BILL ANALYSIS

Senate Research Center

S.B. 1731
By: Duncan
State Affairs
4/4/2007
As Filed

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 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.

As proposed, 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 patents 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 commissioner of insurance in SECTION 4 (Sections 38.352 and 38.353, Insurance Code), SECTION 5 (Section 1456.006, Insurance Code), and SECTION 16 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," "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 state entities.

(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 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.

(c) Requires the facility to provide an estimate of the facility's charges for any service or supply on request and before the scheduling of either an elective admission or nonemergency outpatient procedures or services. Requires the estimate to be provided within a reasonable time based on the number of charge estimates requested and whether the request was made during the facility's business office's normal operating hours. Sets forth certain issues on which the facility is required to advise the consumer requesting the estimate.

(d) 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.

(e) Authorizes the facility to charge a reasonable fee for the third and subsequent copies of a statement if the consumer requests more than two. Prohibits the fee from exceeding the cost to copy, process, and deliver the copy to the consumer.

(f) 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 relating to the charges for services and supplies. Requires the facility to make a good faith effort to resolve a complaint

stemming from an objection to the billed amount for a particular service or supply in an informal manner based on its complaint procedures.

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

SUBCHAPTER H. BILLING

Sec. 101.351. New heading: BILLING POLICIES AND INFORMATION. (a) Requires a health care professional (professional) to develop, implement, and enforce written policies for the billing of services and supplies. Sets forth certain provisions that these policies are required to address.

(b) Requires each professional 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.

(c) Requires the professional to provide an estimate of the facility's charges for any services or supplies on request. Requires the estimate to be provided within a reasonable time based on the number of charge estimates requested and whether the request was made during the professional's business office's normal operating hours. Sets forth certain issues on which the professional is required to advise the consumer requesting the estimate.

(d) Requires a professional 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 professional to provide the statement to the consumer within 10 days of the consumer's request.

(e) Authorizes a professional to charge a reasonable fee for the third and subsequent copies of a statement if the consumer requests more than two. Prohibits the fee from exceeding the cost to copy, process, and deliver the copy to the consumer.

(f) Redesignated from existing text. Requires a professional 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. Deletes existing text providing that the request be written.

(g) Requires a professional to refund a consumer's overpayment to the consumer within 30 days after the professional'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.

SECTION 3. 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 4. Amends Chapter 38, Insurance Code, by adding Subchapter H, as follows:

SUBCHAPTER H. HEALTH CARE COST 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 to enable consumers to compare and evaluate health care costs.

Sec. 38.352. APPLICABILITY OF SUBCHAPTER. (a) Applies this subchapter only to the issuer of a group health benefit plan that provides benefits for medical or surgical expense incurred as a result of certain health conditions, accidents, or sicknesses.

(b) Applies this chapter to the issuer of a group health benefit plan that is a preferred provider benefit plan.

(c) 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.

(d) 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 (f).

(e) Provides that this subchapter does not apply to a standard health benefit plan provided under Chapter 1507 (Consumer Choice of Benefit Plans), Insurance Code, or a children's health benefit plan provided under Chapter 1502 (Health Benefit Plans for Children), Insurance Code. Provides that this subchapter does not apply to health care benefits provided under a workers' compensation insurance policy.

(f) 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. 38.353. RULES. Authorizes the commissioner to adopt rules as provided by Subchapter A (Rules), Chapter 36, Insurance Code, to implement this subchapter.

Sec. 38.354. 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, reimbursement rates paid by the issuer for health care services and certain supporting information required by TDI.

(b) Requires TDI to require that data submitted under this section (data) be submitted in a standardized format established by TDI to permit comparison of health care costs. 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 and supporting information are required to be filed under this section.

Sec. 38.355. 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 38.356, Insurance Code.

Sec. 38.356. PUBLICATION OF AGGREGATE HEALTH CARE COST INFORMATION. Requires TDI to publish, for identified regions of this state, aggregate health care cost information derived from collected data. Prohibits the published

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

Sec. 38.357. 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 5. 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.

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.

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 the 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 appropriate regulatory agency that issued a license, certification, or registration to the physician who committed the violation.

(c) Requires the regulatory agency to notify the physician of the regulatory agency'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.

(d) Provides that the complaints brought under this section are not considered to require a determination of medical competency and that Section 154.058 (Determination of Medical Competency), Occupations Code, does not apply.

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. 1456.007. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF HEALTH PLANS. (a) Defines "commissioner" and "health plan."

(b) Requires the commissioner to direct the Technical Advisory Committee on Claim Processing (committee) to study facility-based provider network adequacy of health plans and the health plans' ability to contract with physicians.

(c) Requires the committee to advise the commissioner periodically of its findings, no later than December, 2008.

(d) Provides that committee members serve without compensation.

SECTION 6. 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 7. 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 8. Amends Section 1204.051, Insurance Code, by redefining "covered person" and defining "financially indigent" and "waiver of deductible or copayment." Makes conforming changes.

SECTION 9. Amends Section 1204.055, Insurance Code, by adding Subsections (c) through (g), as follows:

(c) Requires a physician or provider to make reasonable efforts to collect a deductible or copayment owed by a covered person (amount due).

(d) Authorizes a physician or provider to waive the amount due only if the consumer is covered by certain governmental programs, to the extent that a waiver is authorized by state or federal law, or is covered employee benefit plan or health insurance policy and is financially indigent and is unable to pay the applicable deductible or copayment amounts.

(e) Requires a physician or provider who waives the amount due to a consumer, pursuant to Subsection (d)(2), to provide notice to the consumer's plan, insurer, or third party administrator that all or part of the applicable deductible or copayment was waived, and to submit a report to TDI including certain information on each claim for which all or part of the amount due was waived.

(f) Provides that a physician or provider in violation of this section is subject to enforcement action by the physician's or the provider's licensing agency or action by the attorney general under Subsection (g).

(g) Authorizes the attorney general to institute an action for an appropriate order to restrain the physician or provider form committing or continuing to commit a violation of this article. Requires that an action under this subsection be brought in a district court of Travis County or of a county in which the violation is occurring or is about to occur. Entitles the attorney general to recover certain reasonable expenses in obtaining injunctive relief.

SECTION 10. 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 11. 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 12. Repealers: (1) Sections 311.002 (Itemized Statement of Billed Services) and 311.0025 (Audits of Billing), Health and Safety Code; and (2) Section 101.203 (Overcharging or Overtreating), Occupations Code.

SECTION 13. Makes application of this Act prospective.

SECTION 14. 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 14 [sic] of this Act.

SECTION 15. 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 16. (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 evaluate the information collected under this section and to adopt rules based on that evaluation under Section 1456.007, Insurance Code, as added by this Act, to be effective not later than March 1, 2009.

(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 17. Effective date: September 1, 2007.