

1-1 By: Duncan S.B. No. 1738
1-2 (In the Senate - Filed March 11, 2005; March 30, 2005, read
1-3 first time and referred to Committee on State Affairs; May 2, 2005,
1-4 reported adversely, with favorable Committee Substitute by the
1-5 following vote: Yeas 6, Nays 0; May 2, 2005, sent to printer.)

1-6 COMMITTEE SUBSTITUTE FOR S.B. No. 1738 By: Duncan

1-7 A BILL TO BE ENTITLED
1-8 AN ACT

1-9 relating to consumer access to health care information and consumer
1-10 protection for services provided by or through hospitals,
1-11 ambulatory surgical centers, and birthing centers; providing
1-12 penalties.

1-13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-14 SECTION 1. SHORT TITLE. This Act may be cited as the
1-15 Consumer Right to Know Act.

1-16 SECTION 2. Subtitle G, Title 4, Health and Safety Code, is
1-17 amended by adding Chapter 322 to read as follows:

1-18 CHAPTER 322. CONSUMER ACCESS TO HEALTH CARE INFORMATION

1-19 SUBCHAPTER A. GENERAL PROVISIONS

1-20 Sec. 322.001. DEFINITIONS. (a) In this chapter:

1-21 (1) "Billed charge" means the amount a facility
1-22 charges for a health care service or supply.

1-23 (2) "Charge master" means a facility's schedule of
1-24 billed charges for each health care service, health care supply, or
1-25 combination of health care services and supplies.

1-26 (3) "Consumer" means any person who is considering
1-27 receiving, is receiving, or has received a health care service or
1-28 supply as a patient from a facility. The term includes the personal
1-29 representative of the patient.

1-30 (4) "Department" means the Department of State Health
1-31 Services.

1-32 (5) "Executive commissioner" means the executive
1-33 commissioner of the Health and Human Services Commission.

1-34 (6) "Facility" means:

1-35 (A) an ambulatory surgical center licensed under
1-36 Chapter 243;

1-37 (B) a birthing center licensed under Chapter 244;

1-38 or

1-39 (C) a hospital licensed under Chapter 241.

1-40 (7) "Health benefit plan" means a health benefit plan
1-41 that provides benefits for medical or surgical expenses incurred as
1-42 a result of a health condition, accident, or sickness, including an
1-43 individual, group, blanket, or franchise insurance policy or
1-44 insurance agreement, a group hospital service contract, or an
1-45 individual or group evidence of coverage that is offered by:

1-46 (A) an insurance company;

1-47 (B) a group hospital service corporation
1-48 operating under Chapter 842, Insurance Code;

1-49 (C) a fraternal benefit society operating under
1-50 Chapter 885, Insurance Code;

1-51 (D) a stipulated premium insurance company
1-52 operating under Chapter 884, Insurance Code;

1-53 (E) a health maintenance organization operating
1-54 under Chapter 843, Insurance Code;

1-55 (F) to the extent permitted by the Employee
1-56 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
1-57 seq.), a health benefit plan that is offered by:

1-58 (i) a multiple employer welfare arrangement
1-59 as defined by Section 3, Employee Retirement Income Security Act of
1-60 1974 (29 U.S.C. Section 1002); or

1-61 (ii) another analogous benefit
1-62 arrangement; or

1-63 (G) an approved nonprofit health corporation

2-1 that is certified under Section 162.001, Occupations Code, and that
 2-2 holds a certificate of authority issued by the commissioner of
 2-3 insurance under Chapter 844, Insurance Code.

2-4 Sec. 322.002. RULES. The executive commissioner may adopt
 2-5 and enforce rules to further the purposes of this chapter.

2-6 [Sections 322.003-322.050 reserved for expansion]

2-7 SUBCHAPTER B. BILLING CHARGES

2-8 Sec. 322.051. NOTICE TO CONSUMER. Before any nonemergency
 2-9 treatment or service is performed, a facility shall provide notice
 2-10 to a consumer before or on admission to a facility of the consumer's
 2-11 right to receive:

2-12 (1) a free copy of the facility's common procedure
 2-13 charge list in accordance with Section 322.054;

2-14 (2) a notice regarding the availability of the common
 2-15 procedure charge information on the Consumer Guide to Healthcare
 2-16 website created under Section 322.055; and

2-17 (3) a free written estimate of charges in accordance
 2-18 with Section 322.056(c).

2-19 Sec. 322.052. CHARGE MASTER. (a) A facility may have only
 2-20 one current charge master.

2-21 (b) A charge master must include an initial effective date.

2-22 Sec. 322.053. CREATION OF FACILITY COMMON PROCEDURES LIST.

2-23 (a) The department shall identify 50 common inpatient procedures
 2-24 and 50 common outpatient procedures performed for patients by
 2-25 facilities in this state. A procedure may be a single health care
 2-26 service or supply or a group of services and supplies commonly
 2-27 provided as a unit to patients.

2-28 (b) A facility shall provide to the department in a format
 2-29 developed by the department a list of the 50 common inpatient
 2-30 procedures and 50 common outpatient procedures performed for
 2-31 patients of the facility in this state. The department shall use the
 2-32 lists provided by facilities to develop the common procedures list
 2-33 described in Subsection (a).

2-34 (c) The department shall update the common procedures list
 2-35 at least every two years.

2-36 Sec. 322.054. FACILITY COMMON PROCEDURE CHARGE LIST.

