BILL ANALYSIS

Senate Research Center

S.B. 1731
By: Duncan
State Affairs
8/21/2007
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

In recent years, health care costs have consistently increased. The rising cost of health care has been a prevalent point of discussion and debate for employers, providers, health plans, and patients. A major point of this discussion is the potential for inaccurate information and the absence of transparency in the costs of health care services. The disclosure of this information may help patients to make appropriate and cost-effective health care choices.

Additionally, current law has created some confusion for health care facilities regarding their authority to waive or discount co-payments, co-insurance, and deductibles, and has not provided the appropriate regulatory structure to sanction offending facilities. Some facilities in the state are waiving the utilization control measures of health plans to entice patients to use their out-of-network services while providers are authorized to balance bill patients for out-of-network services.

S.B. 1731 creates a "Consumer Guide to Health Care" on the Department of State Health Services' Internet website to provide certain information to the general public. This bill also requires that physicians and hospitals create and maintain consistent billing policies, that these policies be posted for disclosure to the patient, and to inform patients about the possibility of an out-of-network physician or provider working in an in-network facility and any potentially resultant costs to the patient. This bill requires the Texas Department of Insurance to create a new data collection program to collect certain reimbursement rates that health plans pay to insurers and to organize this information in a specific fashion. Lastly, this bill prohibits the waiving or discounting of co-payments, co-insurance, or deductibles and provides penalties for such.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 324.002, Health and Safety Code) of this bill.

Rulemaking authority is expressly granted to the Texas Medical Board in SECTION 6 (Section 101.352, Occupations Code), of this bill.

Rulemaking authority is expressly granted to the Texas Department of Insurance in SECTION 8 (Section 38.355, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 8 (Sections 38.353 and 38.354, Insurance Code), SECTION 11 (Section 1456.006, Insurance Code), and SECTION 20 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle G, Title 4, Health and Safety Code, by adding Chapter 324, as follows:

CHAPTER 324. CONSUMER ACCESS TO HEALTH CARE INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 324.001. DEFINITIONS. Defines "average charge," "billed charge," "costs," "consumer," "department," "executive commissioner," and "facility."

Sec. 324.002. RULES. Requires the executive commissioner of the Health and Human Services Commission (HHSC) to adopt and enforce rules to further the purposes of this chapter.

[Reserves Sections 324.003-324.050 for expansion.]

SUBCHAPTER B. CONSUMER GUIDE TO HEALTH CARE

Sec. 324.051. DEPARTMENT WEBSITE. (a) Requires the Department of State Health Services (DSHS) to make a consumer guide to health care (guide) available on its Internet website. Requires DSHS to include information in its guide concerning facility pricing practices and the correlation between certain prices, including variation on prices relating to certain aspects of a person's medical condition and resultant treatment.

(b) Sets forth certain information required to be included in the guide by DSHS.

(c) Requires DSHS to include in the guide an Internet link for consumers to access quality of care data from certain websites and a disclaimer noting that those linked websites .are not provided by this state or an agency of this state.

(d) Authorizes DSHS to accept gifts and grants to fund the guide. Prohibits DSHS from identifying, recognizing, or acknowledging in any format any such donors or grantors.

[Reserves Sections 324.052-324.100 for expansion.]

SUBCHAPTER C. BILLING OF FACILITY SERVICES AND SUPPLIES

Sec. 324.101. FACILITY POLICIES. (a) Requires each facility to develop, implement, and enforce written policies for the billing of facility health care services and supplies (services and supplies). Sets forth certain provisions that these policies are required to address.

(b) Requires a hospital that provides services in an emergency department of the hospital or as a result of an emergent direct admission to provide the written disclosure required under Subsection (a)(6) before discharging the patient from the emergency department or hospital, as appropriate.

(c) Requires each facility to post a clear and conspicuous notice of the availability of the policies required by Subsection (a) in the general waiting area and in the waiting areas of certain offices.

(d) Requires the facility to provide an estimate of the facility's charges for any elective inpatient admission (admission) or nonemergency outpatient surgical procedure (procedure) or other service on request and before the scheduling of either an admission, procedure, or service. Requires the estimate to be provided not later than the 10th business day after the date on which the estimate was requested. Sets forth certain issues on which the facility is required to advise the consumer requesting the estimate.

