

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.

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

3           (3) "Charge master" means:

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

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

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

16           (4) "Consumer" means any person who is considering  
17 receiving, is receiving, or has received a health care service or  
18 supply as a patient from a facility, facility-based physician, or  
19 facility vendor. The term includes the personal representative of  
20 the patient and any other person paying for a health care service or  
21 supply on behalf of the patient.

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

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

26           (7) "Facility" means:

27                 (A) an ambulatory surgical center licensed under

1 Chapter 243; or

2 (B) a hospital licensed under Chapter 241.

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

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

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

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

17 (10) "Health care provider" means a person who  
18 furnishes services under a license, certificate, registration, or  
19 other authority issued by this state or another state to diagnose,  
20 prevent, alleviate, or cure a human illness or injury. The term  
21 does not include a facility-based physician.

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

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

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

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

5 [Sections 322.003-322.050 reserved for expansion]

6 SUBCHAPTER B. BILLING CHARGES

7 Sec. 322.051. NOTICE TO CONSUMER. (a) A facility must  
8 provide notice to a consumer before or on admission to a facility of  
9 the consumer's right to receive:

10 (1) a free copy of the facility's charge master in  
11 accordance with Section 322.052;

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

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

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

18 (1) the physician's charge master; and

19 (2) the physician's procedure charge list.

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

22 (1) the vendor's charge master; and

23 (2) the vendor's procedure charge list.

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

27 (b) A charge master must:

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

3           (2) include an initial effective date.

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

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

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

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

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

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

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

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

25           Sec. 322.053. FACILITY MOST COMMON PROCEDURES LIST. (a)  
26 The department shall identify the 100 most common procedures  
27 performed on patients by facilities in this state. A procedure may

1 be a single health care service or supply or a group of services and  
2 supplies commonly provided as a unit to patients.

3 (b) The department shall update the most common procedures  
4 list at least every two years.

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

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

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

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

22 (e) A facility shall:

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

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

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

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

4 (f) The facility shall:

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

8 (2) inform the person that the requested version is  
9 posted on the facility's Internet website and provide the person  
10 with the Internet website address.

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

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

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

20 Sec. 322.056. FACILITY-BASED PHYSICIAN AND FACILITY VENDOR  
21 MOST COMMON PROCEDURES LIST. (a) The board shall:

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

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

26 (b) A regulatory agency shall:

27 (1) identify the 20 most common procedures performed

1 by a facility vendor; and

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

1 plan; and

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

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

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

13 [Sections 322.060-322.100 reserved for expansion]

14 SUBCHAPTER C. REASONABLE CHARGES

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

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

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

6           [Sections 322.102-322.150 reserved for expansion]

7           SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

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

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

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

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

22           Sec. 322.153. ADMINISTRATIVE PENALTY. (a) In addition to  
23 all other disciplinary actions authorized under other law, the  
24 department may impose an administrative penalty for a facility's  
25 violation of Subchapter B as if the facility violated Chapter 241 or  
26 243.

27           (b) In addition to all other disciplinary actions

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

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

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

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

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

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

1 separate violation.

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

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

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

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

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

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

22 (5) the amount necessary to deter future violations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 billed services provided to the person. The itemized statement  
2 must:

- 3 (1) be printed in a conspicuous manner;
- 4 (2) list the date services and supplies were provided;
- 5 (3) state whether:
  - 6 (A) a claim has been submitted to a third party
  - 7 payor; and

- 8 (B) a third party payor has paid the claim;
- 9 (4) if payment is not required, state that payment is  
10 not required:

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

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

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

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

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

- 27 (c) Before any nonemergency treatment or service is



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

6 (j) If a patient overpays a hospital, the hospital must  
7 refund the amount of the overpayment not later than the 30th day  
8 after the date it is determined that an overpayment has been made.  
9 This subsection does not apply to an overpayment covered by Chapter  
10 1301, Insurance Code, or Section 843.350, Insurance Code.

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

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

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

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

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

9 (d) In this section:

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

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

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

18 (4) [~~2~~] "Hospital" means a hospital licensed under  
19 Chapter 241.