2-37 (a) A facility shall establish and maintain a list of the average
 2-38 charge for each procedure identified in the common procedures list
 2-39 created by the department under Section 322.053 if the procedure is
 2-40 performed within the facility.

2-41 (b) The average charge for each procedure in a facility's
 2-42 procedure charge list must be based on the charges listed for
 2-43 individual services and supplies in the facility's current charge
 2-44 master at the time the list was compiled.

2-45 (c) A facility shall have only one current procedure charge
 2-46 list and shall update the facility's procedure charge list on a
 2-47 semi-annual basis to reflect any changes made to the facility's
 2-48 charge master.

2-49 (d) A facility shall:

2-50 (1) identify each version of the procedure charge list
 2-51 by the list's initial effective date;

2-52 (2) retain a copy of each version until the second
 2-53 anniversary of each list's effective date;

2-54 (3) post on the facility's Internet website, if any, a
 2-55 copy of the current version of the procedure charge list;

2-56 (4) provide notice to a consumer requesting the
 2-57 procedure charge list that the actual charges for a procedure will
 2-58 vary based on the person's medical condition and other factors
 2-59 associated with performance of the procedure; and

2-60 (5) provide notice to a consumer requesting the
 2-61 procedure charge list that the range of charges for a procedure may
 2-62 differ from the amount to be paid by the consumer or the consumer's
 2-63 third party payor.

2-64 (e) The facility shall:

2-65 (1) provide free of charge to a consumer on request a
 2-66 written copy of any version of the procedure charge list retained
 2-67 under Subsection (d); and

2-68 (2) inform the consumer that the current procedure
 2-69 charge list is posted on the facility's Internet website, if any,

3-1 and provide the consumer with the Internet website address.
3-2 Sec. 322.055. CONSUMER GUIDE TO HEALTH CARE. (a) A
3-3 facility shall file with the department the procedure charge list
3-4 created under Section 322.054.

3-5 (b) The department shall make available on the department's
3-6 Internet website a consumer guide to health care. The guide must
3-7 include the procedure charge list for each facility that submits
3-8 the list required under Subsection (a).

3-9 (c) The department may accept gifts and grants to fund the
3-10 consumer guide to health care.

3-11 Sec. 322.056. BILLING OF FACILITY SERVICES. (a) Each
3-12 facility shall develop, implement, and enforce written policies for
3-13 the billing of hospital services and supplies. The policies must
3-14 address:

3-15 (1) the provision of the itemized statements required
3-16 by Subsection (d);

3-17 (2) whether interest will be applied to any billed
3-18 service not covered by a third party payor and the rate of any
3-19 interest charged;

3-20 (3) the providing of a notice concerning the ability
3-21 to complain regarding the billed amount in accordance with Sections
3-22 322.101 and 311.0025;

3-23 (4) the providing of a notice that if a consumer
3-24 objects to the bill or treatment, the consumer may file a complaint
3-25 with the department and include the name, mailing address, and
3-26 telephone number of the department;

3-27 (5) the procedure for handling complaints relating to
3-28 billed services; and

3-29 (6) a disclosure to a consumer requesting services
3-30 from the facility that:

3-31 (A) provides confirmation whether the facility
3-32 is a participating provider under the consumer's third party payor
3-33 coverage on the date services are to be rendered; and

3-34 (B) informs the consumer that physicians or other
3-35 providers who may provide services to the consumer while in the
3-36 facility may not be a participating provider with the same third
3-37 party payors as the facility.

3-38 (b) Each facility shall post in the general waiting area and
3-39 in the waiting areas of any off-site or onsite registration,
3-40 admission, or business office a clear and conspicuous notice of the
3-41 availability of the policies required by Subsection (a).

3-42 (c) Before any nonemergency treatment or service is
3-43 performed and before a consumer is discharged from a facility, the
3-44 facility shall disclose to the consumer the consumer's right to
3-45 receive a written estimate of the charges for any procedure,
3-46 service, or supply.

3-47 (d) Not later than the 30th business day after the date of
3-48 the discharge of a consumer who receives facility services, the
3-49 facility shall provide to the consumer at the consumer's request an
3-50 itemized statement of the billed services. The itemized statement
3-51 must:

3-52 (1) be printed in a conspicuous manner;

3-53 (2) list the date services and supplies were provided;

3-54 (3) state whether:

3-55 (A) a claim has been submitted to a third party

3-56 payor; and

3-57 (B) a third party payor has paid the claim;

3-58 (4) if payment is not required, state that payment is

3-59 not required:

3-60 (A) in a typeface that is bold-faced,
3-61 capitalized, underlined, or otherwise set out from surrounding
3-62 written material; or

3-63 (B) by other reasonable means so as to be
3-64 conspicuous that payment is not required; and

3-65 (5) contain the telephone number of the facility to
3-66 call for an explanation of acronyms, abbreviations, and numbers
3-67 used to describe the services provided or supplies used or any other
3-68 questions regarding the bill.

3-69 (e) To be entitled to receive a statement, a consumer must

4-1 request the statement not later than one year after the date on
 4-2 which the person is discharged from the facility. The facility
 4-3 shall provide the statement to the consumer not later than the 30th
 4-4 day after the date on which the statement is requested.

