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 and ambulatory surgical centers; providing penalties.

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

SECTION 1. 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, facility-based physician, or facility vendor charges for a health care service or supply provided to a patient at a facility. The term does not apply to a billed amount that is:

(A) a negotiated charge for a health plan;

(B) a statutory-mandated reimbursement amount for a health plan;

(C) a reduction in the charge because of the consumer's inability to pay; or

(D) a reduction in the charge because of a professional courtesy discount provided to a physician or a physician's family or office staff.

(2) "Board" means the Texas State Board of Medical Examiners.

(3) "Charge master" means:

(A) a facility's schedule of billed charges for each health care service, health care supply, or combination of health care services and supplies provided to a patient and charged to a consumer by the facility;

(B) a facility-based physician's schedule of billed charges for each health care service, health care supply, or combination of health care services and supplies provided to a patient and charged to a consumer by the physician; and

(C) a facility vendor's schedule of billed charges for each health care service, health care supply, or combination of health care services and supplies provided to a patient and charged to a consumer by the vendor.

(4) "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, facility-based physician, or facility vendor. The term includes the personal representative of the patient and any other person paying for a health care service or supply on behalf of the patient.

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

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

(7) "Facility" means:

(A) an ambulatory surgical center licensed under

Chapter 243; or

(B) a hospital licensed under Chapter 241.

(8) "Facility-based physician" means a physician licensed to practice medicine in this state who:

(A) is granted clinical privileges by a facility and its staff to provide medical services to the facility's patients, including a radiologist, anesthesiologist, pathologist, neonatologist, or emergency department physician; or

(B) provides medical care to a facility's patients in a clinical area of a facility that along with the facility's medical staff limits the grant of clinical privileges to a closed staff for medical care provided in the clinical area.

(9) "Facility vendor" means a person that provides health care services or supplies directly to patients under an agreement with a facility. The term does not include a facility, a facility-based physician, or a health plan.

(10) "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. The term does not include a facility-based physician.

(11) "Regulatory agency" means an agency of this state that regulates and licenses or registers health care providers who are facility vendors under this chapter.

(b) For purposes of this chapter, a member of the medical staff of a health care facility is not a "facility-based physician" as described by Subsection (a)(8)(B) solely because the member is

appointed to the facility's medical staff and granted clinical privileges by the facility.

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. (a) A facility must 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 charge master in accordance with Section 322.052;

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

(3) for a hospital, a free written estimate of charges in accordance with Section 311.002.

(b) A facility-based physician shall provide notice to the consumer of the consumer's right to receive a free copy of:

(1) the physician's charge master; and

(2) the physician's procedure charge list.

(c) A facility vendor shall provide notice to the consumer of the consumer's right to receive a free copy of:

(1) the vendor's charge master; and

(2) the vendor's procedure charge list.

Sec. 322.052. CHARGE MASTER. (a) A facility, facility-based physician, or facility vendor may have only one current charge master.

(b) A charge master must:

(1) categorize billed charges by the types of health care services or supplies provided; and

(2) include an initial effective date.

(c) A facility, facility-based physician, or facility vendor may only adopt a new version of the charge master effective at the beginning of a calendar day.

(d) A facility, facility-based physician, or facility vendor shall:

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

(2) retain a copy of each version until at least the fourth anniversary of the master's initial effective date; and

(3) post on the facility's, physician's, or vendor's Internet website a copy of each version retained under Subdivision (2) that highlights the changes from a previous version and is in a format that may be downloaded on a personal computer free of charge.

(e) A facility, facility-based physician, or facility vendor shall:

(1) provide free of charge to any person on request a written copy of any version of the charge master retained under Subsection (d); or

(2) inform the person that the requested version is posted on the facility's, physician's, or vendor's Internet website and provide the person with the Internet website address.

Sec. 322.053. FACILITY MOST COMMON PROCEDURES LIST. (a) The department shall identify the 100 most common procedures performed on 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) The department shall update the most common procedures list at least every two years.

Sec. 322.054. FACILITY PROCEDURE CHARGE LIST. (a) A facility shall establish and maintain a list of the charges for each procedure identified in the most common procedure list created by the department under Section 322.053. For a procedure that consists of a group of health care services and supplies that vary based on a patient's needs or condition, the facility may use the average billed charge for that procedure.

