

A BILL TO BE ENTITLED

1 AN ACT

2 relating to consumer access to health care information and consumer  
3 protection for services provided by or through hospitals,  
4 ambulatory surgical centers, and birthing centers; providing  
5 penalties.

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

7 SECTION 1. SHORT TITLE. This Act may be cited as the  
8 Consumer Right to Know Act.

9 SECTION 2. Subtitle G, Title 4, Health and Safety Code, is  
10 amended by adding Chapter 322 to read as follows:

11 CHAPTER 322. CONSUMER ACCESS TO HEALTH CARE INFORMATION

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Sec. 322.001. DEFINITIONS. (a) In this chapter:

14 (1) "Billed charge" means the amount a facility  
15 charges for a health care service or supply.

16 (2) "Charge master" means a facility's schedule of  
17 billed charges for each health care service, health care supply, or  
18 combination of health care services and supplies.

19 (3) "Consumer" means any person who is considering  
20 receiving, is receiving, or has received a health care service or  
21 supply as a patient from a facility. The term includes the personal  
22 representative of the patient.

23 (4) "Department" means the Department of State Health  
24 Services.

1           (5) "Executive commissioner" means the executive  
2 commissioner of the Health and Human Services Commission.

3           (6) "Facility" means:

4                   (A) an ambulatory surgical center licensed under  
5 Chapter 243;

6                   (B) a birthing center licensed under Chapter 244;  
7 or

8                   (C) a hospital licensed under Chapter 241.

9           (7) "Health benefit plan" means a health benefit plan  
10 that provides benefits for medical or surgical expenses incurred as  
11 a result of a health condition, accident, or sickness, including an  
12 individual, group, blanket, or franchise insurance policy or  
13 insurance agreement, a group hospital service contract, or an  
14 individual or group evidence of coverage that is offered by:

15                   (A) an insurance company;

16                   (B) a group hospital service corporation  
17 operating under Chapter 842, Insurance Code;

18                   (C) a fraternal benefit society operating under  
19 Chapter 885, Insurance Code;

20                   (D) a stipulated premium insurance company  
21 operating under Chapter 884, Insurance Code;

22                   (E) a health maintenance organization operating  
23 under Chapter 843, Insurance Code;

24                   (F) to the extent permitted by the Employee  
25 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
26 seq.), a health benefit plan that is offered by:

27                           (i) a multiple employer welfare arrangement

1 as defined by Section 3, Employee Retirement Income Security Act of  
2 1974 (29 U.S.C. Section 1002); or

3 (ii) another analogous benefit  
4 arrangement; or

5 (G) an approved nonprofit health corporation  
6 that is certified under Section 162.001, Occupations Code, and that  
7 holds a certificate of authority issued by the commissioner of  
8 insurance under Chapter 844, Insurance Code.

9 Sec. 322.002. RULES. The executive commissioner may adopt  
10 and enforce rules to further the purposes of this chapter.

11 [Sections 322.003-322.050 reserved for expansion]

12 SUBCHAPTER B. BILLING CHARGES

13 Sec. 322.051. NOTICE TO CONSUMER. Before any nonemergency  
14 treatment or service is performed, a facility shall provide notice  
15 to a consumer before or on admission to a facility of the consumer's  
16 right to receive:

17 (1) a free copy of the facility's common procedure  
18 charge list in accordance with Section 322.054;

19 (2) a notice regarding the availability of the common  
20 procedure charge information on the Consumer Guide to Healthcare  
21 website created under Section 322.055; and

22 (3) a free written estimate of charges in accordance  
23 with Section 322.056(c).

24 Sec. 322.052. CHARGE MASTER. (a) A facility may have only  
25 one current charge master.

26 (b) A charge master must include an initial effective date.

27 Sec. 322.053. CREATION OF FACILITY COMMON PROCEDURES LIST.

1 (a) The department shall identify 50 common inpatient procedures  
2 and 50 common outpatient procedures performed for patients by  
3 facilities in this state. A procedure may be a single health care  
4 service or supply or a group of services and supplies commonly  
5 provided as a unit to patients.

6 (b) A facility shall provide to the department in a format  
7 developed by the department a list of the 50 common inpatient  
8 procedures and 50 common outpatient procedures performed for  
9 patients of the facility in this state. The department shall use the  
10 lists provided by facilities to develop the common procedures list  
11 described in Subsection (a).

