AN ACT

relating to the electronic transmission of health benefit information between a health benefit plan issuer and a physician or health care provider.

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

SECTION 1. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1274 to read as follows:

CHAPTER 1274. ELECTRONIC TRANSMISSION OF ELIGIBILITY AND PAYMENT STATUS

Sec. 1274.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible for coverage under a health benefit plan, including a covered dependent.

(2) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage only for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation insurance coverage or similar insurance coverage;

(L) automobile medical payment insurance coverage;

(M) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance coverage;

(O) reinsurance contracts issued on a stop-loss,

quota-share, or similar basis;

(P) liability insurance coverage, including general liability insurance and automobile liability insurance coverage; or

(Q) coverage that provides other limited benefits specified by federal regulations.

(3) "Health benefit plan issuer" means a health maintenance organization operating under Chapter 843, a preferred provider organization operating under Chapter 1301, an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, and any other entity that issues a health benefit plan, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885; or

(D) a stipulated premium company operating under Chapter 884.

(4) "Health care provider" means:

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a pharmacist or dentist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by

a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

(5) "Participating provider" means:

(A) a physician or health care provider who contracts with a health benefit plan issuer to provide medical care or health care to enrollees in a health benefit plan; or

(B) a physician or health care provider who accepts and treats a patient on a referral from a physician or provider described by Paragraph (A).

(6) "Physician" means:

(A) an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

(C) a nonprofit health corporation certified under Chapter 162, Occupations Code;

(D) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) another entity wholly owned by physicians.

Sec. 1274.0015. EXEMPTION. This chapter does not apply to a

single-service health maintenance organization that provides coverage only for dental or vision benefits.

Sec. 1274.002. TRANSMISSION OF ENROLLEE ELIGIBILITY AND PAYMENT STATUS. (a) Each health benefit plan issuer shall, upon the participating provider's submission of the patient's name, relationship to the primary enrollee, and birth date, make available telephonically, electronically, or by an Internet website portal to each participating provider information maintained in the ordinary course of business and sufficient for the provider to determine at the time of the enrollee's visit information concerning:

(1) the enrollee, including:

(A) the enrollee's identification number assigned by the health benefit plan issuer;

(B) the name of the enrollee and all covered dependents, if appropriate;

(C) the birth date of the enrollee and the birth dates of all covered dependents, if appropriate;

(D) the gender of the enrollee and the gender of each covered dependent, if appropriate; and

(E) the current enrollment and eligibility status of the enrollee under the health benefit plan;

(2) the enrollee's benefits, including:

(A) whether a specific type or category of service is a covered benefit; and

(B) excluded benefits or limitations, both group and individual; and

(3) the enrollee's financial information, including:

(A) copayment requirements, if any; and

(B) the unmet amount of the enrollee's deductible or enrollee financial responsibility.

(b) Information required to be made available under this section may be made available only to a participating provider who is authorized under state and federal law to receive personally identifiable information on an enrollee or dependent.

Sec. 1274.003. CERTAIN CHARGES PROHIBITED. A health benefit plan issuer may not directly or indirectly charge or hold a physician, health care provider, or enrollee responsible for a fee for making available or accessing information under this chapter.

Sec. 1274.004. RULES. (a) The commissioner shall adopt rules as necessary to implement this chapter.

(b) Before adopting rules under this section, the commissioner shall consult and receive advice from the technical advisory committee on claims processing established under Article 21.52Y.

Sec. 1274.005. WAIVER OF CERTAIN PROVISIONS FOR CERTAIN FEDERAL PLANS. If the commissioner, in consultation with the commissioner of health and human services, determines that a provision of Section 1274.002 will cause a negative fiscal impact on the state with respect to providing benefits or services under Subchapter XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), or Subchapter XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), the commissioner of insurance by rule shall waive the application of that provision to the providing of those

benefits or services.

SECTION 2. (a) Except as provided by Subsection (b) of this section, the commissioner of insurance shall adopt rules necessary to implement Chapter 1274, Insurance Code, as added by this Act, not later than January 1, 2006.

(b) As soon as practicable, but not later than the 90th day after the effective date of this Act, the commissioner of insurance shall adopt rules necessary to implement Section 1274.005, Insurance Code, as added by this Act. The commissioner may use the procedures under Section 2001.034, Government Code, for adopting emergency rules under this subsection. The commissioner is not required to make the finding described by Subsection (a), Section 2001.034, Government Code, to adopt emergency rules under this subsection.

SECTION 3. (a) The change in law made by this Act applies only to a contract between a health benefit plan issuer and a physician or health care provider that is entered into or renewed on or after January 31, 2006. For the purposes of this section, a contract renewed includes a contract that renews from one term to the next in the absence of contrary notice by one of the parties.

(b) A contract entered into or renewed before January 31, 2006, is, until a renewal date for that contract that occurs on or after January 31, 2006, governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 4. 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.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1149 passed the Senate on May 3, 2005, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendments on May 27, 2005, by the following vote: Yeas 29, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1149 passed the House, with amendments, on May 25, 2005, by a non-record vote.

Chief Clerk of the House

Approved:

Date

Governor