(b) The amount of a charge in a facility's procedure charge list must be based on the amount listed in the facility's current charge master.

(c) A facility may have only one current procedure charge list.

(d) A facility shall update the facility's procedure charge list as necessary at the time the facility makes any changes to or adopts a new version of the facility's charge master. The procedure charge list must prominently identify for each new version of the charge list all the changes from the immediately preceding version.

(e) 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 at least until the fourth anniversary of each list's effective date; and

(3) post on the facility's Internet website a copy of

each version retained under Subdivision (2) that highlights the changes from a previous version and in a format that may be downloaded on a personal computer free of charge.

(f) The facility shall:

(1) provide free of charge to any person on request a written copy of any version of the procedure charge list retained under Subsection (e); or

(2) inform the person that the requested version is posted on the facility's Internet website and provide the person 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. FACILITY-BASED PHYSICIAN AND FACILITY VENDOR MOST COMMON PROCEDURES LIST. (a) The board shall:

(1) identify the 20 most common procedures performed by a facility-based physician; and

(2) update the most common procedures list at least every two years.

(b) A regulatory agency shall:

(1) identify the 20 most common procedures performed

by a facility vendor; and

(2) update the most common procedures list at least every two years.

(c) The department shall identify the 20 most common procedures performed by a facility vendor who is not licensed and regulated by a regulatory agency and update the list at least every two years.

(d) A procedure under Subsection (a), (b), or (c) may be a single health care service or supply or a group of services and supplies commonly provided as a unit to patients.

Sec. 322.057. FACILITY-BASED PHYSICIAN OR FACILITY VENDOR PROCEDURE CHARGE LIST. (a) A facility-based physician and a facility vendor shall establish and maintain a list of the charges for each procedure identified in the most common procedure list created by a board or agency under Section 322.056. For a procedure that consists of a group of health care services and supplies that vary based on a patient's needs or condition, the physician or vendor may use the average billed charge for that procedure.

(b) The amount of a charge in a facility-based physician's or facility vendor's procedure charge list must be based on the amount charged in the physician's or vendor's current charge master.

(c) A facility-based physician or a facility vendor may have only one current procedure charge list.

(d) A facility-based physician or a facility vendor shall update the physician's or vendor's procedure charge list as necessary at the time the physician or vendor makes any changes to

or adopts a new version of the physician's or vendor's charge master. The procedure charge list must prominently identify for each new version of the charge list all the changes from the immediately preceding version.

(e) A facility-based physician or a facility vendor shall:

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

(2) retain a copy of each version at least until the fourth anniversary of each list's effective date; and

(3) post on the physician's or vendor's Internet website a copy of each version retained under Subdivision (2) that highlights the changes from a previous version and in a format that may be downloaded on a personal computer free of charge.

(f) The facility-based physician or facility vendor shall:

(1) provide free of charge to any person on request a written copy of any version of the procedure charge list retained under Subsection (e); or

(2) inform the person that the requested version is posted on the physician's or vendor's Internet website and provide the person with the Internet website address.

Sec. 322.058. BILLING FOR AND COLLECTION OF COPAYMENTS, DEDUCTIBLES, AND COINSURANCE. (a) A facility, facility-based physician, facility vendor, or health care provider:

(1) may not knowingly ignore or waive a copayment, coinsurance, deductible, or other amount a patient is financially responsible for under an insurance policy, health maintenance organization evidence of coverage, or employer sponsored health

plan; and

(2) shall make reasonable, diligent efforts to collect the amounts billed under Subdivision (1).

(b) Nothing in Subsection (a) prevents a facility, facility-based physician, facility vendor, or health care provider from waiving any amount of a payment for health care services provided to Medicaid recipients, Medicare patients, or medically indigent persons who qualify for a sliding fee scale.

Sec. 322.059. CONSUMER WAIVER PROHIBITED. The provisions of this subchapter may not be waived, voided, or nullified by a contract or an agreement between a facility, facility-based physician, facility vendor, or health care provider and a consumer.

[Sections 322.060-322.100 reserved for expansion]

SUBCHAPTER C. REASONABLE CHARGES

Sec. 322.101. RIGHT TO REASONABLE CHARGE. (a) A patient may not be billed for more than a reasonable charge for a health care service or supply provided to a patient by a facility, facility-based physician, or facility vendor.

