BILL ANALYSIS

Senate Research Center

C.S.S.B. 1738
By: Duncan
State Affairs
5/2/2005
Committee Report (Substituted)

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.

C.S.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. C.S.S.B. 1738 also prohibits the balanced billing of patients once an out-of-network provider accepts payment from the health plan.

C.S.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) and SECTION 13 (Section 1456.005, Health and Safety 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) [sic] 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 (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, 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 specific procedures, a notice regarding availability of the common procedure charge information on the Consumer Guide to Health Care website, and a written estimate of charges.

Sec. 322.052. CHARGE MASTER. Authorizes a facility to have only one current charge master. Requires a charge master to 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. 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.

(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 and is required to update 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 posting a charge master and informing the public on the manner in which to locate the charge master.

(e) Requires the facility to provide, free of charge to a consumer on request, a written copy of any version of the procedure charge list retained under Subsection (d) and inform the consumer that the current procedure charge list is posted on the facility's Internet website, if any, and provide the consumer 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. BILLING OF FACILITY SERVICES. (a) Requires each facility to develop, implement, and enforce specific written policies for billing of hospital services and supplies.

(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 disclose to the customer their right to receive a written estimate of the charges for any procedure, service, or supply to the consumer before any nonemergency treatment or service is performed and before a consumer is discharged from a facility.

(d) Requires the facility to provide a specific itemized statement of billed services to the consumer, at their request, no later than the 30th business day after the date of the discharge upon receiving facility services.

(e) Requires a consumer to request the statement not later than one year after the date on which the person is discharged from the facility to be entitled to receive a statement. 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. Requires the third party payor, to be entitled to receive a statement, to request the statement from the facility and have received a claim for payment. Requires the request to 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. Authorizes a third party payor to request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies, upon receiving a claim for payment of part but not all of the billed service.

(g) Authorizes a facility to charge a reasonable fee for the third and subsequent copies provided if a consumer or third party payor requests more than two copies of the statement. Prohibits the fee from exceeding the facility's cost to copy, process, and deliver the copy to the requesting party.

(h) Requires the facility, if a consumer overpays a facility, to 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 the provisions of this subchapter from being waived, voided, or nullified 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. Requires the facility to advise the consumer that a complaint may be filed with DSHS and provide DSHS's mailing address and the telephone number, if the objection cannot be resolved informally.

(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 DSHS 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 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 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 843.251(a), Insurance Code, as follows:

(a) Requires a health maintenance organization to have a procedure for handling complaints by non-participating providers relating to the health maintenance organization's determination of usual and customary charges for out-of-network health care services and supplies. Provides that if a non-participating provider objects to the health maintenance organization's determination of usual and customary charges for a particular service or supply pursuant to this subsection, the health maintenance organization will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. Requires the health maintenance organization, if the objection cannot be resolved informally, to advise the provider that a complaint may be filed with DSHS and to provide the third party payor with DSHS's mailing address and telephone number.

SECTION 4. Amends Section 1301.055, Insurance Code, by adding Subsection (c), as follows:

(c) Requires an insurer to have a procedure for handling complaints by non-participating providers relating to the insurer's determination of usual and customary charges for out-of-network health care services and supplies. Provides that if a non-participating

provider objects to the insurer's determination of usual and customary charges for a particular service or supply pursuant to this subsection, the insurer will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. Requires the insurer, if the objection cannot be resolved informally, to advise the provider that a complaint may be filed with DSHS and to provide the third party payor with DSHS's mailing address and telephone number.

SECTION 5. Amends Section 1204.051, Insurance Code, as effective April, 1, 2005, to define "facility," "facility-based physician," and "facility-based physician reasonable and customary rate."

SECTION 6. Amends Article 21.60, Insurance Code, by adding Subsection 2(e), as follows:

(c) [sic] Requires a managed care entity, upon request from DSHS and after receipt of a complaint, to submit a copy of the methodology and origin of information used to compute usual and customary reimbursement paid to providers for out-of-network goods and services to DSHS. Requires the managed care entity to provide the percentage used if a specified percentage of charges is used as a basis for the determination of usual and customary reimbursement. Provides that the information provided by the health plan under this section is confidential and is not subject to disclosure under the public information act and its subsequent amendments.

SECTION 7. Amends Section 1271.001, Insurance Code, as effective April 1, 2005, as follows:

Sec. 1271.001. New heading: DEFINITIONS. Defines "facility," "facility-based physician," and "facility-based physician reasonable and customary rate."

SECTION 8. Amends Section 1271.055, Insurance Code, as effective April 1, 2005, by adding Subsection (d), as follows:

(d) 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 9. 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."

SECTION 10. 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 facility-based physician reasonable and customary rate or an agreed rate for covered services.

SECTION 11. (a) Amends Section 1301.001, Insurance Code, as effective April 1, 2005, to define "facility" and "facility-based physician."

(b) 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 12. 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 patient 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 patient 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 by the insurer of the facility-based physician or health care provider reasonable and customary rate or the agreed rate for covered services, 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 13. Amends Subtitle F, Title 8, Insurance Code, as effective April 1, 2005, by adding Chapter 1456, as follows:

CHAPTER 1456. FACILITY BASED PROVIDER REQUIREMENTS

Sec. 1456.001. DEFINITIONS. Defines "balance billing," "enrollee," "facility-based physician reasonable and customary rate," "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 certain notices to its enrollees.

(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 of the plan's insurance policy or evidence of coverage.

(c) Provides that if a health benefit plan provides an explanation of payment summary to an enrollee, it is required to include an explanation that the facility-based physician or prohibits a provider from charging or billing the enrollee for amounts other than applicable copayments, coinsurance, and deductibles.

Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY. (a) [sic] Requires each health care facility that has entered into a contract with a health benefit plan to serve as a provider in the health benefit plan' provider network to prominently post a notice to enrollees receiving health care services at the facility that states specific information.

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

Sec. 1456.005. 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.

Sec. 1456.006. COMPLAINTS PROCESS CONCERNING FACILITY BASED PHYSICIANS. (a) Requires a health benefit plan to have a procedure for handling complaints relating to the charges for health care services and supplies. Provides that if a facility-based physician or health care provider objects to the facility-based physician or health care provider [sic] reasonable and customary rate for a particular service or supply, the health plan will make a good faith effort to resolve the complain in an informal manner based on its complaint procedures. Requires the health plan to advise the consumer that a complain may be filed with DSHS and provide the mailing address and telephone number, if the objection cannot be resolved informally.

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

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

SECTION 14. 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 15. Amends Section 105.001, Occupations Code, as follows:

Sec. 105.001. New heading: DEFINITIONS. Defines "consumer," "facility-based physician," and "licensing authority." Makes a conforming change.

SECTION 16. 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 commits specific fraudulent claims.

(b) Provides that a facility-based physician 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 is paid the facility-based physician reasonable and customary rate or an agreed rate of payment from the health maintenance organization, preferred provider organization, or insurer for health care services.

(c) Prohibits the provisions of Subsection (b) from being waived, voided, or nullified, in whole or in part, by a contract or an agreement between a health care provider and consumer.

(d) Provides that in addition to other provisions of civil or criminal law, commission of unprofessional conduct under Subsection (a) and (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 17. Repealer: Section 311.002 (Itemized Statement of Billed Services), Health and Safety Code.

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, birthing 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, 2006.

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