20 (5) [~~3~~] "Mental health facility" means a mental  
21 health facility licensed under Chapter 577.

22 (6) [~~4~~] "Treatment facility" means a treatment  
23 facility licensed under Chapter 464.

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

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

4 SECTION 6. Section 1204.051, Insurance Code, as effective  
5 April 1, 2005, is amended to read as follows:

6 Sec. 1204.051. DEFINITIONS. (a) In this subchapter:

7 (1) "Covered person" means a person who is insured or  
8 covered by a health insurance policy or is a participant in an  
9 employee benefit plan. The term includes:

10 (A) a person covered by a health insurance policy  
11 because the person is an eligible dependent; and

12 (B) an eligible dependent of a participant in an  
13 employee benefit plan.

14 (2) "Employee benefit plan" or "plan" means a plan,  
15 fund, or program established or maintained by an employer, an  
16 employee organization, or both, to the extent that it provides,  
17 through the purchase of insurance or otherwise, health care  
18 services to employees, participants, or the dependents of employees  
19 or participants.

20 (2-a) "Facility" means a health care facility licensed  
21 to operate in this state as:

22 (A) an ambulatory surgical center under Chapter  
23 243, Health and Safety Code; or

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

26 (2-b) "Facility-based physician or health care  
27 provider" includes:

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

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

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

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

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

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

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

24                   (5) "Health insurance policy" means an individual,  
25 group, blanket, or franchise insurance policy, or an insurance  
26 agreement, that provides reimbursement or indemnity for health care  
27 expenses incurred as a result of an accident or sickness.

1           (6) "Insurer" means an insurance company,  
2 association, or organization authorized to engage in business in  
3 this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886,  
4 887, 888, 941, 942, or 982.

5           (7) "Person" means an individual, association,  
6 partnership, corporation, or other legal entity.

7           (8) "Physician" means an individual licensed to  
8 practice medicine in this or another state of the United States.

9           (b) For purposes of this chapter, a member of the medical  
10 staff of a health care facility is not a "facility-based health care  
11 provider" as described by Subdivision (2-b)(B) solely because the  
12 member is appointed to the facility's medical staff and granted  
13 clinical privileges by the facility.

14           SECTION 7. Section 1204.052, Insurance Code, as effective  
15 April 1, 2005, is amended to read as follows:

16           Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR  
17 PROGRAMS. (a) This subchapter applies to:

18           (1) an employee benefit plan, to the extent not  
19 preempted by the Employee Retirement Income Security Act of 1974  
20 (29 U.S.C. Section 1001 et seq.);

21           (2) benefit programs under Chapters 1551 and 1601, to  
22 the extent that the benefit programs are self-insuring; and

23           (3) insurance coverage provided under Chapter 1575.

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

26           SECTION 8. Chapter 1204, Insurance Code, as effective April  
27 1, 2005, is amended by adding Subchapter G to read as follows:

1           SUBCHAPTER G. RESTRICTIONS ON CERTAIN BALANCE BILLING

2           Sec. 1204.301. APPLICABILITY OF DEFINITIONS.     In this  
3 subchapter, terms defined by Section 1204.051 have the meanings  
4 assigned by that section.

5           Sec. 1204.302. APPLICABILITY TO CERTAIN PLANS OR  
6 PROGRAMS.     This subchapter applies to:

7                   (1) an employee benefit plan, to the extent not  
8 preempted by the Employee Retirement Income Security Act of 1974  
9 (29 U.S.C. Section 1001 et seq.);

10                   (2) benefit programs under Chapters 1551 and 1601, to  
11 the extent that the benefit programs are self-insuring; and

12                   (3) insurance coverage provided under Chapters 1575  
13 and 1579.

