

By: Duncan

S.B. No. 1731

A BILL TO BE ENTITLED

AN ACT

1
2 relating to consumer access to health care information and consumer
3 protection for services provided by or through health benefit
4 plans, hospitals, ambulatory surgical centers, birthing centers,
5 and other health care facilities; providing penalties.

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

7 SECTION 1. Subtitle G, Title 4, Health and Safety Code, is
8 amended by adding Chapter 324 to read as follows:

9 CHAPTER 324. CONSUMER ACCESS TO HEALTH CARE INFORMATION

10 SUBCHAPTER A. GENERAL PROVISIONS

11 Sec. 324.001. DEFINITIONS. In this chapter:

12 (1) "Average charge" means the mathematical average of
13 facility charges for an inpatient admission or outpatient surgical
14 procedure. The term does not include charges for a particular
15 inpatient admission or outpatient surgical procedure that exceed
16 the average by more than two standard deviations.

17 (2) "Billed charge" means the amount a facility
18 charges for an inpatient admission, outpatient surgical procedure,
19 or health care service or supply.

20 (3) "Costs" means the fixed and variable expenses
21 incurred by a facility in the provision of a health care service.

22 (4) "Consumer" means any person who is considering
23 receiving, is receiving, or has received a health care service or
24 supply as a patient from a facility. The term includes the personal

1 representative of the patient.

2 (5) "Department" means the Department of State Health
3 Services.

4 (6) "Executive commissioner" means the executive
5 commissioner of the Health and Human Services Commission.

6 (7) "Facility" means:

7 (A) an ambulatory surgical center licensed under
8 Chapter 243;

9 (B) a birthing center licensed under Chapter 244;

10 or

11 (C) a hospital licensed under Chapter 241.

12 Sec. 324.002. RULES. The executive commissioner shall
13 adopt and enforce rules to further the purposes of this chapter.

14 [Sections 324.003-324.050 reserved for expansion]

15 SUBCHAPTER B. CONSUMER GUIDE TO HEALTH CARE

16 Sec. 324.051. DEPARTMENT WEBSITE. (a) The department
17 shall make available on the department's Internet website a
18 consumer guide to health care. The department shall include
19 information in the guide concerning facility pricing practices and
20 the correlation between a facility's average charge for an
21 inpatient admission or outpatient surgical procedure and the
22 actual, billed charge for the admission or procedure, including
23 notice that the average charge for a particular inpatient admission
24 or outpatient surgical procedure will vary from the actual, billed
25 charge for the admission or procedure based on:

26 (1) the person's medical condition;

27 (2) any unknown medical conditions of the person;

1 (3) the person's diagnosis and recommended treatment
2 protocols ordered by the physician providing care to the person;
3 and

4 (4) other factors associated with the inpatient
5 admission or outpatient surgical procedure.

6 (b) The department shall include information in the guide to
7 advise consumers that:

8 (1) the average charge for an inpatient admission or
9 outpatient surgical procedure may vary between facilities
10 depending on a facility's cost structure, the range and frequency
11 of the services provided, intensity of care, and payor mix;

12 (2) the average charge by a facility for an inpatient
13 admission or outpatient surgical procedure will vary from the
14 facility's costs or the amount that the facility may be reimbursed
15 by a health benefit plan for the admission or surgical procedure;

16 (3) the consumer may be personally liable for payment
17 for an inpatient admission, outpatient surgical procedure, or
18 health care service or supply depending on the consumer's health
19 benefit plan coverage;

20 (4) the consumer should contact the consumer's health
21 benefit plan for accurate information regarding the plan structure,
22 benefit coverage, deductibles, copayments, coinsurance, and other
23 plan provisions that may impact the consumer's liability for
24 payment for an inpatient admission, outpatient surgical procedure,
25 or health care service or supply; and

26 (5) the consumer, if uninsured, may be eligible for a
27 discount on facility charges based on a sliding fee scale or a

1 written charity care policy established by the facility.

2 (c) The department shall include on the consumer guide to
3 health care website:

4 (1) an Internet link for consumers to access quality
5 of care data, including:

6 (A) the Texas Health Care Information Collection
7 website;

8 (B) the Hospital Compare website within the
9 United States Department of Health and Human Services website;

10 (C) the Joint Commission on Accreditation of
11 Healthcare Organizations website; and

12 (D) the Texas Hospital Association's Texas
13 PricePoint website; and

14 (2) a disclaimer noting the websites that are not
15 provided by this state or an agency of this state.

