the composition of the committee.

(e) Provides that members of the committee serve without compensation.

SECTION 7. Section 311.002 (Itemized Statement of Billed Services), Health and Safety Code, is repealed.

SECTION 8. Provides that the Act applies to an insurance policy, certificate, or contract or evidence of coverage delivered, issued for delivery or renewed on or after the effective date. A policy, certificate, or contract or evidence of coverage delivered, issued for delivery or renewed before the effective date is governed by the law as it existed immediately before the effective date.

SECTION 9. Requires the executive commissioner of HHSC and appropriate regulatory agencies to adopt rules necessary to implement Chapter 322, Health and Safety Code, as added by this Act, no later than May 1, 2006. Requires DSHS to develop the common procedures lists and the consumer guide to health care as required by Chapter 322, Health and Safety Code, as added by this Act, no later than September 1, 2006.

SECTION 10. Provides that notwithstanding Subchapter D, Chapter 322, Health and Safety Code, as added by this Act, a hospital, ambulatory surgical center, birthing center or health care provider is not subject to disciplinary action, a civil penalty, an administrative penalty, or a civil action for damages for conduct that violates Chapter 322 or a rule adopted under that chapter before January 1, 2006.

SECTION 11. Effective date September 1, 2005.

EFFECTIVE DATE

September 1, 2005