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

18                   (1) bill the covered person for any amount above the  
19 applicable copayment, coinsurance, or deductible for the health  
20 care services if the facility-based physician or health care  
21 provider accepts the usual and customary rate as defined by the  
22 health insurance policy or plan subject to this subchapter under  
23 Section 1204.302 or an agreed rate of payment for health care  
24 services from the insurer or plan subject to this subchapter under  
25 Section 1204.302; or

26                   (2) bill the covered person any amount above the  
27 applicable copayment, coinsurance, or deductible for the health

1 care services if the facility-based physician or health care  
2 provider fails to provide the disclosure required under Section  
3 105.002(a)(4), Occupations Code.

4 SECTION 9. Section 1271.001, Insurance Code, as effective  
5 April 1, 2005, is amended to read as follows:

6 Sec. 1271.001. [~~APPLICABILITY OF~~] DEFINITIONS. (a) In  
7 this chapter:

8 (1) "Facility" means a health care facility licensed  
9 to operate in this state as:

10 (A) an ambulatory surgical center under Chapter  
11 243, Health and Safety Code; or

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

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

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

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

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

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

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

1 patients under an agreement with the facility.

2 (b) For purposes of this chapter, a member of the medical  
3 staff of a health care facility is not a "facility-based provider"  
4 as described by Subsection (a)(2)(B) solely because the member is  
5 appointed to the facility's medical staff and granted clinical  
6 privileges by the facility.

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

9 SECTION 10. Section 1271.055, Insurance Code, as effective  
10 April 1, 2005, is amended by adding Subsections (d) and (e) to read  
11 as follows:

12 (d) A facility that is a member of a health maintenance  
13 organization delivery network must make a reasonable attempt to  
14 provide enrollees with facility-based physicians or providers who  
15 are members of the network while the enrollee is receiving services  
16 from the facility.

17 (e) If professional services are provided to an enrollee by  
18 a facility-based physician or provider who is not a member of the  
19 health maintenance organization delivery network, on the health  
20 maintenance organization's payment to the facility-based physician  
21 or provider at the usual and customary rate as defined by the health  
22 care plan or at an agreed rate for covered services, the enrollee is  
23 not liable for any further payments to the facility-based  
24 physician or provider, except for payment of any applicable  
25 copayments, coinsurance, or deductibles for the covered services.

26 SECTION 11. Section 1272.001(a), Insurance Code, as  
27 effective April 1, 2005, is amended by adding Subdivisions (4-a)



1 and (4-b) to read as follows:

2 (4-a) "Facility" means a health care facility licensed  
3 to operate in this state as:

4 (A) an ambulatory surgical center under Chapter  
5 243, Health and Safety Code; or

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

8 (4-b) "Facility-based physician or provider"  
9 includes:

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

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

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

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

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

24 SECTION 12. Section 1272.001, Insurance Code, as effective  
25 April 1, 2005, is amended by adding Subsection (c) to read as  
26 follows:

27 (c) For purposes of this chapter, a member of the medical

1 staff of a health care facility is not a "facility-based provider"  
2 as described by Subsection (a)(4-b)(B) solely because the member is  
3 appointed to the facility's medical staff and granted clinical  
4 privileges by the facility.

5 SECTION 13. Section 1272.301, Insurance Code, as effective  
6 April 1, 2005, is amended by adding Subsection (e) to read as  
7 follows:

8 (e) If a limited provider network or delegated entity  
9 provides or arranges to provide services to enrollees through a  
10 facility-based physician or provider who is not a member of the  
11 health maintenance organization delivery network, on payment by the  
12 health maintenance organization of the usual and customary rate as  
13 defined by the health care plan or an agreed rate for covered  
14 services, the enrollee is not liable for any further payments to the  
15 facility-based physician or provider, except for payment of any  
16 applicable copayments, coinsurance, or deductibles for the covered  
17 services.

18 SECTION 14. (a) Section 1301.001, Insurance Code, as  
19 effective April 1, 2005, is amended to read as follows:

20 Sec. 1301.001. DEFINITIONS. (a) In this chapter:

21 (1) "Facility" means a health care facility licensed  
22 to operate in this state as:

23 (A) an ambulatory surgical center under Chapter  
24 243, Health and Safety Code; or

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

27 (2) "Facility-based physician or health care

1 provider" includes:

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

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

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

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

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

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

22 (4) [~~2~~] "Health insurance policy" means a group or  
23 individual insurance policy, certificate, or contract providing  
24 benefits for medical or surgical expenses incurred as a result of an  
25 accident or sickness.