16 (d) The department may accept gifts and grants to fund the
17 consumer guide to health care. On the department's Internet
18 website, the department may not identify, recognize, or acknowledge
19 in any format the donors or grantors to the consumer guide to health
20 care.

21 [Sections 324.052-324.100 reserved for expansion]

22 SUBCHAPTER C. BILLING OF FACILITY SERVICES AND SUPPLIES

23 Sec. 324.101. FACILITY POLICIES. (a) Each facility shall
24 develop, implement, and enforce written policies for the billing of
25 facility health care services and supplies. The policies must
26 address:

27 (1) any discounting of facility charges to an

1 uninsured consumer, subject to Chapter 552, Insurance Code;

2 (2) any discounting of facility charges provided to a
3 financially or medically indigent consumer who qualifies for
4 indigent services based on a sliding fee scale or a written charity
5 care policy established by the facility and the documented income
6 and other resources of the consumer;

7 (3) the providing of an itemized statement required by
8 Subsection (e);

9 (4) whether interest will be applied to any billed
10 service not covered by a third-party payor and the rate of any
11 interest charged;

12 (5) the procedure for handling complaints; and

13 (6) the providing of a conspicuous written disclosure
14 to a consumer at the time the consumer is first admitted to the
15 facility or first receives services at the facility that:

16 (A) provides confirmation whether the facility
17 is a participating provider under the consumer's third-party payor
18 coverage on the date services are to be rendered based on the
19 information received from the consumer at the time the confirmation
20 is provided; and

21 (B) informs the consumer that a physician or
22 other health care provider who may provide services to the consumer
23 while in the facility may not be a participating provider with the
24 same third-party payors as the facility.

25 (b) For services provided in an emergency department of a
26 hospital or as a result of an emergent direct admission, the
27 hospital shall provide the written disclosure required by

1 Subsection (a)(6) before discharging the patient from the emergency
2 department or hospital, as appropriate.

3 (c) Each facility shall post in the general waiting area and
4 in the waiting areas of any off-site or on-site registration,
5 admission, or business office a clear and conspicuous notice of the
6 availability of the policies required by Subsection (a).

7 (d) The facility shall provide an estimate of the facility's
8 charges for any elective inpatient admission or nonemergency
9 outpatient surgical procedure or other service on request and
10 before the scheduling of the admission or procedure or service. The
11 estimate must be provided not later than the 10th business day after
12 the date on which the estimate is requested. The facility must
13 advise the consumer that:

14 (1) the request for an estimate of charges may result
15 in a delay in the scheduling and provision of the inpatient
16 admission, outpatient surgical procedure, or other service;

17 (2) the actual charges for an inpatient admission,
18 outpatient surgical procedure, or other service will vary based on
19 the person's medical condition and other factors associated with
20 performance of the procedure or service;

21 (3) the actual charges for an inpatient admission,
22 outpatient surgical procedure, or other service may differ from the
23 amount to be paid by the consumer or the consumer's third-party
24 payor;

25 (4) the consumer may be personally liable for payment
26 for the inpatient admission, outpatient surgical procedure, or
27 other service depending on the consumer's health benefit plan

1 coverage; and

2 (5) the consumer should contact the consumer's health
3 benefit plan for accurate information regarding the plan structure,
4 benefit coverage, deductibles, copayments, coinsurance, and other
5 plan provisions that may impact the consumer's liability for
6 payment for the inpatient admission, outpatient surgical
7 procedure, or other service.

8 (e) A facility shall provide to the consumer at the
9 consumer's request an itemized statement of the billed services if
10 the consumer requests the statement not later than the first
11 anniversary of the date the person is discharged from the facility.
12 The facility shall provide the statement to the consumer not later
13 than the 10th business day after the date on which the statement is
14 requested.

