BILL ANALYSIS

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S.B. 1738
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AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

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.

As proposed, S.B. 1738 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 and post a notice that informs 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. S.B. 1738 also prohibits the balanced billing of patients once an out-of-network provider accepts payment from the health plan.

S.B. 1738 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) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. 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. (a) DEFINITIONS. Defines "billed charge," "board," "charge master," "consumer," "department," "executive commissioner," "facility," "facility-based physician," "facility vendor," "health care provider," and "regulatory agency."

(b) Defines for purposes of this chapter who is not a facility-based physician.

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

[Reserves Sections 322.003-322.050 for expansion.]

SUBCHAPTER B. BILLING CHARGES

Sec. 322.051. NOTICE TO CONSUMER. Requires a facility to provide notice to a consumer before or on admission to a facility of the consumer's right to receive a free copy of specific procedures and charges. Requires a facility-based physician to provide notice to the consumer of the consumer's right to receive a free copy of a physician's charge master and the physician's procedure charge list. Requires a facility vendor to provide notice to the consumer of the consumer's right to receive a free copy of the vendor's charge master and the vendor's procedure charge list.

Sec. 322.052. CHARGE MASTER. (a) Authorizes a facility, facility-based physician, or facility vendor to have only one current charge master.

(b) Requires a charge master to categorize billed charges by the types of health care services or supplies provided and include an initial effective date.

(c) Authorizes a facility, facility-based physician, or facility vendor to only adopt a new version of the charge master effective at the beginning of a calendar day.

(d) Requires a facility, facility-based physician, or facility vendor to complete specific functions regarding identifying, retaining, and posting the charge master.

(e) Requires a facility, facility-based physician, or facility vendor to provide free of charge to any person on request a written copy of any version of the charge master retained under Subsection (d) or inform the person that the requested version is posted on the Internet website and provide the person with the Internet website address.

Sec. 322.053. FACILITY MOST COMMON PROCEDURES LIST. Requires the Department of State Health Services (DSHS) to identify the 100 most common procedures performed on patients by facilities in this state. Authorizes a procedure to be a single health care service, supply, or a group of services and supplies most commonly provided as a unit to patients. Requires DSHS to update the most common procedures list at least every two years.

Sec. 322.054. FACILITY PROCEDURE CHARGE LIST. (a) Requires a facility to establish and maintain a list of the charges for each procedure identified in the most common procedure list created by DSHS under Section 322.053. Authorizes the facility, for a procedure that consists of a group of health care services and supplies that vary based on a patient's needs or condition, to use the average billed charge for that procedure.

(b) Requires the amount of a charge in a facility's procedure charge list to be based on the amount listed in the facility's current charge master.

(c) Provides that the facility may have only one current procedure charge list.

(d) Requires a facility to update their procedure charge list as necessary at the time the facility makes any changes to or adopts a new version of the facility's charge master. Requires the procedure charge list to prominently identify for each new version of the charge list all the changes from the immediately preceding version.

(e) Requires a facility to identify each version of the procedure charge list by the list's initial effective date, retain a copy of each version at least until the fourth anniversary of each list's effective date, and post on the facility's Internet website a copy of each version retained under Subdivision (2) that highlights the changes

from a previous version and in a format that can be downloaded on a personal computer free of charge.

(f) Requires the facility to provide, free of charge, to any person on request, a written copy of any version of the procedure charge list retained under Subsection (e) or inform the person that the requested version is posted on the facility's Internet website and provide the person 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 the DSHS Internet website a consumer guide to health care. Requires the guide to 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. FACILITY-BASED PHYSICIAN AND FACILITY VENDOR MOST COMMON PROCEDURES LIST. (a) Requires the Texas State Board of Medical Examiners (TSBME) to identify the 20 most common procedures performed by a facility-based physician and update the most common procedures list at least every two years.

(b) Requires a regulatory agency to identify the 20 most common procedures performed by a facility vendor and update the most common procedures list at least every two years.

(c) Requires DSHS to identify the 20 most common procedures performed by a facility vendor not licensed and regulated by a regulatory agency and update the list at least every two years.

(d) Authorizes a procedure under Subsection (a), (b), or (c) to be a single health care service or supply a group of services and supplies commonly provided as a unit to patients.