(e) Requires a facility to provide to the consumer an itemized statement of the billed services if the consumer requests this statement not later than the first anniversary of the date the person is discharged from the facility. Requires the facility to provide the statement to the consumer within 10 days of the consumer's request.

(f) Requires a facility to provide an itemized statement of billed services to a third-party payor (payor) who is actually or potentially responsible for paying all

or part of the billed services provided to a patient and who has received a claim for payment of those services. Requires the payor to request the statement from the facility and to have received a claim for payment in order to be entitled to receive a statement. Requires the request to be made not later than one year after the date on which the payor received the claim for payment. Requires the facility to provide the statement to the payor not later than the 30th day after the date on which the payor requests it. Authorizes the payor to request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies if the payor receives a claim for payment of part but not all of the billed services.

(g) Provides that a facility in violation of this section is subject to enforcement action by the appropriate licensing agency.

(h) Authorizes the facility to charge a reasonable fee for the third and subsequent copies of a statement if the consumer or a third-party payor requests more than two. Prohibits the fee from exceeding the sum of certain figures related to the cost of copying and delivering the copies.

(i) Requires a facility to refund a consumer's overpayment to the consumer within 30 days after the facility's determination that an overpayment has been made. Provides that this subsection does not apply to an overpayment related to a preferred provider benefit plan or a health maintenance organization, subject to Sections 1301.132 (Submission of Claim) and 843.350 (Overpayment), Insurance Code, respectively.

Sec. 324.102. COMPLAINT PROCESS. Requires a facility to establish and implement a procedure for handling consumer complaints and to make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. Requires the facility to advise the consumer that a complaint may be filed with DSHS and to provide the consumer with certain contact information for DSHS if the complaint cannot be resolved informally.

Sec. 324.103. CONSUMER WAIVER PROHIBITED. Prohibits the waiving, voiding, or nullification of the provisions of this chapter by a contract or an agreement between a facility and a consumer.

SECTION 2. Amends Section 108.0002(10), Health and Safety Code, to redefine "health care facility."

SECTION 3. Amends Section 108.009(k), Health and Safety Code, to require the Texas Health Care Information Council (council) to prioritize data collection efforts on inpatient and outpatient surgical and radiological procedures from hospitals, ambulatory surgical centers, and free-standing radiology centers.

SECTION 4. Amends Section 241.025, Health and Safety Code, by adding Subsection (e), to authorize the Texas Department of Health (TDH), to the extent that money received from the fees collected under this chapter exceeds the costs to TDH to conduct the activity for which the fee is imposed, to use the money to administer Chapter 324 and similar laws that require the department to provide information related to hospital care to the public. Prohibits TDH from considering the costs of administering Chapter 324 or similar laws in adopting a fee imposed under this section (License Fees).

SECTION 5. Amends Section 311.002(h), Health and Safety Code, to redefine "hospital."

SECTION 6. Amends Chapter 101, Occupations Code, by adding Subchapter H, redesignating Section 101.202, Occupations Code, as Section 101.351, transferring it to Subsection H, and further amending that section, and adding Section 101.352, as follows:

SUBCHAPTER H. BILLING

Sec. 101.351. FAILURE TO PROVIDE BILLING INFORMATION. (a) Provides that this section does not apply to a physician subject to Section 101.352, Health and Safety Code.

Sec. 101.352. BILLING POLICIES AND INFORMATION; PHYSICIANS. (a) Requires a physician to develop, implement, and enforce written policies for the billing of health care services and supplies (services and supplies). Sets forth certain issues which the policies are required to address.

(b) Requires each physician to post a clear and conspicuous notice of the availability of the policies required by Subsection (a) in the general waiting area and in the waiting areas of certain offices in which patients are reasonably expected to seek service.

(c) Requires the physician to provide an estimate of the facility's charges for any services or supplies on request of a patient who is seeking the provision of services on an out-of-network basis or who does not have coverage under certain programs. Requires the estimate to be provided not later than the 10th business day after the date the request was made. Sets forth certain issues on which the physician is required to advise the consumer requesting the estimate.

(d) Requires the physician, for services provided in an emergency department of a hospital or as a result of an emergent direct admission, to provide the estimate of charges required by Subsection (c) not later than the 10th business day after the request or before discharging the patient from the emergency department or hospital, whichever is later, as appropriate.

(e) Requires a physician to provide to the consumer an itemized statement of the billed services if the consumer requests this statement not later than the first anniversary of the date the services or supplies were provided. Requires a physician to provide the statement to the consumer within 10 days of the consumer's request.

