By: Thompson H.B. No. 2665

A BILL TO BE ENTITLED

AN ACT

relating to restrictions on balance billing by certain health care providers; providing an administrative penalty.

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

SECTION 1. Section 1204.051, Insurance Code, as effective April 1, 2005, is amended to read as follows:

Sec. 1204.051. DEFINITIONS. (a) In this subchapter:

(1) "Covered person" means a person who is insured or covered by a health insurance policy or is a participant in an employee benefit plan. The term includes:

(A) a person covered by a health insurance policy because the person is an eligible dependent; and

(B) an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that it provides, through the purchase of insurance or otherwise, health care services to employees, participants, or the dependents of employees or participants.

(2-a) "Facility" means a health care facility licensed to operate in this state as:

(A) an ambulatory surgical center under Chapter 243, Health and Safety Code; or

1 (B) a hospital under Chapter 241, Health and
2 Safety Code.
3 (2-b) "Facility-based physician or health care
4 provider" includes:
5 (A) a radiologist, an anesthesiologist, a
6 pathologist, a neonatologist, a hospitalist, or an emergency
7 department physician or health care provider:
8 (i) to whom the facility has granted
9 clinical privileges; and
10 (ii) who provides services to patients of
11 the facility under those clinical privileges;
12 (B) a physician or health care provider who
13 provides physician or provider services to a facility's patients in
14 a clinical area if the facility grants clinical privileges on a
15 closed staff basis for the clinical area; and
16 (C) a person or entity other than a facility,
17 physician, or health care provider that provides health care
18 services or supplies directly to patients under an agreement with
19 the facility.
20 (3) "Health care provider" means a person who provides
21 health care services under a license, certificate, registration, or
22 other similar evidence of regulation issued by this or another
23 state of the United States.
24 (4) "Health care service" means a service to diagnose,
25 prevent, alleviate, cure, or heal a human illness or injury that is
26 provided to a covered person by a physician or other health care
27 provider.

(5) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, or an insurance agreement, that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(7) "Person" means an individual, association, partnership, corporation, or other legal entity.

(8) "Physician" means an individual licensed to practice medicine in this or another state of the United States.

(b) 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 2. Section 1204.052, Insurance Code, as effective April 1, 2005, is amended to read as follows:

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS. (a) This subchapter applies to:

(1) 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.);

(2) benefit programs under Chapters 1551 and 1601, to the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575.

1 (b) This subchapter does not apply to a facility-based
2 physician or health care provider.
3 SECTION 3. Chapter 1204, Insurance Code, as effective April
4 1, 2005, is amended by adding Subchapter G to read as follows:
5 SUBCHAPTER G. RESTRICTIONS ON CERTAIN BALANCE BILLING
6 Sec. 1204.301. APPLICABILITY OF DEFINITIONS. In this
7 subchapter, terms defined by Section 1204.051 have the meanings
8 assigned by that section.
9 Sec. 1204.302. APPLICABILITY TO CERTAIN PLANS OR
10 PROGRAMS. This subchapter applies to:
11 (1) an employee benefit plan, to the extent not
12 preempted by the Employee Retirement Income Security Act of 1974
13 (29 U.S.C. Section 1001 et seq.);
14 (2) benefit programs under Chapters 1551 and 1601, to
15 the extent that the benefit programs are self-insuring; and
16 (3) insurance coverage provided under Chapters 1575
17 and 1579.
18 Sec. 1204.303. RESTRICTIONS ON BALANCE BILLING. A
19 facility-based physician or health care provider may not, in
20 connection with the provision of health care services to a covered
21 person:
22 (1) bill the covered person for any amount above the
23 applicable copayment, coinsurance, or deductible for the health
24 care services if the facility-based physician or health care
25 provider accepts the usual and customary rate as defined by the
26 health insurance policy or plan subject to this subchapter under
27 Section 1204.302 or an agreed rate of payment for health care

1 services from the insurer or plan subject to this subchapter under
2 Section 1204.302; or
3 (2) bill the covered person any amount above the
4 applicable copayment, coinsurance, or deductible for the health
5 care services if the facility-based physician or health care
6 provider fails to provide the disclosure required under Section
7 105.002(a)(3), Occupations Code.
8 SECTION 4. Section 1271.001, Insurance Code, as effective
9 April 1, 2005, is amended to read as follows:
10 Sec. 1271.001. [~~APPLICABILITY OF~~] DEFINITIONS. (a) In
11 this chapter:
12 (1) "Facility" means a health care facility licensed
13 to operate in this state as:
14 (A) an ambulatory surgical center under Chapter
15 243, Health and Safety Code; or
16 (B) a hospital under Chapter 241, Health and
17 Safety Code.
18 (2) "Facility-based physician or provider" includes:
19 (A) a radiologist, an anesthesiologist, a
20 pathologist, a neonatologist, a hospitalist, or an emergency
21 department physician or provider:
22 (i) to whom the facility has granted
23 clinical privileges; and
24 (ii) who provides services to patients of
25 the facility under those clinical privileges;
26 (B) a physician or provider who provides
27 physician or provider services to a facility's patients in a