15 (f) A facility shall provide an itemized statement of billed
16 services to a third-party payor who is actually or potentially
17 responsible for paying all or part of the billed services provided
18 to a patient and who has received a claim for payment of those
19 services. To be entitled to receive a statement, the third-party
20 payor must request the statement from the facility and must have
21 received a claim for payment. The request must be made not later
22 than one year after the date on which the payor received the claim
23 for payment. The facility shall provide the statement to the payor
24 not later than the 30th day after the date on which the payor
25 requests the statement. If a third-party payor receives a claim for
26 payment of part but not all of the billed services, the third-party
27 payor may request an itemized statement of only the billed services

1 for which payment is claimed or to which any deduction or copayment
2 applies.

3 (g) A facility in violation of this section is subject to
4 enforcement action by the appropriate licensing agency.

5 (h) If a consumer or a third-party payor requests more than
6 two copies of the statement, the facility may charge a reasonable
7 fee for the third and subsequent copies provided. The fee may not
8 exceed the sum of:

9 (1) a basic retrieval or processing fee, which must
10 include the fee for providing the first 10 pages of the copies and
11 which may not exceed \$30;

12 (2) a charge for each page of:

13 (A) \$1 for the 11th through the 60th page of the
14 provided copies;

15 (B) 50 cents for the 61st through the 400th page
16 of the provided copies; and

17 (C) 25 cents for any remaining pages of the
18 provided copies; and

19 (3) the actual cost of mailing, shipping, or otherwise
20 delivering the provided copies.

21 (i) If a consumer overpays a facility, the facility must
22 refund the amount of the overpayment not later than the 30th day
23 after the date the facility determines that an overpayment has been
24 made. This subsection does not apply to an overpayment subject to
25 Section 1301.132 or 843.350, Insurance Code.

26 Sec. 324.102. COMPLAINT PROCESS. A facility shall
27 establish and implement a procedure for handling consumer

1 complaints, and must make a good faith effort to resolve the
2 complaint in an informal manner based on its complaint procedures.
3 If the complaint cannot be resolved informally, the facility shall
4 advise the consumer that a complaint may be filed with the
5 department and shall provide the consumer with the mailing address
6 and telephone number of the department.

7 Sec. 324.103. CONSUMER WAIVER PROHIBITED. The provisions
8 of this chapter may not be waived, voided, or nullified by a
9 contract or an agreement between a facility and a consumer.

10 SECTION 2. Subdivision (10), Section 108.002, Health and
11 Safety Code, is amended to read as follows:

12 (10) "Health care facility" means:

13 (A) a hospital;

14 (B) an ambulatory surgical center licensed under
15 Chapter 243;

16 (C) a chemical dependency treatment facility
17 licensed under Chapter 464;

18 (D) a renal dialysis facility;

19 (E) a birthing center;

20 (F) a rural health clinic; ~~or~~

21 (G) a federally qualified health center as
22 defined by 42 U.S.C. Section 1396d(1)(2)(B); or

23 (H) a free-standing imaging center.

24 SECTION 3. Subsection (k), Section 108.009, Health and
25 Safety Code, is amended to read as follows:

26 (k) The council shall collect health care data elements
27 relating to payer type, the racial and ethnic background of

1 patients, and the use of health care services by consumers. The
2 council shall prioritize data collection efforts on inpatient and
3 outpatient surgical and radiological procedures from hospitals,
4 ambulatory surgical centers, and free-standing radiology centers.

5 SECTION 4. Subsection (h), Section 311.002, Health and
6 Safety Code, is amended to read as follows:

7 (h) In this section, "hospital" includes:

8 (1) [~~a hospital licensed under Chapter 241,~~

9 [~~2~~] a treatment facility licensed under Chapter 464;

10 and

11 (2) [(3)] a mental health facility licensed under
12 Chapter 577.

13 SECTION 5. Chapter 101, Occupations Code, is amended by
14 adding Subchapter H, transferring Section 101.202 to Subchapter H
15 redesignated as Section 101.351 and further amending that section,
16 and adding Section 101.352 to read as follows:

17 SUBCHAPTER H. BILLING

18 Sec. 101.351 [~~101.202~~]. FAILURE TO PROVIDE BILLING
19 INFORMATION. On the written request of a patient, a health care
20 professional shall provide, in plain language, a written
21 explanation of the charges for professional services previously
22 made on a bill or statement for the patient. This section does not
23 apply to a physician subject to Section 101.352.