4-5 (f) A facility shall provide an itemized statement of billed
 4-6 services to a third party payor that is responsible or is paying all
 4-7 or part of the billed services provided and who has received a claim
 4-8 for payment of those services. To be entitled to receive a
 4-9 statement, the third party payor must request the statement from
 4-10 the facility and must have received a claim for payment. The
 4-11 request must be made not later than one year after the date on which
 4-12 the payor received the claim for payment. The facility shall
 4-13 provide the statement to the payor not later than the 30th day after
 4-14 the date on which the payor requests the statement. If a third
 4-15 party payor receives a claim for payment of part but not all of the
 4-16 billed services, the third party payor may request an itemized
 4-17 statement of only the billed services for which payment is claimed
 4-18 or to which any deduction or copayment applies.

4-19 (g) If a consumer or a third party payor requests more than
 4-20 two copies of the statement, the facility may charge a reasonable
 4-21 fee for the third and subsequent copies provided. The fee may not
 4-22 exceed the facility's cost to copy, process, and deliver the copy to
 4-23 the consumer or third party payor.

4-24 (h) If a consumer overpays a facility, the facility must
 4-25 refund the amount of the overpayment not later than the 30th day
 4-26 after the date it is determined that an overpayment has been made.
 4-27 This subsection does not apply to an overpayment covered by Chapter
 4-28 1301, Insurance Code, or Section 843.350, Insurance Code.

4-29 Sec. 322.057. CONSUMER WAIVER PROHIBITED. The provisions
 4-30 of this subchapter may not be waived, voided, or nullified by a
 4-31 contract or an agreement between a facility and a consumer.

4-32 [Sections 322.058-322.100 reserved for expansion]

4-33 SUBCHAPTER C. COMPLAINT RESOLUTION

4-34 Sec. 322.101. COMPLAINT PROCESS. (a) A facility shall
 4-35 have a procedure for handling complaints relating to the charges
 4-36 for health care services and supplies. If a consumer objects to the
 4-37 billed amount for a particular service or supply, the facility will
 4-38 make a good faith effort to resolve the complaint in an informal
 4-39 manner based on its complaint procedures. If the objection cannot
 4-40 be resolved informally, the facility shall advise the consumer that
 4-41 a complaint may be filed with the department and shall provide the
 4-42 consumer with the mailing address and telephone number of the
 4-43 department.

4-44 (b) If a facility is not a participating provider with a
 4-45 third party payor, the facility shall have a procedure for handling
 4-46 complaints by those third party payors relating to the charges for
 4-47 health care services and supplies. If a third party payor objects to
 4-48 the billed amount for a particular service or supply pursuant to
 4-49 this subsection, the facility will make a good faith effort to
 4-50 resolve any complaints in an informal manner based on its complaint
 4-51 procedures. If the objection cannot be resolved informally, the
 4-52 facility shall advise the third party payor that a complaint may be
 4-53 filed with the department and shall provide the third party payor
 4-54 with the mailing address and telephone number of the department.

4-55 (c) The department shall complete an investigation of a
 4-56 complaint filed pursuant to this section not later than the 60th day
 4-57 after the date the department receives the complaint and all
 4-58 information necessary for the department to make a determination
 4-59 concerning the validity of the complaint.

4-60 (d) The department may extend the time necessary to complete
 4-61 an investigation if:

- 4-62 (1) additional information is needed;
- 4-63 (2) an on-site review is necessary;
- 4-64 (3) the facility, consumer, or the third party payor
 4-65 does not provide all documentation necessary to complete the
 4-66 investigation; or
- 4-67 (4) other circumstances beyond the control of the
 4-68 department occur.

4-69 (e) If the department determines that a complaint regarding

5-1 charges for health care services and supplies is valid, the
5-2 department may take disciplinary action as provided under
5-3 Subchapter D.

5-4 [Sections 322.102-322.150 reserved for expansion]

5-5 SUBCHAPTER D. ENFORCEMENT AND DISCIPLINARY ACTIONS

5-6 Sec. 322.151. AUDIT AND INVESTIGATION. The department may
5-7 audit, investigate, or take any other necessary action to
5-8 reasonably ensure a facility is complying with Subchapter B or C.

5-9 Sec. 322.152. DISCIPLINARY ACTION. (a) A facility that
5-10 violates Subchapter B or C is subject to disciplinary action by the
5-11 department, as authorized by the applicable licensing law.

5-12 (b) Prior to taking any disciplinary action under
5-13 Subsection (a), the department shall:

5-14 (1) notify a facility that the facility is violating
5-15 or has violated this chapter or a rule adopted under this chapter;
5-16 and

5-17 (2) provide the facility with an opportunity to
5-18 correct the violation.

5-19 SECTION 3. Subsection (a), Section 843.251, Insurance Code,
5-20 is amended to read as follows:

5-21 (a) A health maintenance organization shall implement and
5-22 maintain a complaint system that provides reasonable procedures to
5-23 resolve an oral or written complaint initiated by a complainant
5-24 concerning health care services. The complaint system must include
5-25 a process for the notice and appeal of a complaint. The health
5-26 maintenance organization shall have a procedure for handling
5-27 complaints by nonparticipating providers relating to the health
5-28 maintenance organization's determination of usual and customary
5-29 charges for out-of-network health care services and supplies. If a
5-30 nonparticipating provider objects to the health maintenance
5-31 organization's determination of usual and customary charges for a
5-32 particular service or supply pursuant to this subsection, the
5-33 health maintenance organization will make a good faith effort to
5-34 resolve the complaint in an informal manner based on its complaint
5-35 procedures. If the objection cannot be resolved informally, the
5-36 health maintenance organization shall advise the provider that a
5-37 complaint may be filed with the department and shall provide the
5-38 third party payor with the mailing address and telephone number of
5-39 the department.