(b) A facility, facility-based physician, or facility vendor shall provide on request to a patient an itemized statement of billed charges that includes a notice to the consumer that if the consumer objects to the billed amount or to treatment, the consumer may file a complaint with the department, the board, or the regulatory agency, as applicable, or the attorney general. The notice must include the name, mailing address, and telephone number of the department, board, or regulatory agency, as applicable, and the attorney general.

(c) A facility, facility-based physician, or facility vendor bears the burden of establishing the reasonableness of a billed charge and must establish the reasonableness of a billed charge on request by a consumer, the department, the board, a regulatory agency, or the attorney general.

[Sections 322.102-322.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

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

(b) The board may audit, investigate, or take any other necessary action to reasonably ensure a facility-based physician is complying with Subchapter B.

(c) A regulatory agency may audit, investigate, or take any other necessary action to reasonably ensure a facility vendor or health care provider is complying with Subchapter B.

Sec. 322.152. DISCIPLINARY ACTION. A facility, facility-based physician, facility vendor, or health care provider that violates this chapter is subject to disciplinary action by the department, the board, or a regulatory agency.

Sec. 322.153. ADMINISTRATIVE PENALTY. (a) In addition to all other disciplinary actions authorized under other law, the department may impose an administrative penalty for a facility's violation of Subchapter B as if the facility violated Chapter 241 or 243.

(b) In addition to all other disciplinary actions

authorized under other law, the board may impose an administrative penalty for a facility-based physician's violation of Subchapter B as if the facility-based physician violated Subtitle B, Title 3, Occupations Code.

(c) In addition to all other disciplinary actions authorized under other law, if the law authorizing a regulatory agency to regulate and license or register a facility vendor or health care provider authorizes the regulatory agency to impose an administrative penalty for a violation of that law, the regulatory agency may impose an administrative penalty for a facility vendor's or health care provider's violation of Subchapter B as if the facility vendor or health care provider violated the law authorizing the regulatory agency to regulate and license or register the facility vendor or health care provider.

(d) The department, board, or regulatory agency shall:

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

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

(e) An administrative penalty assessed as provided by this section for a violation of Subchapter B is $2,000 for each violation. Each day of a continuing violation may be considered a

separate violation.

Sec. 322.154. CIVIL PENALTY. (a) A facility, facility-based physician, facility vendor, or health care provider that violates this chapter or a rule adopted or enforced under this chapter is liable for a civil penalty of at least $100 but not more than $500 for each day of violation and for each act of violation.

(b) The attorney general or district or county attorney for the county in which the violation occurred may bring an action in district court to impose and collect the civil penalty. In determining the amount of the penalty, the district court shall consider:

(1) the previous violations by the facility, facility-based physician, facility vendor, or health care provider;

(2) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;

(3) whether the health and safety of the public was threatened by the violation;

(4) the demonstrated good faith of the facility, facility-based physician, facility vendor, or health care provider; and

(5) the amount necessary to deter future violations.

(c) A penalty collected under this section by the attorney general shall be deposited to the credit of the general revenue fund. A penalty collected under this section by a district or county attorney shall be deposited to the credit of the general fund of the county in which the suit was heard.

Sec. 322.155. INJUNCTION. (a) The department, the board, or a regulatory agency may petition a district court for a temporary restraining order to restrain a continuing violation of this chapter if the department, the board, or a regulatory agency finds that the violation creates an immediate threat to the health and safety of the patients of a facility, facility-based physician, facility vendor, or health care provider.

(b) A district court, on petition of the department, the board, or a regulatory agency and on a finding by the court that a person is violating this chapter, may by injunction:

(1) prohibit a person from continuing a violation of this chapter; or

(2) grant any other injunctive relief warranted by the facts.

(c) The attorney general shall institute and conduct a suit authorized by this section at the request of the department, the board, or a regulatory agency.

(d) Venue for a suit brought under this section is in the county in which the facility is located or in Travis County.

SECTION 3. Sections 108.009(a) and (k), Health and Safety Code, are amended to read as follows:

(a) The council shall [~~may~~] collect, and, except as provided by Subsections (c) and (d), providers shall submit to the council or another entity as determined by the council, all data required by this section. The data shall be collected according to uniform submission formats, coding systems, and other technical specifications necessary to make the incoming data substantially

valid, consistent, compatible, and manageable using electronic data processing, if available.