12 (c) The department shall update the common procedures list  
13 at least every two years.

14 Sec. 322.054. FACILITY COMMON PROCEDURE CHARGE LIST.

15 (a) A facility shall establish and maintain a list of the average  
16 charge for each procedure identified in the common procedures list  
17 created by the department under Section 322.053 if the procedure is  
18 performed within the facility.

19 (b) The average charge for each procedure in a facility's  
20 procedure charge list must be based on the charges listed for  
21 individual services and supplies in the facility's current charge  
22 master at the time the list was compiled.

23 (c) A facility shall have only one current procedure charge  
24 list and shall update the facility's procedure charge list on a  
25 semi-annual basis to reflect any changes made to the facility's  
26 charge master.

27 (d) A facility shall:

1           (1) identify each version of the procedure charge list  
2 by the list's initial effective date;

3           (2) retain a copy of each version until the second  
4 anniversary of each list's effective date;

5           (3) post on the facility's Internet website, if any, a  
6 copy of the current version of the procedure charge list;

7           (4) provide notice to a consumer requesting the  
8 procedure charge list that the actual charges for a procedure will  
9 vary based on the person's medical condition and other factors  
10 associated with performance of the procedure; and

11           (5) provide notice to a consumer requesting the  
12 procedure charge list that the range of charges for a procedure may  
13 differ from the amount to be paid by the consumer or the consumer's  
14 third party payor.

15           (e) The facility shall:

16           (1) provide free of charge to a consumer on request a  
17 written copy of any version of the procedure charge list retained  
18 under Subsection (d); and

19           (2) inform the consumer that the current procedure  
20 charge list is posted on the facility's Internet website, if any,  
21 and provide the consumer with the Internet website address.

22           Sec. 322.055. CONSUMER GUIDE TO HEALTH CARE. (a) A  
23 facility shall file with the department the procedure charge list  
24 created under Section 322.054.

25           (b) The department shall make available on the department's  
26 Internet website a consumer guide to health care. The guide must  
27 include the procedure charge list for each facility that submits

1 the list required under Subsection (a).

2 (c) The department may accept gifts and grants to fund the  
3 consumer guide to health care.

4 Sec. 322.056. BILLING OF FACILITY SERVICES. (a) Each  
5 facility shall develop, implement, and enforce written policies for  
6 the billing of hospital services and supplies. The policies must  
7 address:

8 (1) the provision of the itemized statements required  
9 by Subsection (d);

10 (2) whether interest will be applied to any billed  
11 service not covered by a third party payor and the rate of any  
12 interest charged;

13 (3) the providing of a notice concerning the ability  
14 to complain regarding the billed amount in accordance with Sections  
15 322.101 and 311.0025;

16 (4) the providing of a notice that if a consumer  
17 objects to the bill or treatment, the consumer may file a complaint  
18 with the department and include the name, mailing address, and  
19 telephone number of the department;

20 (5) the procedure for handling complaints relating to  
21 billed services; and

22 (6) a disclosure to a consumer requesting services  
23 from the facility that:

24 (A) provides confirmation whether the facility  
25 is a participating provider under the consumer's third party payor  
26 coverage on the date services are to be rendered; and

27 (B) informs the consumer that physicians or other

1 providers who may provide services to the consumer while in the  
2 facility may not be a participating provider with the same third  
3 party payors as the facility.

4 (b) Each facility shall post in the general waiting area and  
5 in the waiting areas of any off-site or onsite registration,  
6 admission, or business office a clear and conspicuous notice of the  
7 availability of the policies required by Subsection (a).

8 (c) The facility shall provide a written estimate of the  
9 facility's charges for any procedure, service, or supply upon  
10 request and before an elective admission or scheduling of  
11 nonemergency outpatient procedures or services. The written  
12 estimate must be provided within a reasonable time based on the  
13 number of charge estimates requested and whether the request was  
14 made during normal operating hours of the facility's business  
15 office. The facility must advise the consumer that:

16 (1) the request for a written estimate of charges may  
17 result in a delay in the scheduling and provision of the procedure,  
18 service, or supply; and

19 (2) the consumer may be personally liable for payment  
20 of the procedure, service, or supply, depending on the consumer's  
21 health benefit plan coverage.