5-40 SECTION 4. Section 1301.055, Insurance Code, is amended by
5-41 adding Subsection (c) to read as follows:

5-42 (c) An insurer shall have a procedure for handling
5-43 complaints by non-participating providers relating to the
5-44 insurer's determination of usual and customary charges for
5-45 out-of-network health care services and supplies. If a
5-46 nonparticipating provider objects to the insurer's determination
5-47 of usual and customary charges for a particular service or supply
5-48 pursuant to this subsection, the insurer will make a good faith
5-49 effort to resolve the complaint in an informal manner based on its
5-50 complaint procedures. If the objection cannot be resolved
5-51 informally, the insurer shall advise the provider that a complaint
5-52 may be filed with the department and shall provide the third party
5-53 payor with the mailing address and telephone number of the
5-54 department.

5-55 SECTION 5. Section 1204.051, Insurance Code, is amended to
5-56 read as follows:

5-57 Sec. 1204.051. DEFINITIONS. In this subchapter:

5-58 (1) "Covered person" means a person who is insured or
5-59 covered by a health insurance policy or is a participant in an
5-60 employee benefit plan. The term includes:

5-61 (A) a person covered by a health insurance policy
5-62 because the person is an eligible dependent; and

5-63 (B) an eligible dependent of a participant in an
5-64 employee benefit plan.

5-65 (2) "Employee benefit plan" or "plan" means a plan,
5-66 fund, or program established or maintained by an employer, an
5-67 employee organization, or both, to the extent that it provides,
5-68 through the purchase of insurance or otherwise, health care
5-69 services to employees, participants, or the dependents of employees

6-1 or participants.

6-2 (2-a) "Facility" means a health care facility licensed
6-3 to operate in this state as:

6-4 (A) an ambulatory surgical center under Chapter
6-5 243, Health and Safety Code; or

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

6-8 (2-b) "Facility-based physician" includes a
6-9 radiologist, an anesthesiologist, a pathologist, or an emergency
6-10 department physician:

6-11 (A) to whom the facility has granted clinical
6-12 privileges; and

6-13 (B) who provides services to patients of the
6-14 facility under those clinical privileges.

6-15 (2-c) "Facility-based physician reasonable and
6-16 customary rate" means the average in-network reimbursement amount
6-17 paid by an insurer for a service or procedure to a physician
6-18 contracted with the insurer. The average in-network reimbursement
6-19 amount paid by an insurer for a service or procedure will be
6-20 determined by the commissioner, based on annual reports, in
6-21 electronic format, filed by the insurer with the department.
6-22 Information provided by the insurer under this subdivision is
6-23 confidential and is not subject to disclosure under the public
6-24 information law, Chapter 552, Government Code.

6-25 (3) "Health care provider" means a person who provides
6-26 health care services under a license, certificate, registration, or
6-27 other similar evidence of regulation issued by this or another
6-28 state of the United States.

6-29 (4) "Health care service" means a service to diagnose,
6-30 prevent, alleviate, cure, or heal a human illness or injury that is
6-31 provided to a covered person by a physician or other health care
6-32 provider.

6-33 (5) "Health insurance policy" means an individual,
6-34 group, blanket, or franchise insurance policy, or an insurance
6-35 agreement, that provides reimbursement or indemnity for health care
6-36 expenses incurred as a result of an accident or sickness.

6-37 (6) "Insurer" means an insurance company,
6-38 association, or organization authorized to engage in business in
6-39 this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886,
6-40 887, 888, 941, 942, or 982.

6-41 (7) "Person" means an individual, association,
6-42 partnership, corporation, or other legal entity.

6-43 (8) "Physician" means an individual licensed to
6-44 practice medicine in this or another state of the United States.

6-45 SECTION 6. Section 2, Article 21.60, Insurance Code, is
6-46 amended by adding Subsection (e) to read as follows:

6-47 (e) A managed care entity shall submit to the department
6-48 upon request after receipt of a complaint a copy of the methodology
6-49 and origin of information used to compute usual and customary
6-50 reimbursement paid to providers for out-of-network goods and
6-51 services. If a specified percentage of charges is used as a basis
6-52 for the determination of usual and customary reimbursement the
6-53 managed care entity shall provide the percentage used. Information
6-54 provided by the health plan under this section is confidential and
6-55 is not subject to disclosure under the public information law,
6-56 Chapter 552, Government Code.

6-57 SECTION 7. Section 1271.001, Insurance Code, is amended to
6-58 read as follows:

6-59 Sec. 1271.001. [~~APPLICABILITY OF~~] DEFINITIONS. (a) In
6-60 this chapter:

6-61 (1) "Facility" means a health care facility licensed
6-62 to operate in this state as:

6-63 (A) an ambulatory surgical center under Chapter
6-64 243, Health and Safety Code; or

6-65 (B) a hospital under Chapter 241, Health and
6-66 Safety Code.

6-67 (2) "Facility-based physician" includes a
6-68 radiologist, an anesthesiologist, a pathologist, or an emergency
6-69 department physician:

7-1 (A) to whom the facility has granted clinical
7-2 privileges; and

7-3 (B) who provides services to patients of the
7-4 facility under those clinical privileges.

