1-1 By: Van de Putte S.B. No. 380
1-2 (In the Senate - Filed January 31, 2007; February 21, 2007,
1-3 read first time and referred to Committee on State Affairs;
1-4 April 24, 2007, reported adversely, with favorable Committee
1-5 Substitute by the following vote: Yeas 8, Nays 0; April 24, 2007,
1-6 sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR S.B. No. 380 By: Williams

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to required disclosures to health benefit plan enrollees
1-11 regarding professional services provided by certain non-network
1-12 health care providers; providing administrative penalties.
1-13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-14 SECTION 1. Subtitle F, Title 8, Insurance Code, is amended
1-15 by adding Chapter 1456 to read as follows:
1-16 CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS
1-17 Sec. 1456.001. DEFINITIONS. In this chapter:
1-18 (1) "Balance billing" means the practice of charging
1-19 an enrollee in a health benefit plan that uses a provider network to
1-20 recover from the enrollee the balance of a non-network health care
1-21 provider's fee for service received by the enrollee from the health
1-22 care provider that is not fully reimbursed by the enrollee's health
1-23 benefit plan.
1-24 (2) "Enrollee" means an individual who is eligible to
1-25 receive health care services through a health benefit plan.
1-26 (3) "Facility-based physician" means a radiologist,
1-27 an anesthesiologist, a pathologist, a neonatologist, or an
1-28 emergency department physician:
1-29 (A) to whom the facility has granted clinical
1-30 privileges; and
1-31 (B) who provides services to patients of the
1-32 facility under those clinical privileges.
1-33 (4) "Health care facility" means a hospital, emergency
1-34 clinic, outpatient clinic, or other facility providing health care
1-35 services.
1-36 (5) "Health care practitioner" means an individual who
1-37 is licensed to provide and provides health care services.
1-38 (6) "Health care provider" means a health care
1-39 facility or health care practitioner.
1-40 (7) "Provider network" means a health benefit plan
1-41 under which health care services are provided to enrollees through
1-42 contracts with health care providers and that requires those
1-43 enrollees to use health care providers participating in the plan
1-44 and procedures covered by the plan. The term includes a network
1-45 operated by:
1-46 (A) a health maintenance organization;
1-47 (B) a preferred provider benefit plan issuer; or
1-48 (C) another entity that issues a health benefit
1-49 plan, including an insurance company.
1-50 Sec. 1456.002. APPLICABILITY OF CHAPTER. (a) This chapter
1-51 applies to any health benefit plan that:
1-52 (1) provides benefits for medical or surgical expenses
1-53 incurred as a result of a health condition, accident, or sickness,
1-54 including an individual, group, blanket, or franchise insurance
1-55 policy or insurance agreement, a group hospital service contract,
1-56 or an individual or group evidence of coverage that is offered by:
1-57 (A) an insurance company;
1-58 (B) a group hospital service corporation
1-59 operating under Chapter 842;
1-60 (C) a fraternal benefit society operating under
1-61 Chapter 885;
1-62 (D) a stipulated premium company operating under
1-63 Chapter 884;

2-1 (E) a health maintenance organization operating
2-2 under Chapter 843;
2-3 (F) a multiple employer welfare arrangement that
2-4 holds a certificate of authority under Chapter 846;
2-5 (G) an approved nonprofit health corporation
2-6 that holds a certificate of authority under Chapter 844; or
2-7 (H) an entity not authorized under this code or
2-8 another insurance law of this state that contracts directly for
2-9 health care services on a risk-sharing basis, including a
2-10 capitation basis; or
2-11 (2) provides health and accident coverage through a
2-12 risk pool created under Chapter 172, Local Government Code,
2-13 notwithstanding Section 172.014, Local Government Code, or any
2-14 other law.
2-15 (b) This chapter does not apply to health benefit plans that
2-16 contract with the Health and Human Services Commission for the
2-17 provision of:
2-18 (1) medical assistance under Chapter 32, Human
2-19 Resources Code; or
2-20 (2) health benefits under the state child health plan.
2-21 Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN.
2-22 (a) Each health benefit plan that provides health care through a
2-23 provider network shall provide a written notice to its enrollees
2-24 that:
2-25 (1) a facility-based physician or other health care
2-26 practitioner might not be included in the health benefit plan's
2-27 provider network; and
2-28 (2) a health care practitioner described by
2-29 Subdivision (1) may balance bill the enrollee for amounts not paid
2-30 by the health benefit plan.
2-31 (b) The health benefit plan shall provide the disclosure in
2-32 writing to each enrollee in English and Spanish. The health benefit
2-33 plan shall provide the disclosure:
2-34 (1) in any materials sent to the enrollee in
2-35 conjunction with issuance or renewal of the plan's insurance policy
2-36 or evidence of coverage;
2-37 (2) in an explanation of payment summary provided to
2-38 the enrollee;
2-39 (3) in any other analogous document that describes the
2-40 enrollee's benefits under the plan; and
2-41 (4) conspicuously displayed, on any Internet website
2-42 that an enrollee is reasonably expected to access.
2-43 Sec. 1456.004. REQUIRED DISCLOSURE: HEALTH CARE FACILITY.
2-44 (a) Each health care facility that has entered into a contract
2-45 with a health benefit plan to serve as a provider in the health
2-46 benefit plan's provider network shall provide oral information to
2-47 each enrollee receiving health care services at the facility, in
2-48 English or, if the enrollee's primary language is not English and
2-49 provision of the information is possible in that language, in the
2-50 enrollee's primary language, that:
2-51 (1) a facility-based physician or other health care
2-52 practitioner might not be included in the health benefit plan's
2-53 provider network; and
2-54 (2) a health care practitioner described by
2-55 Subdivision (1) may balance bill the enrollee for amounts not paid
2-56 by the health benefit plan.
2-57 (b) In addition to the oral information required under
2-58 Subsection (a), each health care facility that has entered into a
2-59 contract with a health benefit plan to serve as a provider in the
2-60 health benefit plan's provider network shall provide a written
2-61 notice in English and Spanish to enrollees receiving health care
2-62 services at the facility that:
2-63 (1) a facility-based physician or other health care
2-64 practitioner might not be included in the health benefit plan's
2-65 provider network; and
2-66 (2) a health care practitioner described by
2-67 Subdivision (1) may balance bill the enrollee for amounts not paid
2-68 by the health benefit plan.
2-69 (c) The health care facility shall provide the oral

