By: Duncan S.B. No. 1738

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COMMITTEE SUBSTITUTE FOR S.B. No. 1738 By: Duncan

A BILL TO BE ENTITLED
AN ACT

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

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

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

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

CHAPTER 322. CONSUMER ACCESS TO HEALTH CARE INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

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

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

(6) "Facility" means:

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

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

(C) a hospital licensed under Chapter 241.

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

(A) an insurance company;

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

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

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

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

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

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement; or

(G) an approved nonprofit health corporation

that is certified under Section 162.001, Occupations Code, and that holds a certificate of authority issued by the commissioner of insurance under Chapter 844, Insurance Code.

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

[Sections 322.003-322.050 reserved for expansion]

SUBCHAPTER B. BILLING CHARGES

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

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

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

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

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

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

Sec. 322.053. CREATION OF FACILITY COMMON PROCEDURES LIST. (a) The department shall identify 50 common inpatient procedures and 50 common outpatient procedures performed for patients by facilities in this state. A procedure may be a single health care service or supply or a group of services and supplies commonly provided as a unit to patients.

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

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

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

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

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

(d) A facility shall:

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

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

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

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

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

(e) The facility shall:

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

(2) inform the consumer that the current procedure charge list is posted on the facility's Internet website, if any,

and provide the consumer with the Internet website address.

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

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

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

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

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

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

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

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

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

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

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

(B) informs the consumer that physicians or other providers who may provide services to the consumer while in the facility may not be a participating provider with the same third party payors as the facility.

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

(c) Before any nonemergency treatment or service is performed and before a consumer is discharged from a facility, the facility shall disclose to the consumer the consumer's right to receive a written estimate of the charges for any procedure, service, or supply.

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

(1) be printed in a conspicuous manner;

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

(3) state whether:

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

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

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

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

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

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

(e) To be entitled to receive a statement, a consumer must

request the statement not later than one year after the date on which the person is discharged from the facility. The facility shall provide the statement to the consumer not later than the 30th day after the date on which the statement is requested.

(f) A facility shall provide an itemized statement of billed services to a third party payor that is responsible or is paying all or part of the billed services provided and who has received a claim for payment of those services. To be entitled to receive a statement, the third party payor must request the statement from the facility and must have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. The facility shall provide the statement to the payor not later than the 30th day after the date on which the payor requests the statement. If a third party payor receives a claim for payment of part but not all of the billed services, the third party payor may request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

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

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

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

[Sections 322.058-322.100 reserved for expansion]

SUBCHAPTER C. COMPLAINT RESOLUTION

Sec. 322.101. COMPLAINT PROCESS. (a) A facility shall have a procedure for handling complaints relating to the charges for health care services and supplies. If a consumer objects to the billed amount for a particular service or supply, the facility will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the objection cannot be resolved informally, the facility shall advise the consumer that a complaint may be filed with the department and shall provide the consumer with the mailing address and telephone number of the department.

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

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

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

(1) additional information is needed;

(2) an on-site review is necessary;

(3) the facility, consumer, or the third party payor does not provide all documentation necessary to complete the investigation; or

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

(e) If the department determines that a complaint regarding

charges for health care services and supplies is valid, the department may take disciplinary action as provided under Subchapter D.

[Sections 322.102-322.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

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

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

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

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

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

SECTION 3. Subsection (a), Section 843.251, Insurance Code, is amended to read as follows:

(a) A health maintenance organization shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint. The health maintenance organization shall have a procedure for handling complaints by nonparticipating providers relating to the health maintenance organization's determination of usual and customary charges for out-of-network health care services and supplies. If a nonparticipating provider objects to the health maintenance organization's determination of usual and customary charges for a particular service or supply pursuant to this subsection, the health maintenance organization will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the objection cannot be resolved informally, the health maintenance organization shall advise the provider that a complaint may be filed with the department and shall provide the third party payor with the mailing address and telephone number of the department.

SECTION 4. Section 1301.055, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) An insurer shall have a procedure for handling complaints by non-participating providers relating to the insurer's determination of usual and customary charges for out-of-network health care services and supplies. If a nonparticipating provider objects to the insurer's determination of usual and customary charges for a particular service or supply pursuant to this subsection, the insurer will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the objection cannot be resolved informally, the insurer shall advise the provider that a complaint may be filed with the department and shall provide the third party payor with the mailing address and telephone number of the department.