7-5 (3) "Facility-based physician reasonable and
7-6 customary rate" means the average in-network reimbursement amount
7-7 paid by a health maintenance organization for a service or
7-8 procedure to a physician contracted with the health maintenance
7-9 organization. The average in-network reimbursement amount paid by
7-10 a health maintenance organization for a service or procedure will
7-11 be determined by the commissioner, based on annual reports, in
7-12 electronic format, filed by the health maintenance organization
7-13 with the department. Information provided by the health
7-14 maintenance organization under this subdivision is confidential
7-15 and is not subject to disclosure under the public information law,
7-16 Chapter 552, Government Code. This subdivision does not apply to
7-17 the Children's Health Insurance Program.

7-18 (b) In this chapter, terms defined by Section 843.002 have
7-19 the meanings assigned by that section.

7-20 SECTION 8. Section 1271.055, Insurance Code, as effective
7-21 April 1, 2005, is amended by adding Subsection (d) to read as
7-22 follows:

7-23 (d) If professional services are provided to an enrollee by
7-24 a facility-based physician who is not a member of the health
7-25 maintenance organization delivery network, on the health
7-26 maintenance organization's payment of the facility-based physician
7-27 reasonable and customary rate or at an agreed rate for covered
7-28 services, the enrollee is not liable for any further payments to the
7-29 facility-based physician except for payment of any applicable
7-30 copayments, coinsurance, or deductibles for the covered services.

7-31 SECTION 9. Subsection (a), Section 1272.001, Insurance
7-32 Code, is amended by adding Subdivisions (4-a) and (4-b) to read as
7-33 follows:

7-34 (4-a) "Facility" means a health care facility licensed
7-35 to operate in this state as:

7-36 (A) an ambulatory surgical center under Chapter
7-37 243, Health and Safety Code; or

7-38 (B) a hospital under Chapter 241, Health and
7-39 Safety Code.

7-40 (4-b) "Facility-based physician" includes a
7-41 radiologist, an anesthesiologist, or an emergency department
7-42 physician:

7-43 (A) to whom the facility has granted clinical
7-44 privileges; and

7-45 (B) who provides services to patients of the
7-46 facility under those clinical privileges.

7-47 SECTION 10. Section 1272.301, Insurance Code, is amended by
7-48 adding Subsection (e) to read as follows:

7-49 (e) If a limited provider network or delegated entity
7-50 provides or arranges to provide services to enrollees through a
7-51 facility-based physician who is not a member of the health
7-52 maintenance organization delivery network, on payment by the health
7-53 maintenance organization of the facility-based physician
7-54 reasonable and customary rate or an agreed rate for covered
7-55 services, the enrollee is not liable for any further payments to the
7-56 facility-based physician except for payment of any applicable
7-57 copayments, coinsurance, or deductibles for the covered services.

7-58 SECTION 11. (a) Section 1301.001, Insurance Code, is
7-59 amended to read as follows:

7-60 Sec. 1301.001. DEFINITIONS. In this chapter:

7-61 (1) "Facility" means a health care facility licensed
7-62 to operate in this state as:

7-63 (A) an ambulatory surgical center under Chapter
7-64 243 Health and Safety Code; or

7-65 (B) a hospital under Chapter 241, Health and
7-66 Safety Code.

7-67 (2) "Facility-based physician" includes a
7-68 radiologist, an anesthesiologist, a pathologist, or an emergency
7-69 department physician:

8-1 (A) to whom the facility has granted clinical
8-2 privileges; and

8-3 (B) who provides services to patients of the
8-4 facility under those clinical privileges.

8-5 (3) "Health care provider" means a practitioner,
8-6 institutional provider, or other person or organization that
8-7 furnishes health care services and that is licensed or otherwise
8-8 authorized to practice in this state. The term does not include a
8-9 physician.

8-10 (4) [~~2~~] "Health insurance policy" means a group or
8-11 individual insurance policy, certificate, or contract providing
8-12 benefits for medical or surgical expenses incurred as a result of an
8-13 accident or sickness.

8-14 (5) [~~3~~] "Hospital" means a licensed public or
8-15 private institution as defined by Chapter 241, Health and Safety
8-16 Code, or Subtitle C, Title 7, Health and Safety Code.

8-17 (6) [~~4~~] "Institutional provider" means a hospital,
8-18 nursing home, or other medical or health-related service facility
8-19 that provides care for the sick or injured or other care that may be
8-20 covered in a health insurance policy.

8-21 (7) [~~5~~] "Insurer" means a life, health, and accident
8-22 insurance company, health and accident insurance company, health
8-23 insurance company, or other company operating under Chapter
8-24 841, 842, 884, 885, 982, or 1501, that is authorized to issue,
8-25 deliver, or issue for delivery in this state health insurance
8-26 policies.

8-27 (8) [~~6~~] "Physician" means a person licensed to
8-28 practice medicine in this state.

8-29 (9) [~~7~~] "Practitioner" means a person who practices
8-30 a healing art and is a practitioner described by Section 1451.001 or
8-31 1451.101.

8-32 (10) "Preauthorization" means a determination by an
8-33 insurer that medical care or health care services proposed to be
8-34 provided to a patient are medically necessary and appropriate.

8-35 (11) [~~8~~] "Preferred provider" means a physician or
8-36 health care provider, or an organization of physicians or health
8-37 care providers, who contracts with an insurer to provide medical
8-38 care or health care to insureds covered by a health insurance
8-39 policy.