3-1 information required under Subsection (a) and the written notice
3-2 required under Subsection (b) at the time the enrollee is first
3-3 admitted to the facility or first receives services at the
3-4 facility.
3-5 (d) For services provided in an emergency department of a
3-6 hospital or as a result of an emergent direct admission, the
3-7 hospital shall provide the oral information required under
3-8 Subsection (a) and the written notice required under Subsection (b)
3-9 before discharge from the emergency department or discharge from
3-10 the hospital, as appropriate.
3-11 (e) Each health care facility shall post the written notice
3-12 described by Subsection (b), in an appropriate format, in each
3-13 public reception area of the facility and in any billing office of
3-14 the facility that is accessible to the public.
3-15 Sec. 1456.005. REQUIRED DISCLOSURE: FACILITY-BASED
3-16 PHYSICIANS. (a) If a facility-based physician bills an enrollee
3-17 who is covered by a health benefit plan, as described in Section
3-18 1456.002, that does not have a contract with the facility-based
3-19 physician, the facility-based physician shall send the enrollee a
3-20 billing statement in English and Spanish that:
3-21 (1) contains an itemized listing of the services and
3-22 supplies provided along with the dates the services and supplies
3-23 were provided;
3-24 (2) contains a conspicuous, plain-language
3-25 explanation that:
3-26 (A) the facility-based physician is not within
3-27 the health plan health delivery network; and
3-28 (B) the health benefit plan has paid the usual
3-29 and customary rate, as determined by the health benefit plan, which
3-30 is below the facility-based physician billed amount;
3-31 (3) contains a telephone number to call to discuss the
3-32 statement, provide an explanation of any acronyms, abbreviations,
3-33 and numbers used on the statement, or discuss any payment issues;
3-34 (4) contains a statement that the enrollee may call to
3-35 discuss alternative payment arrangements;
3-36 (5) contains a notice that the enrollee may file
3-37 complaints with the Texas Medical Board and includes the Texas
3-38 Medical Board mailing address and complaint telephone number; and
3-39 (6) for billing statements that total an amount
3-40 greater than $200, over any applicable copayments or deductibles,
3-41 states in plain language that if the enrollee finalizes a payment
3-42 plan agreement within 45 days of receiving the first billing
3-43 statement and substantially complies with the agreement, the
3-44 facility-based physician may not furnish adverse information to a
3-45 consumer reporting agency regarding an amount owed by the enrollee
3-46 for the receipt of medical treatment.
3-47 (b) For purposes of Subsection (a)(6), an enrollee may be
3-48 considered by the facility-based physician to be out of substantial
3-49 compliance with the payment plan agreement if payments are not made
3-50 in compliance with the agreement for a period of 90 days.
3-51 Sec. 1456.006. DISCIPLINARY ACTION AND ADMINISTRATIVE
3-52 PENALTY. (a) The commissioner shall take disciplinary action
3-53 against a health benefit plan issuer that violates this chapter, in
3-54 accordance with Chapter 84. A health care provider that violates
3-55 this chapter is subject to disciplinary action by the appropriate
3-56 regulatory agency.
3-57 (b) A violation of this chapter by a health care provider or
3-58 facility-based physician is grounds for disciplinary action and
3-59 imposition of an administrative penalty by the appropriate
3-60 regulatory agency that issued a license, certification, or
3-61 registration to the health care provider or facility-based
3-62 physician who committed the violation.
3-63 (c) The regulatory agency shall:
3-64 (1) notify a health care provider or facility-based
3-65 physician of a finding by the regulatory agency that the health care
3-66 provider or facility-based physician is violating or has violated
3-67 this chapter or a rule adopted under this chapter; and
3-68 (2) provide the health care provider or facility-based
3-69 physician with an opportunity to correct the violation in a timely

4-1 manner.
4-2 (d) Complaints brought under this section do not require a
4-3 determination of medical competency, and Section 154.058,
4-4 Occupations Code, does not apply.
4-5 Sec. 1456.007. COMMISSIONER RULES; FORM OF DISCLOSURE. The
4-6 commissioner by rule may prescribe specific requirements for the
4-7 written disclosures required under Sections 1456.003 and 1456.004.
4-8 The form of the disclosure must be substantially as follows:
4-9 NOTICE
4-10 ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO
4-11 YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER
4-12 NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL
4-13 SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY
4-14 PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS
4-15 OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART
4-16 OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR
4-17 COVERED BY YOUR HEALTH BENEFIT PLAN.
4-18 SECTION 2. This Act takes effect immediately if it receives
4-19 a vote of two-thirds of all the members elected to each house, as
4-20 provided by Section 39, Article III, Texas Constitution. If this
4-21 Act does not receive the vote necessary for immediate effect, this
4-22 Act takes effect September 1, 2007.

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