1 clinical area if the facility grants clinical privileges on a
2 closed staff basis for the clinical area; and
3 (C) a person other than a facility, physician, or
4 provider that provides health care services or supplies directly to
5 patients under an agreement with the facility.
6 (b) For purposes of this chapter, a member of the medical
7 staff of a health care facility is not a "facility-based provider"
8 as described by Subsection (a)(2)(B) solely because the member is
9 appointed to the facility's medical staff and granted clinical
10 privileges by the facility.
11 (c) In this chapter, terms defined by Section 843.002 have
12 the meanings assigned by that section.
13 SECTION 5. Section 1271.055, Insurance Code, as effective
14 April 1, 2005, is amended by adding Subsections (d) and (e) to read
15 as follows:
16 (d) A facility that is a member of a health maintenance
17 organization delivery network must make a reasonable attempt to
18 provide enrollees with facility-based physicians or providers who
19 are members of the network while the enrollee is receiving services
20 from the facility.
21 (e) If professional services are provided to an enrollee by
22 a facility-based physician or provider who is not a member of the
23 health maintenance organization delivery network, on the health
24 maintenance organization's payment to the facility-based physician
25 or provider at the usual and customary rate as defined by the health
26 care plan or at an agreed rate for covered services, the enrollee is
27 not liable for any further payments to the facility-based

1 physician or provider except for payment of any applicable
2 copayments, coinsurance, or deductibles for the covered services.
3 SECTION 6. Section 1272.001(a), Insurance Code, as
4 effective April 1, 2005, is amended by adding Subdivisions (4-a)
5 and (4-b) to read as follows:
6 (4-a) "Facility" means a health care facility licensed
7 to operate in this state as:
8 (A) an ambulatory surgical center under Chapter
9 243, Health and Safety Code; or
10 (B) a hospital under Chapter 241, Health and
11 Safety Code.
12 (4-b) "Facility-based physician or provider"
13 includes:
14 (A) a radiologist, an anesthesiologist, a
15 pathologist, a neonatologist, a hospitalist, or an emergency
16 department physician or provider:
17 (i) to whom the facility has granted
18 clinical privileges; and
19 (ii) who provides services to patients of
20 the facility under those clinical privileges;
21 (B) a physician or provider who provides
22 physician or provider services to a facility's patients in a
23 clinical area if the facility grants clinical privileges on a
24 closed staff basis for the clinical area; and
25 (C) a person other than a facility, physician, or
26 provider that provides health care services or supplies directly to
27 patients under an agreement with the facility.

SECTION 7. Section 1272.001, Insurance Code, as effective April 1, 2005, is amended by adding Subsection (c) to read as follows:

(c) 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 Subsection (a)(4-b)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

SECTION 8. Section 1272.301, Insurance Code, as effective April 1, 2005, is amended by adding Subsection (e) to read as follows:

(e) 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, 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.

SECTION 9. (a) Section 1301.001, Insurance Code, as effective April 1, 2005, is amended to read as follows:

Sec. 1301.001. DEFINITIONS. (a) In this chapter:

(1) "Facility" means a health care facility licensed to operate in this state as:

(A) an ambulatory surgical center under Chapter

1 243, Health and Safety Code; or
2 (B) a hospital under Chapter 241, Health and
3 Safety Code.
4 (2) "Facility-based physician or health care
5 provider" includes:
6 (A) a radiologist, an anesthesiologist, a
7 pathologist, a neonatologist, a hospitalist, or an emergency
8 department physician or health care provider:
9 (i) to whom the facility has granted
10 clinical privileges; and
11 (ii) who provides services to patients of
12 the facility under those clinical privileges;
13 (B) a physician or health care provider who
14 provides physician or provider services to a facility's patients in
15 a clinical area if the facility grants clinical privileges on a
16 closed staff basis for the clinical area; and
17 (C) a person or entity other than a facility,
18 physician, or health care provider that provides health care
19 services or supplies directly to patients under an agreement with
20 the facility.
21 (3) "Health care provider" means a practitioner,
22 institutional provider, or other person or organization that
23 furnishes health care services and that is licensed or otherwise
24 authorized to practice in this state. The term does not include a
25 physician.
26 (4) [~~(2)~~] "Health insurance policy" means a group or
27 individual insurance policy, certificate, or contract providing

benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(5) [~~(3)~~] "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code.

(6) [~~(4)~~] "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

(7) [~~(5)~~] "Insurer" means a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(8) [~~(6)~~] "Physician" means a person licensed to practice medicine in this state.

(9) [~~(7)~~] "Practitioner" means a person who practices a healing art and is a practitioner described by Section 1451.001 or 1451.101.