8-40 (12) [~~9~~] "Preferred provider benefit plan" means a
8-41 benefit plan in which an insurer provides, through its health
8-42 insurance policy, for the payment of a level of coverage that is
8-43 different from the basic level of coverage provided by the health
8-44 insurance policy if the insured person uses a preferred provider.

8-45 (13) [~~10~~] "Service area" means a geographic area or
8-46 areas specified in a health insurance policy or preferred provider
8-47 contract in which a network of preferred providers is offered and
8-48 available.

8-49 (14) "Verification" means a reliable representation
8-50 by an insurer to a physician or health care provider that the
8-51 insurer will pay the physician or provider for proposed medical
8-52 care or health care services if the physician or provider renders
8-53 those services to the patient for whom the services are proposed.
8-54 The term includes precertification, certification,
8-55 recertification, and any other term that would be a reliable
8-56 representation by an insurer to a physician or provider.

8-57 (b) To the extent of any conflict, this section prevails
8-58 over another Act of the 79th Legislature, Regular Session, 2005,
8-59 relating to nonsubstantive additions and corrections in enacted
8-60 codes.

8-61 SECTION 12. Subchapter D, Chapter 1301, Insurance Code, is
8-62 amended by adding Section 1301.164 to read as follows:

8-63 Sec. 1301.164. BALANCE BILLING PROHIBITED. If health care
8-64 services are provided to an insured patient in a facility that is
8-65 part of the preferred provider network by a facility-based
8-66 physician or health care provider who is not a preferred provider,
8-67 on payment by the insurer of the facility-based physician or health
8-68 care provider reasonable and customary rate or the agreed rate for
8-69 covered services, the insured patient is not liable for further

9-1 payments to the facility-based physician or health care provider
9-2 except for payment of any applicable copayments, coinsurance, or
9-3 deductibles owed by the insured for the covered services.

9-4 SECTION 13. Subtitle F, Title 8, Insurance Code, is amended
9-5 by adding Chapter 1456 to read as follows:

9-6 CHAPTER 1456. FACILITY BASED PROVIDER REQUIREMENTS

9-7 Sec. 1456.001. DEFINITIONS. In this chapter:

9-8 (1) "Balance billing" means the practice of charging
9-9 an enrollee of a health benefit plan that uses a provider network to
9-10 recover from the enrollee the balance of a non-network health care
9-11 provider's fee for services received by the enrollee from the
9-12 health care provider that are not fully reimbursed by the
9-13 enrollee's health benefit plan.

9-14 (2) "Enrollee" means an individual who is eligible to
9-15 receive health care services through a health benefit plan.

9-16 (3) "Facility-based physician reasonable and
9-17 customary rate" means the average in-network reimbursement amount
9-18 paid by a health benefit plan for a service or procedure to a
9-19 facility-based physician contracted with the health benefit plan.
9-20 The average in-network reimbursement amount paid by a health
9-21 benefit plan for a service or procedure will be determined by the
9-22 commissioner, based on annual reports, in electronic format, filed
9-23 by the health benefit plan with the department. Information
9-24 provided by the health benefit plan under this subdivision is
9-25 confidential and is not subject to disclosure under the public
9-26 information law, Chapter 552, Government Code.

9-27 (4) "Health care facility" means a hospital, emergency
9-28 clinic, outpatient clinic, or other facility providing health care
9-29 services.

9-30 (5) "Health care practitioner" means an individual who
9-31 is licensed to provide and provides health care services.

9-32 (6) "Health care provider" means a health care
9-33 facility or health care practitioner.

9-34 (7) "Provider network" means a health benefit plan
9-35 under which health care services are provided to enrollees through
9-36 contracts with health care providers and that requires those
9-37 enrollees to use health care providers participating in the plan
9-38 and procedures covered by the plan. The term includes a network
9-39 operated by:

- 9-40 (A) a health maintenance organization;
- 9-41 (B) a preferred provider benefit plan issuer; or
- 9-42 (C) another entity that issues a health benefit
9-43 plan, including an insurance company.

9-44 Sec. 1456.002. APPLICABILITY OF CHAPTER. (a) This chapter
9-45 applies to any health benefit plan that:

9-46 (1) provides benefits for medical or surgical expenses
9-47 incurred as result of a health condition, accident, or sickness,
9-48 including an individual, group, blanket, or franchise insurance
9-49 policy or insurance agreement, a group hospital service contract,
9-50 or an individual or group evidence of coverage that is offered by:

- 9-51 (A) an insurance company;
- 9-52 (B) a group hospital service corporation
9-53 operating under Chapter 842;
- 9-54 (C) a fraternal benefit society operating under
9-55 Chapter 885;
- 9-56 (D) a stipulated premium company operating under
9-57 Chapter 884;
- 9-58 (E) a health maintenance organization operating
9-59 under Chapter 843;
- 9-60 (F) a multiple employer welfare arrangement that
9-61 holds a certificate of authority under Chapter 846;
- 9-62 (G) an approved nonprofit health corporation
9-63 that holds a certificate of authority under Chapter 844; or
- 9-64 (H) an entity not authorized under this code or
9-65 another insurance law of this state that contracts directly for
9-66 health care services on a risk-sharing basis, including a
9-67 capitation basis; or

9-68 (2) provides health and accident coverage through a
9-69 risk pool created under Chapter 172, Local Government Code,

10-1 notwithstanding Section 172.014, Local Government Code, or any
10-2 other law.

