Amend **SB 23** (House Committee Printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES of the bill accordingly:

ARTICLE ____. TEXAS CHOICE PROVIDER PROGRAM

SECTION ____.01. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1465 to read as follows:

CHAPTER 1465. TEXAS CHOICE PROVIDER PROGRAM

Sec. 1465.001. DEFINITIONS. In this chapter:

(1) "Balance bill" means the practice by which a health care provider that does not have a contract with a health benefit plan issuer charges an individual covered under a health benefit plan the difference between the provider's fee for a health care service the individual received and the amount that the health benefit plan reimbursed the provider for the health care service, excluding deductibles, copayments, coinsurance, and annual or maximum payment limits under the health benefit plan.

(2) "Choice health care provider" means a health care provider that is in the registry maintained by the department under Section 1465.003.

(3) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, a group subscriber contract issued by a health insurer, or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage only for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or

benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation insurance coverage or similar insurance coverage;

(L) automobile medical payment insurance coverage;

(M) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance coverage;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) liability insurance coverage, including general liability insurance and automobile liability insurance coverage; or

(Q) coverage that provides other limited benefits specified by federal regulations.

(4) "Health benefit plan issuer" means a health maintenance organization operating under Chapter 843, a preferred provider organization operating under Chapter 1301, an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, and any other entity that issues a health benefit plan, including:

(A) an insurance company;

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

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

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

(5) "Health care provider" means a person, corporation, facility, or institution that is:

(A) licensed by a state to provide or is otherwise lawfully providing health care services; and

(B) eligible for independent reimbursement for those health care services.

Sec. 1465.002. CONSTRUCTION WITH OTHER LAW. Notwithstanding any other law, to the extent of any conflict between a provision in this chapter and another law, the provision in this chapter prevails.

Sec. 1465.003. CREATION OF REGISTRY, LOGO, AND INFORMATION SYSTEM. The department shall:

(1) establish and maintain a registry of health care providers that have agreed to provide health care services in accordance with this chapter; and

(2) develop:

(A) a logo that health care providers that are in the registry established and maintained under Subdivision (1) may use as a designation of the provider's status as a choice health care provider; and

(B) an information system, which may include an education campaign, to inform health care service consumers of the existence of the registry and the conditions that are placed on health care providers under this chapter as a condition of being choice health care providers.

Sec. 1465.004. INCLUSION IN REGISTRY; APPLICATION AND RENEWAL; EFFECT OF INCLUSION IN REGISTRY. (a) The department by rule shall establish an application form and registration process under which a health care provider is included in the registry established and maintained under Section 1465.003.

(b) A health care provider is eligible for inclusion in the registry on application to the department and payment of the application fee under Subsection (c). The provider may renew the registration by submitting a renewal application to the department and paying the renewal fee under Subsection (c).

(c) The department shall set the application fee and renewal fee in an amount not to exceed $25.

(d) Inclusion of a health care provider in the registry does not constitute an endorsement of the provider by the department.

Sec. 1465.005. NOTICE OF STATUS AS CHOICE HEALTH CARE PROVIDER. (a) The department by rule shall develop a notice that a choice health care provider must provide to an individual covered by a health benefit plan before provision of nonemergency health care services. The notice must describe the Texas Choice Provider Program established under this chapter and inform an individual covered by a health benefit plan of the provider's status as a choice health care provider.

(b) The department by rule shall establish when and how a provider must provide the notice described in Subsection (a).

Sec. 1465.006. BENEFITS AND CONDITIONS OF INCLUSION IN REGISTRY. A choice health care provider who does not have a contract with a health benefit plan issuer:

(1) is entitled to prompt payment of a reasonable fee from a health benefit plan issuer for a health care service that is covered by the health benefit plan under which the patient is covered if:

(a) the service was provided in connection with a medical emergency;

(b) the service was provided in connection with a surgical procedure which was not prescheduled at least 48 hours before the beginning of the procedure;

(c) no network provider was reasonably available at the time and place the service was rendered, or

(d) the service was provided upon a referral by a network provider, and the referral was reasonably necessary for the health of the enrollee;

(2) may not balance bill a patient for a health care service that is covered by the health benefit plan under which the patient is covered; and

(3) may only use the logo developed by the department under Section 1465.003 if the choice health care provider has paid the annual fee under Section 1465.004.

Sec. 1465.007. CLAIM REQUIREMENTS; CALCULATION OF PENALTY. (a) A choice health care provider must submit a claim for health care services to the health benefit plan issuer in accordance with Subchapter J, Chapter 843, or Subchapters C and C-1, Chapter 1301, as applicable.

(b) In calculating any penalties payable to a choice health care provider by a health benefit plan issuer under Subchapter J, Chapter 843, or Subchapters C and C-1, Chapter 1301, the amount of a reasonable fee, as determined by the rules adopted by the commissioner under this chapter, shall be used in place of the contracted rate when there is not a contract in place between the choice health care provider and a health benefit plan issuer.

Sec. 1465.008. ARBITRATION OF DISPUTES. (a) The commissioner shall adopt rules that provide for the arbitration of disputes arising under this chapter that concern the payment or determination of the amount of a reasonable fee under this chapter.

(b) The department may require the payment of reasonable fees by choice health care providers and health benefit plan issuers for arbitration of disputes arising under this chapter. Fees imposed under this section may not exceed the actual cost of the arbitration, including administrative costs.

Sec. 1465.009. VIOLATION BY HEALTH CARE PROVIDER. (a) A violation of this chapter by a health care provider is grounds for disciplinary action and imposition of an administrative penalty by the appropriate regulatory agency that issued a license, certification, or registration to the health care provider.

(b) The regulatory agency shall:

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

(2) provide the health care provider with an opportunity to correct the violation in a timely manner.

(c) Complaints brought under this section do not require a determination of medical competency, and Section 154.058, Occupations Code, does not apply.

Sec. 1465.010. DATA COLLECTION; STATISTICAL AGENT. (a) The commissioner may collect data from health benefit plan issuers

and other sources reasonably necessary to determine reasonable fee amounts under this chapter.

(b) The commissioner may designate or contract with a qualified organization to serve as the statistical agent for the commissioner to gather data relevant for regulatory purposes or as otherwise provided by this code.

Sec. 1465.011. RULES. The commissioner may adopt rules necessary to implement this chapter, including rules to determine what constitutes a reasonable fee for the purposes of Section 1465.006(1).

SECTION ___.02. (a) The Texas Department of Insurance shall implement the registry described by Chapter 1465, Insurance Code, as added by this Act, not later than June 1, 2008.

(b) The reimbursement and fee conditions described by Section 1465.006, Insurance Code, as added by this Act, apply beginning on January 1, 2009.