Sec. 322.057. FACILITY-BASED PHYSICIAN OR FACILITY VENDOR PROCEDURE CHARGE LIST. (a) Requires a facility-based physician and a facility vendor to establish and maintain a list of the charges for each procedure identified in the most common procedure list created by TSBME or regulatory agency under Section 322.056. Authorizes the physician, for a procedure that consists of a group of health care services and supplies that vary based on a patient's needs or condition, to use the average billed charge for that procedure.

(b) Requires the amount of a charge in a facility-based physician's or facility vendor's procedure charge list to be based on the amount charged in the physician's or vendor's current charge master.

(c) Provides that a facility-based physician or a facility vendor may have only one current procedure charge list.

(d) Requires a facility-based physician or a facility vendor to update the physician's or vendor's procedure charge list as necessary at the time the physician or vendor makes any changes to or adopts a new version of the physician's or vendor's charge master. Requires the procedure charge list to prominently identify, for each new version of the charge list, all the changes from the immediately preceding version.

(e) Requires a facility-based physician or facility vendor to identify each version of the procedure charge list by the list's initial effective date, retain a copy of each version at least until the fourth anniversary of each list's effective date, and post on the facility's Internet website a copy of each version retained under

Subdivision (2) that highlights the changes from a previous version and in a format that can be downloaded on a personal computer free of charge.

(f) Requires the facility-based physician or facility vendor to provide, free of charge, to any person on request, a written copy of any version of the procedure charge list retained under Subsection (e) or inform the person that the requested version is posted on the facility's Internet website and provide the person with the Internet website address.

Sec. 322.058. BILLING FOR AND COLLECTION OF COPAYMENTS, DEDUCTIBLES, AND COINSURANCE. (a) Prohibits a facility, facility-based physician, facility vendor, or health care provider to knowingly ignore or waive a copyament, coinsurance, deductible, or other amount a patient is financially responsible for under an insurance policy, health maintenance organization evidence of coverage, or employer sponsored health plan and requires them to make reasonable, diligent efforts to collect the amounts billed under Subdivision (1).

(b) Provides that nothing in Subsection (a) prevents a facility, facility-based physician, facility vendor, or health care provider from waiving any amount of a payment for health care services provided to Medicaid recipients, Medicare patients, or medically indigent persons who qualify for a sliding fee scale.

Sec. 322.059. CONSUMER WAIVER PROHIBITED. Prohibits the provisions of this subchapter from being waived, voided, or nullified by a contract or an agreement between a facility, facility-based physician, facility vendor, or health care provider and a consumer.

[Reserves Sections 322.060-322.100 for expansion.]

SUBCHAPTER C. REASONABLE CHARGES

Sec. 322.101. RIGHT TO REASONABLE CHARGE. (a) Prohibits a patient from being billed for more than a reasonable charge for a health care service or supply provided to a patient by a facility, facility-based physician, or facility vendor.

(b) Requires a facility, facility-based physician, or facility vendor to provide, on request to a patient, an itemized statement of billed charges that includes a notice to the consumer that if the consumer objects to the billed amount or to treatment, the consumer may file a complaint with DSHS, TSBME, or the regulatory agency, as applicable, or the attorney general. Requires the notice to include the name, mailing address, and telephone number of DSHS, TSBME, or regulatory agency, as applicable, and the attorney general.

(c) Provides that a facility, facility-based physician, or facility vendor bears the burden of establishing the reasonableness of a billed charge and is required to establish the reasonableness of a billed charge on request by a consumer, DSHS, TSBME, a regulatory agency, or the attorney general.

[Reserves Sections 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.

(b) Authorizes TSBME to audit, investigate, or take any other necessary action to reasonably ensure a facility-based physician is complying with Subchapter B.

(c) Authorizes a regulatory agency to audit, investigate, or take any other necessary action to reasonably ensure a facility vendor or health care provider is complying with Subchapter B.

Sec. 322.152. DISCIPLINARY ACTION. Provides that a facility, facility-based physician, facility vendor, or health care provider that violates this chapter is subject to disciplinary action by DSHS, TSBME, or a regulatory agency.

Sec. 322.153. ADMINISTRATIVE PENALTY. (a) Authorizes DSHS, in addition to all other disciplinary actions authorized under other law, to impose an administrative penalty for a facility's violation of Subchapter B as if the facility violated Chapter 241 (Hospitals) or 243 (Ambulatory Surgical Centers).