22 (d) Not later than the 30th business day after the date of  
23 the discharge of a consumer who receives facility services, the  
24 facility shall provide to the consumer at the consumer's request an  
25 itemized statement of the billed services. The itemized statement  
26 must:

27 (1) be printed in a conspicuous manner;

1           (2) list the date services and supplies were provided;

2           (3) state whether:

3                   (A) a claim has been submitted to a third party  
4 payor; and

5                   (B) a third party payor has paid the claim;

6           (4) if payment is not required, state that payment is  
7 not required:

8                   (A) in a typeface that is bold-faced,  
9 capitalized, underlined, or otherwise set out from surrounding  
10 written material; or

11                   (B) by other reasonable means so as to be  
12 conspicuous that payment is not required; and

13           (5) contain the telephone number of the facility to  
14 call for an explanation of acronyms, abbreviations, and numbers  
15 used to describe the services provided or supplies used or any other  
16 questions regarding the bill.

17           (e) To be entitled to receive a statement, a consumer must  
18 request the statement not later than one year after the date on  
19 which the person is discharged from the facility. The facility  
20 shall provide the statement to the consumer not later than the 30th  
21 day after the date on which the statement is requested.

22           (f) A facility shall provide an itemized statement of billed  
23 services to a third party payor that is responsible or is paying all  
24 or part of the billed services provided and who has received a claim  
25 for payment of those services. To be entitled to receive a  
26 statement, the third party payor must request the statement from  
27 the facility and must have received a claim for payment. The



1 request must be made not later than one year after the date on which  
2 the payor received the claim for payment. The facility shall  
3 provide the statement to the payor not later than the 30th day after  
4 the date on which the payor requests the statement. If a third  
5 party payor receives a claim for payment of part but not all of the  
6 billed services, the third party payor may request an itemized  
7 statement of only the billed services for which payment is claimed  
8 or to which any deduction or copayment applies.

9 (g) If a consumer or a third party payor requests more than  
10 two copies of the statement, the facility may charge a reasonable  
11 fee for the third and subsequent copies provided. The fee may not  
12 exceed the facility's cost to copy, process, and deliver the copy to  
13 the consumer or third party payor.

14 (h) If a consumer overpays a facility, the facility must  
15 refund the amount of the overpayment not later than the 30th day  
16 after the date it is determined that an overpayment has been made.  
17 This subsection does not apply to an overpayment covered by Chapter  
18 1301, Insurance Code, or Section 843.350, Insurance Code.

19 Sec. 322.057. CONSUMER WAIVER PROHIBITED. The provisions  
20 of this subchapter may not be waived, voided, or nullified by a  
21 contract or an agreement between a facility and a consumer.

22 [Sections 322.058-322.100 reserved for expansion]

23 SUBCHAPTER C. COMPLAINT RESOLUTION

24 Sec. 322.101. COMPLAINT PROCESS. (a) A facility shall  
25 have a procedure for handling complaints relating to the charges  
26 for health care services and supplies. If a consumer objects to the  
27 billed amount for a particular service or supply, the facility will

1 make a good faith effort to resolve the complaint in an informal  
2 manner based on its complaint procedures. If the objection cannot  
3 be resolved informally, the facility shall advise the consumer that  
4 a complaint may be filed with the department and shall provide the  
5 consumer with the mailing address and telephone number of the  
6 department.

7 (b) If a facility is not a participating provider with a  
8 third party payor, the facility shall have a procedure for handling  
9 complaints by those third party payors relating to the charges for  
10 health care services and supplies. If a third party payor objects to  
11 the billed amount for a particular service or supply pursuant to  
12 this subsection, the facility will make a good faith effort to  
13 resolve any complaints in an informal manner based on its complaint  
14 procedures. If the objection cannot be resolved informally, the  
15 facility shall advise the third party payor that a complaint may be  
16 filed with the department and shall provide the third party payor  
17 with the mailing address and telephone number of the department.

18 (c) The department shall complete an investigation of a  
19 complaint filed pursuant to this section not later than the 60th day  
20 after the date the department receives the complaint and all  
21 information necessary for the department to make a determination  
22 concerning the validity of the complaint.

23 (d) The department may extend the time necessary to complete  
24 an investigation if:

25 (1) additional information is needed;

26 (2) an on-site review is necessary;

27 (3) the facility, consumer, or the third party payor

1 does not provide all documentation necessary to complete the  
2 investigation; or

3 (4) other circumstances beyond the control of the  
4 department occur.