SECTION 5. Section 1204.051, Insurance Code, is amended to read as follows:

Sec. 1204.051. DEFINITIONS. 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" includes a radiologist, an anesthesiologist, a pathologist, or an emergency department physician:

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

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

(2-c) "Facility-based physician reasonable and customary rate" means the average in-network reimbursement amount paid by an insurer for a service or procedure to a physician contracted with the insurer. The average in-network reimbursement amount paid by an insurer for a service or procedure will be determined by the commissioner, based on annual reports, in electronic format, filed by the insurer with the department. Information provided by the insurer under this subdivision is confidential and is not subject to disclosure under the public information law, Chapter 552, Government Code.

(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.

SECTION 6. Section 2, Article 21.60, Insurance Code, is amended by adding Subsection (e) to read as follows:

(e) A managed care entity shall submit to the department upon request after receipt of a complaint a copy of the methodology and origin of information used to compute usual and customary reimbursement paid to providers for out-of-network goods and services. If a specified percentage of charges is used as a basis for the determination of usual and customary reimbursement the managed care entity shall provide the percentage used. Information provided by the health plan under this section is confidential and is not subject to disclosure under the public information law, Chapter 552, Government Code.

SECTION 7. Section 1271.001, Insurance Code, 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" includes a radiologist, an anesthesiologist, a pathologist, or an emergency department physician:

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

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

(3) "Facility-based physician reasonable and customary rate" means the average in-network reimbursement amount paid by a health maintenance organization for a service or procedure to a physician contracted with the health maintenance organization. The average in-network reimbursement amount paid by a health maintenance organization for a service or procedure will be determined by the commissioner, based on annual reports, in electronic format, filed by the health maintenance organization with the department. Information provided by the health maintenance organization under this subdivision is confidential and is not subject to disclosure under the public information law, Chapter 552, Government Code. This subdivision does not apply to the Children's Health Insurance Program.

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

SECTION 8. Section 1271.055, Insurance Code, as effective April 1, 2005, is amended by adding Subsection (d) to read as follows:

(d) If professional services are provided to an enrollee by a facility-based physician who is not a member of the health maintenance organization delivery network, on the health maintenance organization's payment of the facility-based physician reasonable and customary rate or at an agreed rate for covered services, the enrollee is not liable for any further payments to the facility-based physician except for payment of any applicable copayments, coinsurance, or deductibles for the covered services.

SECTION 9. Subsection (a), Section 1272.001, Insurance Code, 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" includes a radiologist, an anesthesiologist, or an emergency department physician:

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

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

SECTION 10. Section 1272.301, Insurance Code, 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 who is not a member of the health maintenance organization delivery network, on payment by the health maintenance organization of the facility-based physician reasonable and customary rate or an agreed rate for covered services, the enrollee is not liable for any further payments to the facility-based physician except for payment of any applicable copayments, coinsurance, or deductibles for the covered services.

SECTION 11. (a) Section 1301.001, Insurance Code, is amended to read as follows:

Sec. 1301.001. DEFINITIONS. 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" includes a radiologist, an anesthesiologist, a pathologist, or an emergency department physician:

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

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

(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) 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 12. Subchapter D, Chapter 1301, Insurance Code, 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 patient 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 by the insurer of the facility-based physician or health care provider reasonable and customary rate or the agreed rate for covered services, the insured patient 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 13. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1456 to read as follows:

CHAPTER 1456. FACILITY BASED PROVIDER REQUIREMENTS

Sec. 1456.001. DEFINITIONS. In this chapter:

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

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

(3) "Facility-based physician reasonable and customary rate" means the average in-network reimbursement amount paid by a health benefit plan for a service or procedure to a facility-based physician contracted with the health benefit plan. The average in-network reimbursement amount paid by a health benefit plan for a service or procedure will be determined by the commissioner, based on annual reports, in electronic format, filed by the health benefit plan with the department. Information provided by the health benefit plan under this subdivision is confidential and is not subject to disclosure under the public information law, Chapter 552, Government Code.

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

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

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

(7) "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a network operated by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

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

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

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

(A) an insurance company;

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

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

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

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

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

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

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

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code,

notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This chapter does not apply to the Children's Health Insurance Program.