24 Sec. 101.352. BILLING POLICIES AND INFORMATION;
25 PHYSICIANS. (a) A physician shall develop, implement, and enforce
26 written policies for the billing of health care services and
27 supplies. The policies must address:

1 (1) any discounting of charges for health care
2 services or supplies provided to an uninsured patient that is not
3 covered by a patient's third-party payor, subject to Chapter 552,
4 Insurance Code;

5 (2) any discounting of charges for health care
6 services or supplies provided to an indigent patient who qualifies
7 for services or supplies based on a sliding fee scale or a written
8 charity care policy established by the physician;

9 (3) whether interest will be applied to any billed
10 health care service or supply not covered by a third-party payor and
11 the rate of any interest charged; and

12 (4) the procedure for handling complaints relating to
13 billed charges for health care services or supplies.

14 (b) Each physician who maintains a waiting area shall post a
15 clear and conspicuous notice of the availability of the policies
16 required by Subsection (a) in the waiting area and in any
17 registration, admission, or business office in which patients are
18 reasonably expected to seek service.

19 (c) On the request of a patient who is seeking services that
20 are to be provided on an out-of-network basis or who does not have
21 coverage under a government program, health insurance policy, or
22 health maintenance organization evidence of coverage, a physician
23 shall provide an estimate of the charges for any health care
24 services or supplies. The estimate must be provided not later than
25 the 10th business day after the date of the request. A physician
26 must advise the consumer that:

27 (1) the request for an estimate of charges may result

1 in a delay in the scheduling and provision of the services;

2 (2) the actual charges for the services or supplies
3 will vary based on the patient's medical condition and other
4 factors associated with performance of the services;

5 (3) the actual charges for the services or supplies
6 may differ from the amount to be paid by the patient or the
7 patient's third-party payor; and

8 (4) the patient may be personally liable for payment
9 for the services or supplies depending on the patient's health
10 benefit plan coverage.

11 (d) For services provided in an emergency department of a
12 hospital or as a result of an emergent direct admission, the
13 physician shall provide the estimate of charges required by
14 Subsection (c) before discharging the patient from the emergency
15 department or hospital, as appropriate.

16 (e) A physician shall provide a patient with an itemized
17 statement of the charges for professional services or supplies not
18 later than the 10th business day after the date on which the
19 statement is requested if the patient requests the statement not
20 later than the first anniversary of the date on which the health
21 care services or supplies were provided.

22 (f) If a patient requests more than two copies of the
23 statement, a physician may charge a reasonable fee for the third and
24 subsequent copies provided. The Texas Medical Board shall by rule
25 set the permissible fee a physician may charge for copying,
26 processing, and delivering a copy of the statement.

27 (g) On the request of a patient, a physician shall provide,

1 in plain language, a written explanation of the charges for
2 services or supplies previously made on a bill or statement for the
3 patient.

4 (h) If a patient overpays a physician, the physician must
5 refund the amount of the overpayment not later than the 30th day
6 after the date the physician determines that an overpayment has
7 been made. This subsection does not apply to an overpayment subject
8 to Section 1301.132 or 843.350, Insurance Code.

9 (i) In this section, "physician" means a person licensed to
10 practice in this state.

11 SECTION 6. Section 154.002, Occupations Code, is amended by
12 adding Subsection (c) to read as follows:

13 (c) The board shall make available on the board's Internet
14 website a consumer guide to health care. The board shall include
15 information in the guide concerning the billing and reimbursement
16 of health care services provided by physicians, including
17 information that advises consumers that:

18 (1) the charge for a health care service or supply will
19 vary based on:

20 (A) the person's medical condition;
21 (B) any unknown medical conditions of the person;
22 (C) the person's diagnosis and recommended
23 treatment protocols; and

24 (D) other factors associated with performance of
25 the health care service;

26 (2) the charge for a health care service or supply may
27 differ from the amount to be paid by the consumer or the consumer's

1 third-party payor;

2 (3) the consumer may be personally liable for payment
3 for the health care service or supply depending on the consumer's
4 health benefit plan coverage; and

5 (4) the consumer should contact the consumer's health
6 benefit plan for accurate information regarding the plan structure,
7 benefit coverage, deductibles, copayments, coinsurance, and other
8 plan provisions that may impact the consumer's liability for
9 payment for the health care services or supplies.