5 (e) If the department determines that a complaint regarding  
6 charges for health care services and supplies is valid, the  
7 department may take disciplinary action as provided under  
8 Subchapter D.

9 [Sections 322.102-322.150 reserved for expansion]

10 SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

11 Sec. 322.151. AUDIT AND INVESTIGATION. The department may  
12 audit, investigate, or take any other necessary action to  
13 reasonably ensure a facility is complying with Subchapter B or C.

14 Sec. 322.152. DISCIPLINARY ACTION. (a) A facility that  
15 violates Subchapter B or C is subject to disciplinary action by the  
16 department, as authorized by the applicable licensing law.

17 (b) Prior to taking any disciplinary action under  
18 Subsection (a), the department shall:

19 (1) notify a facility that the facility is violating  
20 or has violated this chapter or a rule adopted under this chapter;  
21 and

22 (2) provide the facility with an opportunity to  
23 correct the violation.

24 SECTION 3. Subsection (b), Section 1271.055, Insurance  
25 Code, is amended to read as follows:

26 (b) If medically necessary covered services are not  
27 available through network physicians or providers, the health

1 maintenance organization, on the request of a network physician or  
2 provider and within a reasonable period, shall:

3 (1) allow referral to a non-network physician or  
4 provider; and

5 (2) [~~fully~~] reimburse the non-network physician or  
6 provider at the usual and customary rate or at an agreed rate.

7 SECTION 4. Subdivision (1), Subsection (a), Section  
8 1272.301, Insurance Code, is amended as follows:

9 (a) A contract between a health maintenance organization  
10 and a limited provider network or delegated entity must provide  
11 that:

12 (1) if medically necessary covered services are not  
13 available through network physicians or providers, the limited  
14 provider network or delegated entity, on the request of a network  
15 physician or provider, shall:

16 (A) allow a referral to a non-network physician  
17 or provider; and

18 (B) [~~fully~~] reimburse the non-network physician  
19 or provider at the usual and customary rate or an agreed rate; and

20 (2) before the limited provider network or delegated  
21 entity may deny a referral to a non-network physician or provider, a  
22 specialist of the same or similar specialty as the type of physician  
23 or provider to whom the referral is requested must conduct a review  
24 of the request.

25 SECTION 5. Subtitle F, Title 8, Insurance Code, is amended  
26 by adding Chapter 1456 to read as follows:

1           CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

2           Sec. 1456.001. DEFINITIONS. In this chapter:

3           (1) "Balance billing" means the practice of charging  
4 an enrollee in a health benefit plan that uses a provider network to  
5 recover from the enrollee the balance of a non-network health care  
6 provider's fee for service received by the enrollee from the health  
7 care provider that is not fully reimbursed by the enrollee's health  
8 benefit plan.

9           (2) "Enrollee" means an individual who is eligible to  
10 receive health care services through a health benefit plan.

11           (3) "Facility-based physician" means a radiologist,  
12 an anesthesiologist, a pathologist, or an emergency department  
13 physician:

14                   (A) to whom the facility has granted clinical  
15 privileges; and

16                   (B) who provides services to patients of the  
17 facility under those clinical privileges.

18           (4) "Health care facility" means a hospital, emergency  
19 clinic, outpatient clinic, or other facility providing health care  
20 services.

21           (5) "Health care practitioner" means an individual who  
22 is licensed to provide and provides health care services.

23           (6) "Health care provider" means a health care  
24 facility or health care practitioner.

25           (7) "Provider network" means a health benefit plan  
26 under which health care services are provided to enrollees through  
27 contracts with health care providers and that requires those

1 enrollees to use health care providers participating in the plan  
2 and procedures covered by the plan. The term includes a network  
3 operated by:

4 (A) a health maintenance organization;

5 (B) a preferred provider benefit plan issuer; or

6 (C) another entity that issues a health benefit  
7 plan, including an insurance company.