26 (5) [~~3~~] "Hospital" means a licensed public or  
27 private institution as defined by Chapter 241, Health and Safety

1 Code, or Subtitle C, Title 7, Health and Safety Code.

2 (6) [~~(4)~~] "Institutional provider" means a hospital,  
3 nursing home, or other medical or health-related service facility  
4 that provides care for the sick or injured or other care that may be  
5 covered in a health insurance policy.

6 (7) [~~(5)~~] "Insurer" means a life, health, and accident  
7 insurance company, health and accident insurance company, health  
8 insurance company, or other company operating under Chapter 841,  
9 842, 884, 885, 982, or 1501, that is authorized to issue, deliver,  
10 or issue for delivery in this state health insurance policies.

11 (8) [~~(6)~~] "Physician" means a person licensed to  
12 practice medicine in this state.

13 (9) [~~(7)~~] "Practitioner" means a person who practices  
14 a healing art and is a practitioner described by Section 1451.001 or  
15 1451.101.

16 (10) "Preauthorization" means a determination by an  
17 insurer that medical care or health care services proposed to be  
18 provided to a patient are medically necessary and appropriate.

19 (11) [~~(8)~~] "Preferred provider" means a physician or  
20 health care provider, or an organization of physicians or health  
21 care providers, who contracts with an insurer to provide medical  
22 care or health care to insureds covered by a health insurance  
23 policy.

24 (12) [~~(9)~~] "Preferred provider benefit plan" means a  
25 benefit plan in which an insurer provides, through its health  
26 insurance policy, for the payment of a level of coverage that is  
27 different from the basic level of coverage provided by the health

1 insurance policy if the insured person uses a preferred provider.

2 (13) [~~(10)~~] "Service area" means a geographic area or  
3 areas specified in a health insurance policy or preferred provider  
4 contract in which a network of preferred providers is offered and  
5 available.

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

14 (b) For purposes of this chapter, a member of the medical  
15 staff of a health care facility is not a "facility-based health care  
16 provider" as described by Subsection (a)(2)(B) solely because the  
17 member is appointed to the facility's medical staff and granted  
18 clinical privileges by the facility.

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

21 (c) In accordance with Section 311.031(c), Government Code,  
22 which gives effect to a substantive amendment enacted by the same  
23 legislature that codifies the amended statute, the text of Section  
24 1301.001, Insurance Code, as set out in this section, gives effect  
25 to changes made by Section 1, Chapter 214, Acts of the 78th  
26 Legislature, Regular Session, 2003.

27 (d) To the extent of any conflict, this section prevails

1 over another Act of the 79th Legislature, Regular Session, 2005,  
2 relating to nonsubstantive additions and corrections in enacted  
3 codes.

4 SECTION 15. Subchapter D, Chapter 1301, Insurance Code, as  
5 effective April 1, 2005, is amended by adding Section 1301.164 to  
6 read as follows:

7 Sec. 1301.164. BALANCE BILLING PROHIBITED. If health care  
8 services are provided to an insured in a facility that is part of  
9 the preferred provider network by a facility-based physician or  
10 health care provider who is not a preferred provider, on payment to  
11 the physician or provider by the insurer of the usual and customary  
12 rate as defined by the health insurance policy or the agreed rate  
13 for covered services, the insured is not liable for further  
14 payments to the facility-based physician or health care provider,  
15 except for payment of any applicable copayments, coinsurance, or  
16 deductibles owed by the insured for the covered services.

17 SECTION 16. Section 105.001, Occupations Code, is amended  
18 to read as follows:

19 Sec. 105.001. DEFINITIONS [~~DEFINITION~~]. In this chapter:

20 (1) "Facility-based physician or health care  
21 provider" has the meaning assigned by Section 1301.001, Insurance  
22 Code.

