By: Zedler H.B. No. 1069

A BILL TO BE ENTITLED

AN ACT

relating to required disclosures to health benefit plan enrollees regarding professional services provided by certain non-network health care providers; providing penalties.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1456 to read as follows:

CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

Sec. 1456.001. DEFINITIONS. In this chapter:

(1) "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

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

(3) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, or an emergency department physician:

(A) to whom the facility has granted clinical privileges; and

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

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

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

(6) "Health care provider" means a health care facility or health care practitioner.

(7) "Provider network" 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 network operated by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

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

Sec. 1456.002. APPLICABILITY OF CHAPTER. This chapter applies to any health benefit plan that:

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

(A) an insurance company;

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

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

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

(E) a health maintenance organization operating under Chapter 843;

(F) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN. (a) Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:

(1) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network; and

(2) a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan.

(b) The health benefit plan shall provide the disclosure in writing to each enrollee:

(1) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;

(2) in an explanation of payment summary provided to the enrollee;

(3) in any other analogous document that describes the enrollee's benefits under the plan; or

(4) conspicuously displayed on any website that an enrollee is reasonably expected to access.

Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY. (a) Each health care facility that has entered into a contract with a health benefit plan to serve as a provider in the health benefit plan's provider network shall provide notice to enrollees receiving health care services at the facility that:

(1) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network; and

(2) a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan.

(b) The health care facility shall provide the disclosure in writing at the time the enrollee is first admitted to the facility or first receives services at the facility.

Sec. 1456.005. REQUIRED DISCLOSURE: FACILITY-BASED PHYSICIANS. If a facility-based physician bills a patient who is

covered by a health benefit plan, as described in Section 1456.002, that does not have a contract with the facility-based physician, the facility-based physician shall send a billing statement that:

(1) contains an itemized listing of the services and supplies provided along with the dates the services and supplies were provided;

(2) contains a conspicuous, plain-language explanation that:

(A) the facility-based physician is not within the provider network; and

(B) the health benefit plan has paid the usual and customary rate, as determined by the health benefit plan, which is below the facility-based physician billed amount;

(3) contains a telephone number to call to discuss the statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;

(4) contains a statement that the patient may call to discuss alternative payment arrangements;

(5) contains a notice that the patient may file complaints with the Texas Medical Board and includes the Texas Medical Board's mailing address and complaint telephone number; and

(6) for billing statements that total an amount greater than $200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 45 days of receiving the first billing statement and substantially complies with the agreement, the facility-based physician may not furnish adverse information to a

consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment for one calendar year from the first statement date. A patient may be considered by the facility-based physician to be out of substantial compliance with the payment plan agreement if payments are not made in compliance with the agreement for a period of 90 days.

Sec. 1456.006. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTY. (a) The commissioner may take disciplinary action against a health benefit plan issuer that violates this chapter in accordance with Chapter 84. A health care provider that violates this chapter is subject to disciplinary action by the appropriate regulatory agency.

(b) A violation of this chapter by a health care provider or facility-based 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 health care provider or facility-based physician who committed the violation.

(c) The regulatory agency shall:

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

(2) provide the health care provider or facility-based physician with an opportunity to correct the violation.

(d) A violation of this chapter by a physician is not considered to require a determination of medical competency, and

Section 154.058, Occupations Code, does not apply to such a violation.

Sec. 1456.007. COMMISSIONER RULES; FORM OF DISCLOSURE. The commissioner by rule may prescribe specific requirements for the disclosure required under Sections 1456.003 and 1456.004. The form of the disclosure must be substantially as follows:

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT COVERED BY YOUR HEALTH BENEFIT PLAN.

SECTION 2. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2007.