8 Sec. 1456.002. APPLICABILITY OF CHAPTER. This chapter  
9 applies to any health benefit plan that:

10 (1) provides benefits for medical or surgical expenses  
11 incurred as a result of a health condition, accident, or sickness,  
12 including an individual, group, blanket, or franchise insurance  
13 policy or insurance agreement, a group hospital service contract,  
14 or an individual or group evidence of coverage that is offered by:

15 (A) an insurance company;

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

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

20 (D) a stipulated premium company operating under  
21 Chapter 884;

22 (E) a health maintenance organization operating  
23 under Chapter 843;

24 (F) a multiple employer welfare arrangement that  
25 holds a certificate of authority under Chapter 846;

26 (G) an approved nonprofit health corporation  
27 that holds a certificate of authority under Chapter 844; or

1           (H) an entity not authorized under this code or  
2 another insurance law of this state that contracts directly for  
3 health care services on a risk-sharing basis, including a  
4 capitation basis; or

5           (2) provides health and accident coverage through a  
6 risk pool created under Chapter 172, Local Government Code,  
7 notwithstanding Section 172.014, Local Government Code, or any  
8 other law.

9           Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN.

10          (a) Each health benefit plan that provides health care through a  
11 provider network shall provide notice to its enrollees that:

12           (1) a facility-based physician or other health care  
13 practitioner may not be included in the health benefit plan's  
14 provider network; and

15           (2) a health care practitioner described by  
16 Subdivision (1) may balance bill the enrollee for amounts not paid  
17 by the health benefit plan.

18          (b) The health benefit plan shall provide the disclosure in  
19 writing to each enrollee:

20           (1) in any materials sent to the enrollee in  
21 conjunction with issuance or renewal of the plan's insurance policy  
22 or evidence of coverage;

23           (2) in an explanation of payment summary provided to  
24 the enrollee;

25           (3) in any other analogous document that describes the  
26 enrollee's benefits under the plan; or

27           (4) conspicuously displayed, on any website that an

1 enrollee is reasonably expected to access.

2 Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY.

3 (a) Each health care facility that has entered into a contract  
4 with a health benefit plan to serve as a provider in the health  
5 benefit plan's provider network shall provide notice to enrollees  
6 receiving health care services at the facility that:

7 (1) a facility-based physician or other health care  
8 practitioner may not be included in the health benefit plan's  
9 provider network; and

10 (2) a health care practitioner described by  
11 Subdivision (1) may balance bill the enrollee for amounts not paid  
12 by the health benefit plan.

13 (b) The health care facility shall provide the disclosure in  
14 writing at the time the enrollee is first admitted to the facility  
15 or first receives services at the facility.

16 Sec. 1456.005. REQUIRED DISCLOSURE: FACILITY-BASED  
17 PHYSICIANS. If a facility-based physician bills a patient who is  
18 covered by a health benefit plan, as described in Section 1456.002,  
19 that does not have a contract with the facility-based physician,  
20 the facility-based physician shall send a billing statement that:

21 (1) contains an itemized listing of the services and  
22 supplies provided along with the dates the services and supplies  
23 were provided;

24 (2) contains a conspicuous, plain-language  
25 explanation that:

26 (A) the facility-based physician is not within  
27 the health plan health delivery network; and



1           (B) the health benefit plan has paid the usual  
2 and customary rate, as determined by the health benefit plan, which  
3 is below the facility-based physician billed amount;

4           (3) contains a telephone number to call to discuss the  
5 statement, provide an explanation of any acronyms, abbreviations,  
6 and numbers used on the statement, or discuss any payment issues;

7           (4) contains a statement that the patient may call to  
8 discuss alternative payment arrangements;

9           (5) contains a notice that the patient may file  
10 complaints with the Texas State Board of Medical Examiners and  
11 includes the Texas State Board of Medical Examiners mailing address  
12 and complaint telephone number; and

13           (6) for billing statements that total an amount  
14 greater than \$200, over any applicable copayments or deductibles,  
15 states, in plain language, that if the patient finalizes a payment  
16 plan agreement within 45 days of receiving the first billing  
17 statement and substantially complies with the agreement, the  
18 facility-based physician may not furnish adverse information to a  
19 consumer reporting agency regarding an amount owed by the patient  
20 for the receipt of medical treatment for one calendar year from the  
21 first statement date. A patient may be considered by the  
22 facility-based physician to be out of substantial compliance with  
23 the payment plan agreement if payments are not made in compliance  
24 with the agreement for a period of 90 days.

25           Sec. 1456.006. DISCIPLINARY ACTION AND ADMINISTRATIVE  
26 PENALTY. (a) The commissioner may take disciplinary action  
27 against a licensee that violates this chapter, in accordance with

1 Chapter 84. A health care provider that violates this chapter is  
2 subject to disciplinary action by the appropriate regulatory  
3 agency.