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

(1) facility-based physicians may not be included in the health benefit plan's provider network; and

(2) facility-based physicians described by Subdivision (1) may not charge or bill the enrollee for amounts other than applicable copayments, coinsurance, and deductibles if the health benefit plan pays the facility-based physician reasonable and customary rate or an agreed rate for covered services.

(b) The health benefit plan shall provide the disclosure in writing to each enrollee in any materials sent to the enrollee in conjunction with issuance of the plan's insurance policy or evidence of coverage.

(c) If a health benefit plan provides an explanation of payment summary to an enrollee, it shall include an explanation that the facility-based physician or provider shall not charge or bill the enrollee for amounts other than applicable copayments, coinsurance, and deductibles.

Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY. Each health care facility that has entered into a contract with a health benefit plan to serve as a provider in the health benefit plan's provider network shall prominently post a notice to enrollees receiving health care services at the facility that states:

(1) facility-based physicians may not be included in the health benefit plan's provider network; and

(2) facility-based physicians described by Subdivision (1) may not charge or bill the enrollee for amounts other than applicable copayments, coinsurance, and deductibles if the health care plan pays the usual and customary rate as defined by the insurer or an agreed rate for covered services.

Sec. 1456.005. COMMISSIONER RULES; FORM OF DISCLOSURE. The commissioner by rule may prescribe specific requirements for the disclosure required under Sections 1456.003 and 1456.004. The form of the disclosure must be substantially similar to the following:

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU ARE NOT RESPONSIBLE FOR PAYMENT TO THE NON-NETWORK PHYSICIANS OF AMOUNTS OTHER THAN APPLICABLE COPAYMENTS, COINSURANCE AND DEDUCTIBLES IF YOUR HEALTH BENEFIT PLAN PAYS THE FACILITY-BASED PHYSICIAN REASONABLE AND CUSTOMARY RATE OR AN AGREED AMOUNT FOR COVERED SERVICES.

Sec. 1456.006. COMPLAINTS PROCESS CONCERNING FACILITY-BASED PHYSICIANS. (a) A health benefit plan shall have a procedure for handling complaints relating to the charges for health care services and supplies. If a facility-based physician or health care provider objects to the facility-based physician or health care provider reasonable and customary rate for a particular service or supply, the health benefit plan will make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the objection cannot be resolved informally, the health benefit plan shall advise the consumer that a complaint may be filed with the department and shall provide the consumer with the mailing address and telephone number of the department.

(b) The department shall complete an investigation of a complaint filed pursuant to this section not later than the 60th day after the date the department receives the complaint and all

information necessary for the department to make a determination concerning the validity of the complaint.

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

(1) additional information is needed;

(2) an on-site review is necessary;

(3) the facility, consumer, or the third party payor does not provide all documentation necessary to complete the investigation; or

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

SECTION 14. Subchapter I, Chapter 843, Insurance Code, is amended by adding Section 843.321 to read as follows:

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

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

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

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

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

(d) The advisory committee shall be composed of:

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

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

(3) at least one physician licensed to practice by the Texas State Board of Medical Examiners;

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

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

(e) Members of the committee serve without compensation.

SECTION 15. Section 105.001, Occupations Code, is amended to read as follows:

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

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

(2) "Facility-based physician" means a physician licensed to practice medicine in this state who is a radiologist, anesthesiologist, pathologist, or emergency room physician.

(3) "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.

(4) "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 16. 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.

(b) A facility-based physician commits unprofessional conduct if the facility-based physician, in connection with professional activities, bills a patient for any amount above the applicable copayment, coinsurance, or deductible for covered services if the facility-based physician is paid the facility-based physician reasonable and customary rate or an agreed rate of payment from the health maintenance organization, preferred provider organization, or insurer for health care services.

(c) The provisions of Subsection (b) may not be waived, voided, or nullified, in whole or in part, by a contract or an agreement between a health care provider and consumer.

(d) In addition to other provisions of civil or criminal law, commission of unprofessional conduct under Subsections [~~Subsection~~] (a) and (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 17. Section 311.002, Health and Safety Code, is repealed.

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

SECTION 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, birthing center, or health care provider is not subject to disciplinary action, a civil penalty, an administrative penalty, or a civil action for damages for conduct that violates Chapter 322 or a rule adopted under that chapter before January 1, 2006.

SECTION 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.

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