(b) Authorizes TSBME, in addition to all other disciplinary actions authorized under other law, to impose an administrative penalty for a facility-based physician's violation of Subchapter B as if the facility-based physician violated Subtitle B (Physicians), Title 3, Occupations Code.

(c) Authorizes the regulatory agency, in addition to all other disciplinary actions authorized under other law, if the law authorizing a regulatory agency to regulate and license or register a facility vendor or health care provider authorizes the regulatory agency to impose an administrative penalty for a violation of that law, to impose an administrative penalty for a facility vendor's or health care provider's violation of Subchapter B as if the facility vendor or health care provider violated the law authorizing the regulatory agency to regulate and license or register the facility vendor or health care provider.

(d) Requires DSHS, TSBME, or the regulatory agency to notify a facility, facility-based physician, facility vendor, or health care provider of a finding by DSHS, TSBME, or the regulatory agency that the facility, facility-based physician, facility vendor, or health care provider is violating or has violated this chapter or a rule adopted under this chapter and provide the facility, facility-based physician, facility vendor, or health care provider with an opportunity to correct the violation.

(e) Provides that an administrative penalty assessed as provided by this section for a violation of Subchapter B is $2,000 for each violation. Authorizes each day of a continuing violation to be considered a separate violation.

Sec. 322.154. CIVIL PENALTY. (a) Provides that a facility, facility-based physician, facility vendor, or health care provider that violates this chapter or a rule adopted or enforced under this chapter is liable for a civil penalty of at least $100 but not more than $500 for each day of violation and for each act of violation.

(b) Authorizes the attorney general or district or county attorney for the county in which the violation occurred to bring an action in district court to impose and collect the civil penalty. Requires the district, in determining the amount of the penalty, to consider specific criteria regarding the violation.

(c) Requires a penalty collected under this section, by the attorney general, to be deposited to the credit of the general revenue fund. Requires a penalty collected under this section, by a district or county attorney, to be deposited to the credit of the general fund of the county in which the suit was heard.

Sec. 322.155. INJUNCTION. (a) Authorizes DSHS, TSBME, or a regulatory agency to petition a district court for a temporary restraining order to restrain a continuing violation of this chapter if DSHS, TSBME, or a regulatory agency finds that the violation creates an immediate threat to the health and safety of the patients of a facility, facility-based physician, facility vendor, or health care provider.

(b) Authorizes a district court, on petition of DSHS, TSBME, or a regulatory agency and on a finding by the court that a person is violating this chapter, to petition for an injunction to prohibit a person from continuing a violation of this chapter or from granting any other injunctive relief warranted by the facts.

(c) Requires the attorney general to institute and conduct a suit authorized by this section at the request of DSHS, TSBME, or a regulatory agency.

(d) Provides that the venue for a suit brought under this section is in the county in which the facility is located or in Travis County.

SECTION 3. Amends Sections 108.09(a) and (k), Health and Safety Code, as follows:

(a) Requires, rather than authorizes, the Texas Health Care Information Council (council), to collect and, except as provided by Subsections (c) and (d), requires providers to submit to the council or another entity as determined by the council, all data required by this section.

(k) Requires the council to collect inpatient and outpatient health care data elements relating to payer type, the racial and ethnic background of patients, infection rates, and the use of health care services by consumers.

SECTION 4. Amends Section 311.002, Health and Safety Code, by amending Subsections (a), (b), and (c), and adding Subsections (a-1) and (j), as follows:

(a) Requires each hospital to disclose a written policy for the billing of hospital services and supplies. Requires the policy to include a statement on whether interest will be applied to any billed service not covered by a third party payor and the rate of any interest charged.

(a-1) Requires a hospital to post in a prominent location in the hospital's lobby, admissions area, and emergency department a clear and conspicuous notice of the availability of information required by Subsections (a), (c), and (d) and a person's right to request the information.

(b) Requires an itemized statement of billed services provided to a person to include specific information regarding reasonableness of charges and methods for addressing complaints.

(c) Requires a hospital, before any non-emergency treatment or service is performed and before a patient is discharged from a hospital, to disclose to a person the person's right to receive a written estimate of the charges for any procedure, service, or supply.

(j) Requires the hospital, if a patient overpays a hospital, to refund the amount of the overpayment not later than the 30th day after the date it is determined that an overpayment has been made. Provides that this subsection does not apply to an overpayment covered by Chapter 1301 (Preferred Provider Benefit Plans), Insurance Code, or Section 843.350 (Overpayment), Insurance Code.

