By: Duncan S.B. No. 1738

A BILL TO BE ENTITLED

AN ACT

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

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

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

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

CHAPTER 322. CONSUMER ACCESS TO HEALTH CARE INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

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

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

(6) "Facility" means:

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

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

(C) a hospital licensed under Chapter 241.

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

(A) an insurance company;

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

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

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

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

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

(i) a multiple employer welfare arrangement

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

(ii) another analogous benefit arrangement; or

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

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

[Sections 322.003-322.050 reserved for expansion]

SUBCHAPTER B. BILLING CHARGES

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

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

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

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

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

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

Sec. 322.053. CREATION OF FACILITY COMMON PROCEDURES LIST.

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

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

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

Sec. 322.054. FACILITY COMMON PROCEDURE CHARGE LIST. (a) A facility shall establish and maintain a list of the average charge for each procedure identified in the common procedures list created by the department under Section 322.053 if the procedure is performed within the facility.

(b) The average charge for each procedure in a facility's procedure charge list must 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) A facility shall have only one current procedure charge list and shall update the facility's procedure charge list on a semi-annual basis to reflect any changes made to the facility's charge master.

(d) A facility shall:

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

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

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

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

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

(e) The facility shall:

(1) 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

(2) 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) A facility shall file with the department the procedure charge list created under Section 322.054.

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

the list required under Subsection (a).

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

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

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

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

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

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

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

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

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

(B) informs the consumer that physicians or other

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

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

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

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

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

(1) be printed in a conspicuous manner;

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

(3) state whether:

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

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

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

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

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

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

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

(f) A facility shall 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. To be entitled to receive a statement, the third party payor must request the statement from the facility and must have received a claim for payment. The

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

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

(h) If a consumer overpays a facility, the facility must refund the amount of the overpayment not later than the 30th day after the date it is determined that an overpayment has been made. 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. The provisions of this subchapter may not be waived, voided, or nullified by a contract or an agreement between a facility and a consumer.

[Sections 322.058-322.100 reserved for expansion]

SUBCHAPTER C. COMPLAINT RESOLUTION

Sec. 322.101. COMPLAINT PROCESS. (a) A facility shall have a procedure for handling complaints relating to the charges for health care services and supplies. 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. If the objection cannot be resolved informally, the facility shall advise the consumer that a complaint may be filed with the department and shall provide the consumer with the mailing address and telephone number of the department.

(b) If a facility is not a participating provider with a third party payor, the facility shall have a procedure for handling complaints by those third party payors relating to the charges for health care services and supplies. 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 any complaints in an informal manner based on its complaint procedures. If the objection cannot be resolved informally, the facility shall advise the third party payor that a complaint may be filed with the department and shall provide the third party payor with the mailing address and telephone number of the department.

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

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

(1) additional information is needed;

(2) an on-site review is necessary;

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

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

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

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

[Sections 322.102-322.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

Sec. 1456.001. DEFINITIONS. In this chapter:

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

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

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

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

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

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

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

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

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

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

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

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

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

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

(A) an insurance company;

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

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

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

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

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

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

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

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

Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN. (a) Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:

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

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

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

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

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

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

(4) conspicuously displayed, on any website that an

enrollee is reasonably expected to access.

Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY. (a) 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's provider network shall provide notice to enrollees receiving health care services at the facility that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The regulatory agency shall:

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

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

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

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

NOTICE

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

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

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

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

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

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

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

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

(d) The advisory committee shall be composed of:

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

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

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

Texas State Board of Medical Examiners;

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

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

(e) Members of the committee serve without compensation.

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

SECTION 8. This Act applies 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 9. (a) The executive commissioner of the Health and Human Services Commission and appropriate regulatory agencies shall adopt rules necessary to implement Chapter 322, Health and Safety Code, as added by this Act, not later than May 1, 2006.

(b) The Department of State Health Services shall 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, not later than September 1, 2006.

SECTION 10. Notwithstanding Subchapter D, Chapter 322, Health and Safety Code, as added by this Act, a hospital, ambulatory surgical center, birthing center, or health care provider 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 11. This Act takes effect September 1, 2005.