10-3 (b) This chapter does not apply to the Children's Health
10-4 Insurance Program.

10-5 Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN.

10-6 (a) Each health benefit plan that provides health care benefits
10-7 through a provider network shall provide notice to its enrollees
10-8 that:

10-9 (1) facility-based physicians may not be included in
10-10 the health benefit plan's provider network; and

10-11 (2) facility-based physicians described by
10-12 Subdivision (1) may not charge or bill the enrollee for amounts
10-13 other than applicable copayments, coinsurance, and deductibles if
10-14 the health benefit plan pays the facility-based physician
10-15 reasonable and customary rate or an agreed rate for covered
10-16 services.

10-17 (b) The health benefit plan shall provide the disclosure in
10-18 writing to each enrollee in any materials sent to the enrollee in
10-19 conjunction with issuance of the plan's insurance policy or
10-20 evidence of coverage.

10-21 (c) If a health benefit plan provides an explanation of
10-22 payment summary to an enrollee, it shall include an explanation
10-23 that the facility-based physician or provider shall not charge or
10-24 bill the enrollee for amounts other than applicable copayments,
10-25 coinsurance, and deductibles.

10-26 Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY.

10-27 Each health care facility that has entered into a contract with a
10-28 health benefit plan to serve as a provider in the health benefit
10-29 plan's provider network shall prominently post a notice to
10-30 enrollees receiving health care services at the facility that
10-31 states:

10-32 (1) facility-based physicians may not be included in
10-33 the health benefit plan's provider network; and

10-34 (2) facility-based physicians described by
10-35 Subdivision (1) may not charge or bill the enrollee for amounts
10-36 other than applicable copayments, coinsurance, and deductibles if
10-37 the health care plan pays the usual and customary rate as defined by
10-38 the insurer or an agreed rate for covered services.

10-39 Sec. 1456.005. COMMISSIONER RULES; FORM OF DISCLOSURE. The
10-40 commissioner by rule may prescribe specific requirements for the
10-41 disclosure required under Sections 1456.003 and 1456.004. The form
10-42 of the disclosure must be substantially similar to the following:

10-43 NOTICE

10-44 ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO
10-45 YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER
10-46 NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL
10-47 SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY
10-48 HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU ARE
10-49 NOT RESPONSIBLE FOR PAYMENT TO THE NON-NETWORK PHYSICIANS OF
10-50 AMOUNTS OTHER THAN APPLICABLE COPAYMENTS, COINSURANCE AND
10-51 DEDUCTIBLES IF YOUR HEALTH BENEFIT PLAN PAYS THE FACILITY-BASED
10-52 PHYSICIAN REASONABLE AND CUSTOMARY RATE OR AN AGREED AMOUNT FOR
10-53 COVERED SERVICES.

10-54 Sec. 1456.006. COMPLAINTS PROCESS CONCERNING FACILITY-BASED

10-55 PHYSICIANS. (a) A health benefit plan shall have a procedure for
10-56 handling complaints relating to the charges for health care
10-57 services and supplies. If a facility-based physician or health
10-58 care provider objects to the facility-based physician or health
10-59 care provider reasonable and customary rate for a particular
10-60 service or supply, the health benefit plan will make a good faith
10-61 effort to resolve the complaint in an informal manner based on its
10-62 complaint procedures. If the objection cannot be resolved
10-63 informally, the health benefit plan shall advise the consumer that
10-64 a complaint may be filed with the department and shall provide the
10-65 consumer with the mailing address and telephone number of the
10-66 department.

10-67 (b) The department shall complete an investigation of a
10-68 complaint filed pursuant to this section not later than the 60th day
10-69 after the date the department receives the complaint and all

11-1 information necessary for the department to make a determination
11-2 concerning the validity of the complaint.

11-3 (c) The department may extend the time necessary to complete
11-4 an investigation if:

- 11-5 (1) additional information is needed;
- 11-6 (2) an on-site review is necessary;
- 11-7 (3) the facility, consumer, or the third party payor
11-8 does not provide all documentation necessary to complete the
11-9 investigation; or
- 11-10 (4) other circumstances beyond the control of the
11-11 department occur.

11-12 SECTION 14. Subchapter I, Chapter 843, Insurance Code, is
11-13 amended by adding Section 843.321 to read as follows:

11-14 Sec. 843.321. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF
11-15 HEALTH PLANS. (a) In this section:

11-16 (1) "Commissioner" means the commissioner of
11-17 insurance.

11-18 (2) "Health plan" means an insurance policy or a
11-19 contract or evidence of coverage issued by a health maintenance
11-20 organization or an employer or employee sponsored health plan.

11-21 (b) The commissioner shall appoint an advisory committee to
11-22 study facility-based provider network adequacy of health plans and
11-23 the health plans' ability to contract on reasonable terms with
11-24 facility-based physicians.

11-25 (c) The advisory committee shall advise the commissioner
11-26 periodically of its findings, no later than December, 2006.

11-27 (d) The advisory committee shall be composed of:

11-28 (1) at least one person affiliated with an insurance
11-29 company, licensed to write health insurance in this state;

11-30 (2) at least one person affiliated with a health
11-31 maintenance organization licensed to offer health coverage in this
11-32 state;

11-33 (3) at least one physician licensed to practice by the
11-34 Texas State Board of Medical Examiners;

11-35 (4) at least one person affiliated with a hospital
11-36 licensed in this state; and

11-37 (5) at least one member of the general public who is
11-38 not employed by or affiliated with an insurance company, health
11-39 maintenance organization, physician, or hospital. A
11-40 representative of the general public includes a person whose only
11-41 affiliation with an insurance company or health maintenance
11-42 organization is as an insured or covered person.