23 (2) "Health[~~,"health~~] care provider" means a person  
24 who furnishes services under a license, certificate, registration,  
25 or other authority issued by this state or another state to  
26 diagnose, prevent, alleviate, or cure a human illness or injury.

27 (3) "Licensing authority" means a department,

1 commission, board, office, or other agency of this state that  
2 issues a license, certificate, registration, or other authority to  
3 regulate under this code the professional practice of a health care  
4 provider.

5 SECTION 17. Section 105.002, Occupations Code, is amended  
6 to read as follows:

7 Sec. 105.002. UNPROFESSIONAL CONDUCT. (a) A health care  
8 provider commits unprofessional conduct if the health care  
9 provider, in connection with the provider's professional  
10 activities or provision of professional services:

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

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

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

20 (4) if the health care provider is not a member of the  
21 network of the contracted health maintenance organization,  
22 insurer, or preferred provider organization to which the facility  
23 at which the services are provided belongs, fails to disclose in  
24 writing to a patient before providing professional services that:

25 (A) the health care provider is not a member of  
26 the network;

27 (B) the patient may be required to file a claim

1 for payment of the services directly with the health maintenance  
2 organization, insurer, or preferred provider organization; and

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

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

11 (1) bills a patient for any amount above the  
12 applicable copayment, coinsurance, or deductible for covered  
13 services if the facility-based physician or health care provider  
14 accepts the usual and customary rate as defined by the health care  
15 plan or health insurance policy or an agreed rate of payment from  
16 the health maintenance organization, preferred provider  
17 organization, or insurer for health care services; or

18 (2) bills the patient any amount above the applicable  
19 copayment, coinsurance, or deductible for covered services if the  
20 facility-based physician or health care provider fails to provide  
21 the disclosure required under Subsection (a)(4).

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

25 (1) the revocation or suspension by the appropriate  
26 licensing authority of a provider's license, permit, registration,  
27 certificate, or other authority;



1           (2) imposition by the appropriate licensing authority  
2 of an administrative penalty in an amount not to exceed \$500 for  
3 each day of violation; or

4           (3) other appropriate disciplinary action.

5           SECTION 18. This Act applies only to an insurance policy,  
6 certificate, or contract or an evidence of coverage delivered,  
7 issued for delivery, or renewed on or after the effective date of  
8 this Act. A policy, certificate, or contract or evidence of  
9 coverage delivered, issued for delivery, or renewed before the  
10 effective date of this Act is governed by the law as it existed  
11 immediately before the effective date of this Act, and that law is  
12 continued in effect for that purpose.

13           SECTION 19. (a) Section 105.002, Occupations Code, as  
14 amended by this Act, applies only to conduct occurring on or after  
15 the effective date of this Act.

16           (b) Conduct occurring before the effective date of this Act  
17 is governed by the law in effect on the date that the conduct  
18 occurred, and the former law is continued in effect for that  
19 purpose.

20           SECTION 20. (a) The executive commissioner of the Health  
21 and Human Services Commission and appropriate regulatory agencies  
22 shall adopt rules necessary to implement Chapter 322, Health and  
23 Safety Code, as added by this Act, not later than May 1, 2006.

24           (b) The Department of State Health Services shall develop  
25 the common procedures lists and the consumer guide to health care as  
26 required by Chapter 322, Health and Safety Code, as added by this  
27 Act, not later than September 1, 2006.

1           SECTION 21. Notwithstanding Subchapter D, Chapter 322,  
2 Health and Safety Code, as added by this Act, a hospital, ambulatory  
3 surgical center, health care provider, or health care vendor is not  
4 subject to disciplinary action, a civil penalty, an administrative  
5 penalty, or a civil action for damages for conduct that violates  
6 Chapter 322 or a rule adopted under that chapter before January 1,  
7 2007.

8           SECTION 22. This Act takes effect immediately if it  
9 receives a vote of two-thirds of all the members elected to each  
10 house, as provided by Section 39, Article III, Texas Constitution.  
11 If this Act does not receive the vote necessary for immediate  
12 effect, this Act takes effect September 1, 2005.