By: Jackson H.B. No. 139

A BILL TO BE ENTITLED

AN ACT

relating to health services provided to health benefit plan enrollees by certain out-of-network health care providers.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:

CHAPTER 1458. DISCLOSURE OF OUT-OF-NETWORK PROVIDER STATUS; BALANCE BILLING

Sec. 1458.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(2) "Health care provider" means:

(A) an individual who is licensed to provide health care services; or

(B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.

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

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

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

(4) "Out-of-network provider" means a health care provider who is not a participating provider.

(5) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Sec. 1458.002. NOTICE OF PROVIDER STATUS AND BALANCE BILLING. (a) A participating provider shall provide written notice to an enrollee as required by this chapter if the participating provider:

(1) refers an enrollee to an out-of-network provider;

(2) is a health care facility that has granted clinical privileges to a surgeon, a radiologist, an anesthesiologist, a pathologist, or another physician who:

(A) is an out-of-network provider; and

(B) is to provide services to the enrollee as a patient of the facility; or

(3) otherwise arranges for health care services for the enrollee through an out-of-network provider.

(b) The notice required by this section must substantially comply with requirements adopted under Section 1458.004 and must disclose that the out-of-network provider:

(1) is not a participating provider for the enrollee's managed care plan; and

(2) may charge the enrollee the balance of the provider's fee for services received by the enrollee that is not

fully paid or reimbursed by the enrollee's managed care plan.

(c) The notice must include a signature line for the enrollee to sign to acknowledge that the enrollee has received the notice.

(d) An out-of-network provider may elect to provide the notice required by this section.

(e) A health care provider that provides notice under this section shall maintain a copy of the notice, signed by the enrollee, in the provider's records.

Sec. 1458.003. TIME OF NOTICE. The notice required by this chapter:

(1) must be provided to an enrollee before services are provided to the enrollee by an out-of-network provider; and

(2) must be provided, to the extent practicable, sufficiently in advance of the time the services are to be provided to allow the enrollee to select a participating provider to provide the services.

Sec. 1458.004. FORM OF NOTICE. The commissioner by rule shall adopt a form for the notice required by this chapter.

Sec. 1458.005. BALANCE BILLING PROHIBITED IF NOTICE NOT PROVIDED. If notice is not provided as required by this chapter, the out-of-network provider may not charge the enrollee for any portion of that provider's fee that is not paid or reimbursed by the enrollee's managed care plan.

Sec. 1458.006. EMERGENCY. A health care provider is not required to provide the notice required by this chapter, and Section 1458.005 does not apply, if the enrollee's treating

physician reasonably determines, in the physician's medical judgment, that an emergency exists and there is insufficient time to provide that notice.

Sec. 1458.007. RULES. The commissioner may adopt rules as necessary to implement this chapter.

SECTION 2. This Act applies only to a managed care plan that is delivered, issued for delivery, or renewed on or after January 1, 2008. A managed care plan that is delivered, issued for delivery, or renewed before January 1, 2008, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2007.