SECTION 5. Amends Section 311.0025, Health and Safety Code, as follows:

Sec. 311.0025. AUDITS OF BILLING. (a) Prohibits a hospital, ambulatory surgical center, treatment facility, mental health facility, or health care professional from submitting to a patient or a third party payor, a bill for a treatment that the hospital, center, facility, vender, or professional knows was not provided or was improper, unreasonable, or medically or clinically unnecessary.

(b) Authorizes a regulatory agency, if the appropriate regulatory agency, or DSHS for a facility vendor, receives a complaint alleging a violation of Subsection (a), to audit the billings and patient records of the hospital, ambulatory

surgical center, treatment facility, mental health facility, facility vendor, or health care professional.

(c) Requires the appropriate regulatory agency or DSHS to require license holders to comply with this section. Provides that a hospital, ambulatory surgical center, treatment facility, mental health facility, facility vendor, or health care professional that violates Subsection (a) is subject to disciplinary action, including denial, revocation, suspension, or nonrenewal of the license of the hospital, center, facility, vendor, or professional, or a civil penalty for a facility vendor. Provides that disciplinary action taken under this section is in addition to any other civil, administrative, or criminal penalty provided by law.

(d) Defines "ambulatory surgical center" and "facility vendor."

(e) Prohibits a regulatory agency from taking disciplinary action against a hospital, ambulatory surgical center, treatment facility, mental health facility, facility vendor, or health care professional for unknowing and isolated billing errors. Prohibits DSHS from taking disciplinary action against a facility vendor for unknowing and isolated billing errors.

SECTION 6. Amends Section 1204.051, Insurance Code, as effective April, 1, 2005, to define "facility" and "facility-based physician or health care provider." Provides that for purposes of this chapter, a member of the medical staff of a health care facility is not a "facility-based health care provider" as described by Subdivision (2-b)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

SECTION 7. Amends Section 1204.052, Insurance Code, as effective April 1, 2005, to provide that this subchapter does not apply to a facility-based physician or health care provider.

SECTION 8. Amends Chapter 1204, Insurance Code, as effective April 1, 2005, by adding Subchapter G, as follows:

SUBCHAPTER G. RESTRICTIONS ON CERTAIN BALANCE BILLING

Sec. 1204.301. APPLICABILITY OF DEFINITIONS. Provides that in this subchapter, terms defined by Section 1204.051 have the meanings assigned by that section.

Sec. 1204.302. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS. Provides that this subchapter applies to an employee benefit plan, to the extent not preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), benefit programs under Chapters 1551 (Texas Employees Group Benefits Act) and 1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and The Texas A&M University System), to the extent that the benefit programs are self-insuring, and insurance coverage provided under Chapters 1575 (Texas Public School Employees Group Benefits Program) and 1579 (Texas School Employees Uniform Group Health Coverage).

Sec. 1204.303. RESTRICTIONS ON BALANCE BILLING. Prohibits a facility-based physician or health care provider, in connection with the provision of health care services to a covered person, from billing additional fess to the covered person in any amount above the applicable copayment, coinsurance, or deductible for the health care services if the facility-based physician or health care provider accepts the usual and customary rate as defined specific sections or fails to provide the disclosure required under Section 105.002(a)(4), Occupations Code.

SECTION 9. Amends Section 1271.001, Insurance Code, as effective April 1, 2005, to define "facility" and "facility-based physician or provider." Provides that for purposes of this chapter, a member of the medical staff of a health care facility is not a "facility-based provider" as described by Subdivision (a)(2)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

SECTION 10. Amends Section 1271.055, Insurance Code, as effective April 1, 2005, by adding Subsections (d) and (e), as follows:

(d) Requires a facility that is a member of a health maintenance organization delivery network to make a reasonable attempt to provide enrollees with facility-based physicians or providers who are members of the network while the enrollee is receiving services from the facility.

(e) Provides that the enrollee is not liable for any further payments to the facility-based physician or provider, except for payment of any applicable copayments, coinsurance, or deductibles for the covered services, if professional services are provided to an enrollee by a facility-based physician or provider who is not a member of the health maintenance organization delivery network, on the health maintenance organization's payment to the facility-based physician or provider at the usual and customary rate as defined by the health care plan or at an agreed rate for covered services.