11-43 (e) Members of the committee serve without compensation.

11-44 SECTION 15. Section 105.001, Occupations Code, is amended
11-45 to read as follows:

11-46 Sec. 105.001. DEFINITIONS [~~DEFINITION~~]. In this chapter:

11-47 (1) "Consumer" means any person who is considering
11-48 receiving, is receiving, or has received a health care service or
11-49 supply as a patient from a facility. The term includes the personal
11-50 representative of the patient.

11-51 (2) "Facility-based physician" means a physician
11-52 licensed to practice medicine in this state who is a radiologist,
11-53 anesthesiologist, pathologist, or emergency room physician.

11-54 (3) "Health[, "health] care provider" means a person
11-55 who furnishes services under a license, certificate, registration,
11-56 or other authority issued by this state or another state to
11-57 diagnose, prevent, alleviate, or cure a human illness or injury.

11-58 (4) "Licensing authority" means a department,
11-59 commission, board, office, or other agency of this state that
11-60 issues a license, certificate, registration, or other authority to
11-61 regulate under this code the professional practice of a health care
11-62 provider.

11-63 SECTION 16. Section 105.002, Occupations Code, is amended
11-64 to read as follows:

11-65 Sec. 105.002. UNPROFESSIONAL CONDUCT. (a) A health care
11-66 provider commits unprofessional conduct if the health care
11-67 provider, in connection with the provider's professional
11-68 activities or provision of professional services:

11-69 (1) knowingly presents or causes to be presented a

12-1 false or fraudulent claim for the payment of a loss under an
12-2 insurance policy; or

12-3 (2) knowingly prepares, makes, or subscribes to any
12-4 writing, with intent to present or use the writing, or to allow it
12-5 to be presented or used, in support of a false or fraudulent claim
12-6 under an insurance policy.

12-7 (b) A facility-based physician commits unprofessional
12-8 conduct if the facility-based physician, in connection with
12-9 professional activities, bills a patient for any amount above the
12-10 applicable copayment, coinsurance, or deductible for covered
12-11 services if the facility-based physician is paid the facility-based
12-12 physician reasonable and customary rate or an agreed rate of
12-13 payment from the health maintenance organization, preferred
12-14 provider organization, or insurer for health care services.

12-15 (c) The provisions of Subsection (b) may not be waived,
12-16 voided, or nullified, in whole or in part, by a contract or an
12-17 agreement between a health care provider and consumer.

12-18 (d) In addition to other provisions of civil or criminal
12-19 law, commission of unprofessional conduct under Subsections
12-20 [Subsection] (a) and (b) constitutes cause for:

12-21 (1) the revocation or suspension by the appropriate
12-22 licensing authority of a provider's license, permit, registration,
12-23 certificate, or other authority;

12-24 (2) imposition by the appropriate licensing authority
12-25 of an administrative penalty in an amount not to exceed \$500 for
12-26 each day of violation; or

12-27 (3) other appropriate disciplinary action.

12-28 SECTION 17. Section 311.002, Health and Safety Code, is
12-29 repealed.

12-30 SECTION 18. This Act applies to an insurance policy,
12-31 certificate, or contract or an evidence of coverage delivered,
12-32 issued for delivery, or renewed on or after the effective date of
12-33 this Act. A policy, certificate, or contract or evidence of
12-34 coverage delivered, issued for delivery, or renewed before the
12-35 effective date of this Act is governed by the law as it existed
12-36 immediately before the effective date of this Act, and that law is
12-37 continued in effect for that purpose.

12-38 SECTION 19. (a) Section 105.002, Occupations Code, as
12-39 amended by this Act, applies only to conduct occurring on or after
12-40 the effective date of this Act.

12-41 (b) Conduct occurring before the effective date of this Act
12-42 is governed by the law in effect on the date that the conduct
12-43 occurred, and the former law is continued in effect for that
12-44 purpose.

12-45 SECTION 20. (a) The executive commissioner of the Health
12-46 and Human Services Commission and appropriate regulatory agencies
12-47 shall adopt rules necessary to implement Chapter 322, Health and
12-48 Safety Code, as added by this Act, not later than May 1, 2006.

12-49 (b) The Department of State Health Services shall develop
12-50 the common procedures lists and the consumer guide to health care as
12-51 required by Chapter 322, Health and Safety Code, as added by this
12-52 Act, not later than September 1, 2006.

12-53 SECTION 21. Notwithstanding Subchapter D, Chapter 322,
12-54 Health and Safety Code, as added by this Act, a hospital, ambulatory
12-55 surgical center, birthing center, or health care provider is not
12-56 subject to disciplinary action, a civil penalty, an administrative
12-57 penalty, or a civil action for damages for conduct that violates
12-58 Chapter 322 or a rule adopted under that chapter before January 1,
12-59 2006.

12-60 SECTION 22. This Act takes effect immediately if it
12-61 receives a vote of two-thirds of all the members elected to each
12-62 house, as provided by Section 39, Article III, Texas Constitution.
12-63 If this Act does not receive the vote necessary for immediate
12-64 effect, this Act takes effect September 1, 2005.

12-65 * * * * *