4 (b) A violation of this chapter by a health care provider or  
5 facility-based physician is grounds for disciplinary action and  
6 imposition of an administrative penalty by the appropriate  
7 regulatory agency that issued a license, certification, or  
8 registration to the health care provider or facility-based  
9 physician who committed the violation.

10 (c) The regulatory agency shall:

11 (1) notify a health care provider or facility-based  
12 physician of a finding by the regulatory agency that the health care  
13 provider or facility-based physician is violating or has violated  
14 this chapter or a rule adopted under this chapter; and

15 (2) provide the health care provider or facility-based  
16 physician with an opportunity to correct the violation.

17 (d) The complaints brought under this section are not  
18 considered to require a determination of medical competency, and  
19 therefore Section 154.058, Occupations Code, shall not apply.

20 Sec. 1456.007. COMMISSIONER RULES; FORM OF DISCLOSURE. The  
21 commissioner by rule may prescribe specific requirements for the  
22 disclosure required under Sections 1456.003 and 1456.004. The form  
23 of the disclosure must be substantially as follows:

24 NOTICE

25 ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT  
26 A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED  
27 BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR

1 HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY HEALTH CARE  
2 PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE  
3 RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE  
4 PROFESSIONAL SERVICES THAT ARE NOT COVERED BY YOUR HEALTH BENEFIT  
5 PLAN.

6 SECTION 6. Subchapter I, Chapter 843, Insurance Code, is  
7 amended by adding Section 843.321 to read as follows:

8 Sec. 843.321. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF  
9 HEALTH PLANS. (a) In this section:

10 (1) "Commissioner" means the commissioner of  
11 insurance.

12 (2) "Health plan" means an insurance policy or a  
13 contract or evidence of coverage issued by a health maintenance  
14 organization or an employer or employee sponsored health plan.

15 (b) The commissioner shall appoint an advisory committee to  
16 study facility-based provider network adequacy of health plans and  
17 the health plans' ability to contract on reasonable terms with  
18 facility-based physicians.

19 (c) The advisory committee shall advise the commissioner  
20 periodically of its findings, no later than December, 2006.

21 (d) The advisory committee shall be composed of:

22 (1) at least one person affiliated with an insurance  
23 company, licensed to write health insurance in this state;

24 (2) at least one person affiliated with a health  
25 maintenance organization licensed to offer health coverage in this  
26 state;

27 (3) at least one physician licensed to practice by the

1 Texas State Board of Medical Examiners;

2 (4) at least one person affiliated with a hospital  
3 licensed in this state; and

4 (5) at least one member of the general public who is  
5 not employed by or affiliated with an insurance company, health  
6 maintenance organization, physician, or hospital. A  
7 representative of the general public includes a person whose only  
8 affiliation with an insurance company or health maintenance  
9 organization is as an insured or covered person.

10 (e) Members of the committee serve without compensation.

11 SECTION 7. Section 311.002, Health and Safety Code, is  
12 repealed.

13 SECTION 8. This Act applies to an insurance policy,  
14 certificate, or contract or an evidence of coverage delivered,  
15 issued for delivery, or renewed on or after the effective date of  
16 this Act. A policy, certificate, or contract or evidence of  
17 coverage delivered, issued for delivery, or renewed before the  
18 effective date of this Act is governed by the law as it existed  
19 immediately before the effective date of this Act, and that law is  
20 continued in effect for that purpose.

21 SECTION 9. (a) The executive commissioner of the Health  
22 and Human Services Commission and appropriate regulatory agencies  
23 shall adopt rules necessary to implement Chapter 322, Health and  
24 Safety Code, as added by this Act, not later than May 1, 2006.

25 (b) The Department of State Health Services shall develop  
26 the common procedures lists and the consumer guide to health care as  
27 required by Chapter 322, Health and Safety Code, as added by this

1 Act, not later than September 1, 2006.

2 SECTION 10. Notwithstanding Subchapter D, Chapter 322,  
3 Health and Safety Code, as added by this Act, a hospital, ambulatory  
4 surgical center, birthing center, or health care provider is not  
5 subject to disciplinary action, a civil penalty, an administrative  
6 penalty, or a civil action for damages for conduct that violates  
7 Chapter 322 or a rule adopted under that chapter before January 1,  
8 2006.

9 SECTION 11. This Act takes effect September 1, 2005.