(f) Authorizes a physician to charge a reasonable fee for the third and subsequent copies of a statement if the consumer requests more than two. Requires the Texas Medical Board (board) by rule to set the permissible fee that a physician is authorized to charge for the copying, processing, and delivering a copy of the statement.

(g) Requires a physician to provide, upon request and in plain language, a written explanation for services or supplies previously made on a bill or statement for the patient.

(h) Requires a physician to refund a consumer's overpayment to the consumer within 30 days after the physician's determination that an overpayment has been made. Provides that this subsection does not apply to an overpayment related to a preferred provider benefit plan or a health maintenance organization, subject to Section 1301.132 or 843.350, Insurance Code, respectively.

(i) Defines "physician" for purposes of this section.

SECTION 7. Amends Section 154.002, Occupations Code, by adding Subsection (c), to require the Texas Medical Board (board) to make a consumer guide to health care (guide) available on its Internet website. Requires the board to include information in its guide concerning the billing and reimbursement of health care services provided by physicians and variations in the costs of those services due to certain factors.

SECTION 8. Amends Chapter 38, Insurance Code, by adding Subchapter H, as follows:

SUBCHAPTER H. HEALTH CARE REIMBURSEMENT RATE INFORMATION

Sec. 38.351. PURPOSE OF SUBCHAPTER. Provides that the purpose of this subchapter is to authorize the Texas Department of Insurance (TDI) to collect data concerning health benefit plan reimbursement rates in a uniform format and to disseminate, on an aggregate basis for geographical regions of this state, information concerning health care costs that are derived from the data.

Sec. 38.352. DEFINITION. Defines "group health benefit plan."

Sec. 38.353. APPLICABILITY OF SUBCHAPTER. (a) Applies this subchapter only to certain issuers of a group health benefit plan.

(b) Applies this subchapter to specific plans and types of coverage provided under Chapters 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits Program), 1579 (Texas School Employees Uniform Group Health Coverage), and 1601 (Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System), Insurance Code, notwithstanding any provisions of those chapters.

(c) Applies this subchapter to a small employer health benefit plan provided under Chapter 1501 (Health Insurance Portability and Availability Act), Insurance Code, except as provided by Subsection (d).

(e) Sets forth certain health benefit plans to which this subchapter does not apply.

(e) Authorizes the commissioner of insurance (commissioner) by rule to exclude a type of health benefit plan from the requirements of this subchapter if the commissioner finds that data collected in relation to the plan would not be relevant in accomplishing the purposes of this subchapter.

Sec. 38.354. RULES. Authorizes the commissioner to adopt rules as provided by Subchapter A (Rules), Chapter 36, Insurance Code, to implement this subchapter.

Sec. 38.355. DATA CALL; STANDARDIZED FORMAT. (a) Requires each health benefit plan issuer (issuer) to submit to TDI, at the time and in the form and manner required by TDI, aggregate reimbursement rates organized by region and paid by the issuer for health care services identified by TDI.

(b) Requires TDI to require that data submitted under this section (data) be submitted in a standardized format, established by rule, to permit comparison of health care reimbursement rates. Requires TDI to develop the data submission requirements in a manner that provides for the submission of specific health care related figures, to the extent feasible.

(c) Requires TDI to specify the period for which reimbursement rates are required to be filed under this section.

(d) Authorizes TDI to contract with a private third party to obtain data. Authorizes TDI, under such a contract, to determine the aggregate data to be collected and published under Section 38.357 if consistent with the purposes of this subchapter described in Section 38.351. Requires TDI to prohibit the third party contractor from selling, leasing, or publishing the obtained data.

Sec. 38.356. CONFIDENTIALITY OF DATA. Provides that data collected under this subchapter (data) is confidential and not subject to disclosure under Chapter 552 (Public Information), Government Code, except as provided by Section 38.357, Insurance Code.

Sec. 38.357. PUBLICATION OF AGGREGATE HEALTH CARE REIMBURSEMENT RATE INFORMATION. Requires TDI to provide to the Department of State Health Services for publication, for identified regions of this state, aggregate health care reimbursement rate information derived from collected data. Prohibits the published

information from revealing the name of any health care provider or issuer. Authorizes TDI to make the information available thorough TDI's website.

