By: Van de Putte S.B. No. 698

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

(B) a hospital under Chapter 241, Health and Safety Code.

(2-b) "Facility-based physician or health care provider" includes:

(A) a radiologist, an anesthesiologist, a pathologist, a neonatologist, a hospitalist, or an emergency department physician or health care provider:

(i) to whom the facility has granted clinical privileges; and

(ii) who provides services to patients of the facility under those clinical privileges;

(B) a physician or health care provider who provides physician or provider services to a facility's patients in a clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area; and

(C) a person or entity other than a facility, physician, or health care provider that provides health care services or supplies directly to patients under an agreement with the facility.

(3) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.

(4) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care 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.

(b) This subchapter does not apply to a facility-based physician or health care provider.

SECTION 3. Chapter 1204, Insurance Code, as effective April 1, 2005, is amended by adding Subchapter G to read as follows:

SUBCHAPTER G. RESTRICTIONS ON CERTAIN BALANCE BILLING

Sec. 1204.301. APPLICABILITY OF DEFINITIONS. 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. 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 Chapters 1575 and 1579.

Sec. 1204.303. RESTRICTIONS ON BALANCE BILLING. A facility-based physician or health care provider may not, in connection with the provision of health care services to a covered person:

(1) bill the covered person for 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 by the health insurance policy or plan subject to this subchapter under Section 1204.302 or an agreed rate of payment for health care

services from the insurer or plan subject to this subchapter under Section 1204.302; or

(2) bill the covered person any amount above the applicable copayment, coinsurance, or deductible for the health care services if the facility-based physician or health care provider fails to provide the disclosure required under Section 105.002(a)(3), Occupations Code.

SECTION 4. Section 1271.001, Insurance Code, as effective April 1, 2005, is amended to read as follows:

Sec. 1271.001. [~~APPLICABILITY OF~~] 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 243, Health and Safety Code; or

(B) a hospital under Chapter 241, Health and Safety Code.

(2) "Facility-based physician or provider" includes:

(A) a radiologist, an anesthesiologist, a pathologist, a neonatologist, a hospitalist, or an emergency department physician or provider:

(i) to whom the facility has granted clinical privileges; and

(ii) who provides services to patients of the facility under those clinical privileges;

(B) a physician or provider who provides physician or provider services to a facility's patients in a

clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area; and

(C) a person other than a facility, physician, or provider that provides health care services or supplies directly to patients under an agreement with the facility.

(b) 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)(2)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

(c) In this chapter, terms defined by Section 843.002 have the meanings assigned by that section.

SECTION 5. Section 1271.055, Insurance Code, as effective April 1, 2005, is amended by adding Subsections (d) and (e) to read as follows:

(d) A facility that is a member of a health maintenance organization delivery network must 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) 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, 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 6. Section 1272.001(a), Insurance Code, as effective April 1, 2005, is amended by adding Subdivisions (4-a) and (4-b) to read as follows:

(4-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

(B) a hospital under Chapter 241, Health and Safety Code.

(4-b) "Facility-based physician or provider" includes:

(A) a radiologist, an anesthesiologist, a pathologist, a neonatologist, a hospitalist, or an emergency department physician or provider:

(i) to whom the facility has granted clinical privileges; and

(ii) who provides services to patients of the facility under those clinical privileges;

(B) a physician or provider who provides physician or provider services to a facility's patients in a clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area; and

(C) a person other than a facility, physician, or provider that provides health care services or supplies directly to 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

243, Health and Safety Code; or

(B) a hospital under Chapter 241, Health and Safety Code.

(2) "Facility-based physician or health care provider" includes:

(A) a radiologist, an anesthesiologist, a pathologist, a neonatologist, a hospitalist, or an emergency department physician or health care provider:

(i) to whom the facility has granted clinical privileges; and

(ii) who provides services to patients of the facility under those clinical privileges;

(B) a physician or health care provider who provides physician or provider services to a facility's patients in a clinical area if the facility grants clinical privileges on a closed staff basis for the clinical area; and

(C) a person or entity other than a facility, physician, or health care provider that provides health care services or supplies directly to patients under an agreement with the facility.

(3) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term does not include a physician.

(4) [~~(2)~~] "Health insurance policy" means a group or 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.

(12) [~~(9)~~] "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

(13) [~~(10)~~] "Service area" means a geographic area or areas specified in a health insurance policy or preferred provider contract in which a network of preferred providers is offered and available.

(14) "Verification" means a reliable representation by an insurer to a physician or health care provider that the insurer will pay the physician or provider for proposed medical care or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, and any other term that would be a reliable representation by an insurer to a physician or provider.

(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 Subsection (a)(2)(B) solely because the member is appointed to the facility's medical staff and granted clinical privileges by the facility.

(b) Section 1, Chapter 214, Acts of the 78th Legislature, Regular Session, 2003, is repealed.

(c) 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) 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

who furnishes services under a license, certificate, registration, or other authority issued by this state or another state to diagnose, prevent, alleviate, or cure a human illness or injury.

(3) "Licensing authority" means a department, commission, board, office, or other agency of this state that issues a license, certificate, registration, or other authority to regulate under this code the professional practice of a health care provider.

SECTION 12. Section 105.002, Occupations Code, is amended to read as follows:

Sec. 105.002. UNPROFESSIONAL CONDUCT. (a) 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:

(1) knowingly presents or causes to be presented a false or fraudulent claim for the payment of a loss under an insurance policy; [~~or~~]

(2) knowingly prepares, makes, or subscribes to any writing, with intent to present or use the writing, or to allow it to be presented or used, in support of a false or fraudulent claim under an insurance policy; or

(3) 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 in writing to a patient before providing professional services that:

(A) the health care provider is not a member of

the network;

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

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

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

(1) 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 by the health care plan or health insurance policy or an agreed rate of payment from the health maintenance organization, preferred provider organization, or insurer for health care services; or

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

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

(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.