(k) The council shall collect inpatient and outpatient health care data elements relating to payer type, the racial and ethnic background of patients, infection rates, and the use of health care services by consumers.

SECTION 4. Section 311.002, Health and Safety Code, is amended by amending Subsections (a), (b), and (c) and adding Subsections (a-1) and (j) to read as follows:

(a) Each hospital shall develop, implement, disclose, and enforce a written policy for the billing of hospital services and supplies. The policy must include:

(1) a periodic review of the itemized statements required by Subsection (b); [~~and~~]

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

(3) a procedure for handling complaints relating to billed services.

(a-1) A hospital shall post in a prominent location in the hospital's lobby, admissions area, and emergency department a clear and conspicuous notice of the availability of information required by Subsections (a), (c), and (d) and a person's right to request the information.

(b) Not later than the 30th business day after the date of the hospital discharge of a person who receives hospital services, the hospital shall provide on request an itemized statement of the

billed services provided to the person. 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;

(6) contain a notice that the charges must be reasonable in accordance with Sections 322.101 and 311.0025; and

(7) contain a notice that if the consumer objects to the bill or treatment, the consumer may file a complaint with the department and the attorney general and include the name, mailing address, and telephone number of the department and attorney general.

(c) Before any nonemergency treatment or service is

performed and before a patient is discharged from a hospital, a hospital shall disclose to a person the person's right to receive a written estimate of the charges for any procedure, service, or supply [~~a person is discharged from a hospital, the hospital shall inform the person of the availability of the statement~~].

(j) If a patient overpays a hospital, the hospital 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.

SECTION 5. Section 311.0025, Health and Safety Code, is amended to read as follows:

Sec. 311.0025. AUDITS OF BILLING. (a) A hospital, ambulatory surgical center, treatment facility, mental health facility, facility vendor, or health care professional may not submit to a patient or a third party payor a bill for a treatment that the hospital, center, facility, vendor, or professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

(b) If the appropriate regulatory [~~licensing~~] agency, or the Department of State Health Services for a facility vendor, receives a complaint alleging a violation of Subsection (a), the agency may audit the billings and patient records of the hospital, ambulatory surgical center, treatment facility, mental health facility, facility vendor, or health care professional.

(c) The appropriate regulatory agency or the Department of State Health Services shall require license holders to comply with

this section. A hospital, ambulatory surgical center, treatment facility, mental health facility, facility vendor, or health care professional that violates Subsection (a) is subject to disciplinary action, including denial, revocation, suspension, or nonrenewal of the license of the hospital, center, facility, vendor, or professional or a civil penalty for a facility vendor. Disciplinary action taken under this section is in addition to any other civil, administrative, or criminal penalty provided by law.

(d) In this section:

(1) "Ambulatory surgical center" means an ambulatory surgical center licensed under Chapter 243.

(2) "Facility vendor" has the meaning assigned by Section 322.001.

(3) "Health care professional" means an individual licensed, certified, or regulated by a health care regulatory agency who is eligible for reimbursement for treatment ordered or rendered by that professional.

(4) [~~(2)~~] "Hospital" means a hospital licensed under Chapter 241.

(5) [~~(3)~~] "Mental health facility" means a mental health facility licensed under Chapter 577.

(6) [~~(4)~~] "Treatment facility" means a treatment facility licensed under Chapter 464.

(e) A regulatory [~~licensing~~] agency may not take disciplinary action against a hospital, ambulatory surgical center, treatment facility, mental health facility, facility vendor, or health care professional for unknowing and isolated

billing errors. The Department of State Health Services may not take disciplinary action against a facility vendor for unknowing and isolated billing errors.

SECTION 6. 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 7. 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 8. 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)(4), Occupations Code.

SECTION 9. 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 10. 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 11. 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 12. 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 13. 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 14. (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 15. 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 16. 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 17. 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;

(3) knowingly violates Chapter 322, Health and Safety Code; or

(4) 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)(4).

(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 18. 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 19. (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 20. (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 21. Notwithstanding Subchapter D, Chapter 322, Health and Safety Code, as added by this Act, a hospital, ambulatory surgical center, health care provider, or health care vendor 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, 2007.

SECTION 22. 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.