Sec. 38.358. PENALTIES. Provides that an issuer that fails to submit data as required in accordance with this subchapter is subject to an administrative penalty under Chapter 84 (Administrative Penalties), Insurance Code. Provides that each day the issuer fails to submit the data as required is a separate violation for purposes of penalty assessment.

SECTION 9. Amends Section 843.155, Insurance Code, by amending Subsection (b) and adding Subsection (d), as follows:

(b) Requires a statement of certain information to be included in an annual report required to be filed by a health maintenance organization under this section (HMO report). Makes conforming changes.

(d) Requires the HMO report to be made publicly available on TDI's Internet website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by a health maintenance organization under this section.

SECTION 10. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.009, as follows:

Sec. 1301.009. ANNUAL REPORT. (a) Requires an insurer to file a report with the commissioner relating to the preferred provider benefit plan offered under this chapter (Preferred Provider Benefit Plans) and covering the preceding calendar year.

(b) Requires the report to be verified by at least two principal officers, to be in a form prescribed by the commissioner, and to include certain information.

(c) Requires the report to be made publicly available on TDI's Internet website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by insurers under this section.

(d) Provides that an insurer providing group coverage of $10 million or less in premiums or individual coverage of $2 million or less in premiums is not required to report a statement of certain information required under Subsection (b)(3)(C).

SECTION 11. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1456, as follows:

Chapter 1456. DISCLOSURE OF PROVIDER STATUS

Sec. 1456.001. DEFINITIONS. Defines "balance billing," "enrollee," "facility-based physician," "health care practitioner," and "provider network."

Sec. 1456.002. APPLICABILITY OF CHAPTER. (a) Applies this chapter to any health benefits plan that provides benefits for medical or surgical expenses incurred as a result of certain health conditions, accidents, or sicknesses, including policies, agreements, or contracts offered by certain entities, or that provides health and accident coverage through a risk pool created under Chapter 172 (Texas Political Subdivisions Uniform Group Benefits Program), Local Government Code, notwithstanding Section 172.014 (Application of Certain Laws), Local Government Code, or any other law.

(b) Applies this chapter to a person to whom a health benefit plan contracts to process or pay claims, to obtain the services of physicians or other providers to provide health care services to enrollees, or to issue verifications or preauthorizations.

(c) Provides that this chapter does not apply to Medicaid managed care programs operated under Chapter 533 (Implementation of Medicaid Manage Care Program), Government Code, Medicaid programs operated under Chapter 32 (Medicial Assistance Program), Health and Safety Code, or the state child health

plan operated under Chapter 62 (Child Health Plan for Certain Low-Income Children) or 63 (Health Benefits Plan for Certain Children), Health and Safety Code.

Sec. 1456.003. REQUIRED DISCLOSURE; HEALTH BENEFIT PLAN. (a) Requires each health benefit plan that provides health care through a provider network to provide notice to enrollees that a facility-based physician (physician) or other health care practitioner (practitioner) may not be included in the health benefit plan's provider network (provider network) and that said practitioner is authorized to balance bill the enrollee for amounts not paid by the health benefit plan.

(b) Sets forth certain areas in which the health benefit plan is required to provide the disclosure in writing to each enrollee.

(c) Requires a plan to clearly identify any facilities within the provider network in which physicians do not participate in the plan's provider network. Requires facilities identified in such a way to be identified in a separate and conspicuous manner in any provider network directory or website directory.

(d) Requires a health benefit plan to include, along with any explanation of benefits sent to an enrollee that contains a remark code indicating that a payment made to a non-network physician has been paid at the plan's allowable or usual and customary amount, the number for TDI's consumer protection division for complaints regarding payment.

Sec. 1456.004. REQUIRED DISCLOSURE; FACILITY-BASED PHYSICIANS. (a) Requires a physician who bills a patient covered by a health benefit plan described in Section 1456.002, Insurance Code, that does not have a contract with the physician, to send a billing statement including certain information. Sets forth certain information to be contained in the billing statement.

(b) Provides that a patient may be considered to be out of substantial compliance with the payment plan agreement between the patient and physician if payments are not made in compliance with the agreement for a period of 90 days.

Sec. 1456.005. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTY. (a) Authorizes the commissioner to take disciplinary action against a licensee that violates this chapter in accordance with Chapter 84, Insurance Code.

(b) Provides that a violation of this chapter by a physician is grounds for disciplinary action and imposition of an administrative penalty by the board.