(10) "Preauthorization" means a determination by an insurer that medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

(11) [~~(8)~~] "Preferred provider" means a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

1 (12) [(9)] "Preferred provider benefit plan" means a
2 benefit plan in which an insurer provides, through its health
3 insurance policy, for the payment of a level of coverage that is
4 different from the basic level of coverage provided by the health
5 insurance policy if the insured person uses a preferred provider.
6 (13) [(10)] "Service area" means a geographic area or
7 areas specified in a health insurance policy or preferred provider
8 contract in which a network of preferred providers is offered and
9 available.
10 (14) "Verification" means a reliable representation
11 by an insurer to a physician or health care provider that the
12 insurer will pay the physician or provider for proposed medical
13 care or health care services if the physician or provider renders
14 those services to the patient for whom the services are proposed.
15 The term includes precertification, certification,
16 recertification, and any other term that would be a reliable
17 representation by an insurer to a physician or provider.
18 (b) For purposes of this chapter, a member of the medical
19 staff of a health care facility is not a "facility-based health care
20 provider" as described by Subsection (a)(2)(B) solely because the
21 member is appointed to the facility's medical staff and granted
22 clinical privileges by the facility.
23 (b) Section 1, Chapter 214, Acts of the 78th Legislature,
24 Regular Session, 2003, is repealed.
25 (c) In accordance with Section 311.031(c), Government Code,
26 which gives effect to a substantive amendment enacted by the same
27 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) 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 10. Subchapter D, Chapter 1301, Insurance Code, as effective April 1, 2005, is amended by adding Section 1301.164 to read as follows:

Sec. 1301.164. BALANCE BILLING PROHIBITED. If health care services are provided to an 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, the insured is not liable for further payments to the 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.

SECTION 11. Section 105.001, Occupations Code, is amended to read as follows:

Sec. 105.001. DEFINITIONS [~~DEFINITION~~]. In this chapter:

(1) "Facility-based physician or health care provider" has the meaning assigned by Section 1301.001, Insurance Code.

(2) "Health[~~, "health~~] care provider" means a person

1 who furnishes services under a license, certificate, registration,
2 or other authority issued by this state or another state to
3 diagnose, prevent, alleviate, or cure a human illness or injury.
4 (3) "Licensing authority" means a department,
5 commission, board, office, or other agency of this state that
6 issues a license, certificate, registration, or other authority to
7 regulate under this code the professional practice of a health care
8 provider.
9 SECTION 12. Section 105.002, Occupations Code, is amended
10 to read as follows:
11 Sec. 105.002. UNPROFESSIONAL CONDUCT. (a) A health care
12 provider commits unprofessional conduct if the health care
13 provider, in connection with the provider's professional
14 activities or provision of professional services:
15 (1) knowingly presents or causes to be presented a
16 false or fraudulent claim for the payment of a loss under an
17 insurance policy; [~~or~~]
18 (2) knowingly prepares, makes, or subscribes to any
19 writing, with intent to present or use the writing, or to allow it
20 to be presented or used, in support of a false or fraudulent claim
21 under an insurance policy; or
22 (3) if the health care provider is not a member of the
23 network of the contracted health maintenance organization,
24 insurer, or preferred provider organization to which the facility
25 at which the services are provided belongs, fails to disclose in
26 writing to a patient before providing professional services that:
27 (A) the health care provider is not a member of

1 the network;

2 (B) the patient may be required to file a claim
3 for payment of the services directly with the health maintenance
4 organization, insurer, or preferred provider organization; and

5 (C) the amount the patient may receive from the
6 health maintenance organization, insurer, or preferred provider
7 organization is based on the usual and customary rate as defined by
8 the health care plan or health insurance policy and the patient may
9 be responsible for any charges over that amount.

10 (b) A facility-based physician or health care provider
11 commits unprofessional conduct if the facility-based physician or
12 health care provider, in connection with professional activities:

13 (1) bills a patient for any amount above the
14 applicable copayment, coinsurance, or deductible for covered
15 services if the facility-based physician or health care provider
16 accepts the usual and customary rate as defined by the health care
17 plan or health insurance policy or an agreed rate of payment from
18 the health maintenance organization, preferred provider
19 organization, or insurer for health care services; or

20 (2) bills the patient any amount above the applicable
21 copayment, coinsurance, or deductible for covered services if the
22 facility-based physician or health care provider fails to provide
23 the disclosure required under Subsection (a)(3).

24 (c) In addition to other provisions of civil or criminal
25 law, commission of unprofessional conduct under Subsection (a) or
26 (b) constitutes cause for:

27 (1) the revocation or suspension by the appropriate

licensing authority of a provider's license, permit, registration, certificate, or other authority;

(2) imposition by the appropriate licensing authority of an administrative penalty in an amount not to exceed $500 for each day of violation; or

(3) other appropriate disciplinary action.

SECTION 13. This Act applies only to an insurance policy, certificate, or contract or an evidence of coverage delivered, issued for delivery, or renewed on or after the effective date of this Act. A policy, certificate, or contract or evidence of coverage delivered, issued for delivery, 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 14. (a) Section 105.002, Occupations Code, as amended by this Act, applies only to conduct occurring on or after the effective date of this Act.

(b) Conduct occurring before the effective date of this Act is governed by the law in effect on the date that the conduct occurred, and the former law is continued in effect for that purpose.

SECTION 15. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2005.