SECTION 11. Amends Section 1272.001(a), Insurance Code, as effective April 1, 2005, by adding Subdivisions (4-a) and (4-b) to define "facility" and "facility-based physician or provider."

SECTION 12. Amends Section 1272.001, Insurance Code, as effective April 1, 2005, by adding Subsection (c), to provide that for purposes of this chapter, a member of the medical staff of a health care facility is not a "facility-based provider" as described by Subdivision (a)(4-b)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

SECTION 13. Amends Section 1272.301, Insurance Code, as effective April 1, 2005, by adding Subsection (e), as follows:

(e) Provides that the enrollee is not liable for any further payments to the facility-based physician or provider, except for payment of any applicable copayments, coinsurance, or deductibles for the covered services, if a limited provider network or delegated entity provides or arranges to provide services to enrollees through a facility-based physician or provider who is not a member of the health maintenance organization delivery network, on payment by the health maintenance organization of the usual and customary rate as defined by the health care plan or an agreed rate for covered services.

SECTION 14. (a) Amends Section 1301.001, Insurance Code, as effective April 1, 2005, to define "facility" and "facility-based physician or health care provider." Provides that for purposes of this chapter, a member of the medical staff of a health care facility is not a "facility-based health care provider" as described by Subdivision (a)(2)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

(b) Repealer: Section 1 (relating to the definitions of "preauthorization" and "verification"), Chapter 214, Acts of the 78th Legislature, Regular Session, 2003.

(c) Provides that in accordance with Section 311.031(c), Government Code, which gives effect to a substantive amendment enacted by the same legislature that codifies the amended statute, the text of Section 1301.001, Insurance Code, as set out in this section, gives effect to changes made by Section 1, Chapter 214, Acts of the 78th Legislature, Regular Session, 2003.

(d) Provides that to the extent of any conflict, this section prevails over another Act of the 79th Legislature, Regular Session, 2005, relating to nonsubstantive additions and corrections in enacted codes.

SECTION 15. Amends Subchapter D, Chapter 1301, Insurance Code, as effective April 1, 2005, by adding Section 1301.164, as follows:

Sec. 1301.164. BALANCE BILLING PROHIBITED. Provides that an insured is not liable for further payments to a facility-based physician or health care provider, except

for payment of any applicable copayments, coinsurance, or deductibles owed by the insured for the covered services, if health care services are provided to the insured in a facility that is part of the preferred provider network by a facility-based physician or health care provider who is not a preferred provider, on payment to the physician or provider by the insurer of the usual and customary rate as defined by the health insurance policy or the agreed rate for covered services.

SECTION 16. Amends Section 105.001, Occupations Code, as follows:

Sec. 105.001. New heading: DEFINITIONS. Defines "facility-based physician or health care provider" and "licensing authority." Makes a conforming change.

SECTION 17. Amends Section 105.002, Occupations Code, as follows:

Sec. 105.002. UNPROFESSIONAL CONDUCT. (a) Provides that a health care provider commits unprofessional conduct if the health care provider, in connection with the provider's professional activities or provision of professional services, knowingly violates Chapter 322, Health and Safety Code, if the health care provider is not a member of the network of the contracted health maintenance organization, insurer, or preferred provider organization to which the facility at which the services are provided belongs, fails to disclose specific information, in writing, to a patient before providing professional services.

(b) Provides that a facility-based physician or health care provider commits unprofessional conduct if the facility-based physician or health care provider, in connection with professional activites, bills a patient for any amount above the applicable copayment, coinsurance, or deductible for covered services if the facility-based physician or health care provider accepts the usual and customary rate as defined specific sections or fails to provide the disclosure required under Subsection (a)(4).

(c) Provides that in addition to other provisions of civil or criminal law, commission of unprofessional conduct under Subsection (a) or (b) constitutes cause for the revocation or suspension by the appropriate licensing authority of a provider's license, permit, registration, certificate, or other authority, the imposition by the appropriate licensing authority of an administrative penalty in an amount not to exceed $500 for each day of violation, or other appropriate disciplinary action.

SECTION 18. Makes application of this Act prospective.

SECTION 19. Makes application of Section 105.002, Occupations Code, as amended by this Act, prospective.

SECTION 20. 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 21. Provides that notwithstanding Subchapter D, Chapter 322, Health and Safety Code, as added by this Act, a hospital, ambulatory surgical center, health care provider, or health care vendor 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, 2007.

SECTION 22. Effective date: upon passage or September 1, 2005.