(c) Requires the board to notify the physician of the board's finding that the physician is violating or has violated this chapter or a rule adopted under this chapter and to provide the physician with an opportunity to correct the violation.

Sec. 1456.006. COMMISSIONER RULES; FORM OF DISCLOSURE. Authorizes the commissioner by rule to prescribe specific requirements for the disclosure required under Section 1456.003, Insurance Code. Sets forth the required substantial language of the disclosure.

Sec. 1456.0065. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF HEALTH PLANS. (a) Defines "commissioner" and "health benefit plan."

(b) Requires the commissioner to appoint an advisory committee (committee) to study facility-based provider network adequacy of health benefit plans.

(c) Sets forth the committee's required composition.

(d) Requires the committee to advise certain governmental officials of its findings periodically and no later than December 1, 2008.

(e) Provides that committee members serve without compensation.

(f) Provides that the committee is abolished and this section expires January 1, 2009.

Sec. 1456.007. HEALTH BENEFIT PLAN ESTIMATE OF CHARGES. Requires a plan that must comply with this chapter under Section 1456.002 to provide an estimate of payments that will be made for any service or supply on request of an enrollee and to also specify certain amounts for which the enrollee is responsible. Requires the estimate to be provided not later than the 10th business day after the date on which the estimate was requested. Sets forth certain issues on which the plan is required to advise the consumer requesting the estimate.

SECTION 12. Amends Section 843.201, Insurance Code, by adding Subsection (d), to require a health maintenance organization (HMO) to provide information regarding whether a physician or provider is in the HMO's network, whether the proposed health services are covered by the health plan, and what the enrollee's personal responsibility will be for payment of applicable copayment or deductible amounts, on the enrollee's request.

SECTION 13. Amends Subchapter F, Chapter 843, Insurance Code, by adding Section 843.211, as follows:

Sec. 843.211. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. Applies Subchapter F (Relations with Enrollees and Group Contract Holders), Chapter 843, Insurance Code, to a person to whom an HMO contracts to process or pay claims, to obtain the services of physicians or providers to provide health care services to enrollees, or to issue verifications or preauthorizations.

SECTION 14. Amends Section 1301.158, Insurance Code, by adding Subsection (d), to require an insurer to provide to an insured on request certain information relating to the presence of a physician or provider in the insurer's network and any resultant affects on the payment to be made for services rendered.

SECTION 15. Amends Subchapter D, Chapter 1301, Insurance Code, by adding Section 1301.163, as follows:

Sec. 1301.163. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH INSURER. Applies this subchapter to a person to whom an insurer contracts to process or pay claims, to obtain the services of physicians or providers to provide health care services to enrollees, or to issue verifications or preauthorizations.

SECTION 16. Amends Section 1506.007, Insurance Code, by adding Subsections (a-1) and (a-2), as follows:

(a-1) Requires an issuer, employer, or other person who is required to provide notice to an individual of the individual's ability to continue coverage in accordance with Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), to also provide notice to the individual of the availability of coverage under the pool at the time that that notice is required.

(a-2) Requires an issuer who is providing coverage to an individual in accordance with Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), to notify the individual of the availability of coverage under the pool not later than the 45th day before the date that coverage expires.

SECTION 17. Makes application of this Act prospective.

SECTION 18. Requires DSHS, the board, and TDI to adopt rules as necessary to implement this Act not later than May 1, 2008, except as provided by SECTION 19 of this Act.

SECTION 19. Requires the commissioner to adopt rules as necessary to implement Subchapter H, Chapter 38, Insurance Code, as added by this Act, not later than December 31, 2007. Requires the rules to require that each issuer subject to that subchapter make the initial submission of data under that subchapter within 60 days of the effective date of the rules.

SECTION 20. (a) Requires the commissioner by rule to require each issuer subject to Chapter 1456, Insurance Code, as added by this Act, to submit information to TDI concerning the use of non-network providers by enrollees and the payments made to those providers. Requires the information to cover a 12-month period specified by the commissioner. Requires the commissioner to work with the network adequacy study group to develop the data collection and evaluate the information collected.

(b) Provides that an issuer that fails to submit data as required in accordance with this section is subject to an administrative penalty under Chapter 84, Insurance Code. Provides that each date the issuer fails to submit the data as required is a separate violation for purposes of penalty assessment.

SECTION 21. Effective date: September 1, 2007.