10 SECTION 7. Chapter 38, Insurance Code, is amended by adding
11 Subchapter H to read as follows:

12 SUBCHAPTER H. HEALTH CARE REIMBURSEMENT RATE INFORMATION

13 Sec. 38.351. PURPOSE OF SUBCHAPTER. The purpose of this
14 subchapter is to authorize the department to:

15 (1) collect data concerning health benefit plan
16 reimbursement rates in a uniform format; and

17 (2) disseminate, on an aggregate basis for
18 geographical regions in this state, information concerning health
19 care reimbursement rates derived from the data.

20 Sec. 38.352. DEFINITION. In this subchapter, "group health
21 benefit plan" means a preferred provider benefit plan as defined by
22 Section 1301.001 or an evidence of coverage for a health care plan
23 that provides basic health care services as defined by Section
24 843.002.

25 Sec. 38.353. APPLICABILITY OF SUBCHAPTER. (a) This
26 subchapter applies to the issuer of a group health benefit plan,
27 including:

- 1 (1) an insurance company;
- 2 (2) a group hospital service corporation;
- 3 (3) a fraternal benefit society;
- 4 (4) a stipulated premium company;
- 5 (5) a reciprocal or interinsurance exchange; or
- 6 (6) a health maintenance organization.

7 (b) Notwithstanding any provision in Chapter 1551, 1575,
8 1579, or 1601 or any other law, and except as provided by Subsection
9 (e), this subchapter applies to:

- 10 (1) a basic coverage plan under Chapter 1551;
- 11 (2) a basic plan under Chapter 1575;
- 12 (3) a primary care coverage plan under Chapter 1579;
- 13 and
- 14 (4) basic coverage under Chapter 1601.

15 (c) Except as provided by Subsection (d), this subchapter
16 applies to a small employer health benefit plan provided under
17 Chapter 1501.

18 (d) This subchapter does not apply to:

- 19 (1) standard health benefit plans provided under
20 Chapter 1507;
- 21 (2) children's health benefit plans provided under
22 Chapter 1502;
- 23 (3) health care benefits provided under a workers'
24 compensation insurance policy;
- 25 (4) Medicaid managed care programs operated under
26 Chapter 533, Government Code;
- 27 (5) Medicaid programs operated under Chapter 32, Human

1 Resources Code; or

2 (6) the state child health plan operated under Chapter
3 62 or 63, Health and Safety Code.

4 (e) The commissioner by rule may exclude a type of health
5 benefit plan from the requirements of this subchapter if the
6 commissioner finds that data collected in relation to the health
7 benefit plan would not be relevant to accomplishing the purposes of
8 this subchapter.

9 Sec. 38.354. RULES. The commissioner may adopt rules as
10 provided by Subchapter A, Chapter 36, to implement this subchapter.

11 Sec. 38.355. DATA CALL; STANDARDIZED FORMAT. (a) Each
12 health benefit plan issuer shall submit to the department, at the
13 time and in the form and manner required by the department,
14 aggregate reimbursement rates by region paid by the health benefit
15 plan issuer for health care services identified by the department.

16 (b) The department shall require that data submitted under
17 this section be submitted in a standardized format, established by
18 rule, to permit comparison of health care reimbursement rates. To
19 the extent feasible, the department shall develop the data
20 submission requirements in a manner that allows collection of
21 reimbursement rates as a dollar amount and not by comparison to
22 other standard reimbursement rates, such as Medicare reimbursement
23 rates.

24 (c) The department shall specify the period for which
25 reimbursement rates must be filed under this section.

26 (d) The department may contract with a private third party
27 to obtain the data under this subchapter. If the department

1 contracts with a third party, the department may determine the
2 aggregate data to be collected and published under Section 38.357
3 if consistent with the purposes of this subchapter described in
4 Section 38.351. The department shall prohibit the third party
5 contractor from selling, leasing, or publishing the data obtained
6 by the contractor under this subchapter.

7 Sec. 38.356. CONFIDENTIALITY OF DATA. Except as provided
8 by Section 38.357, data collected under this subchapter is
9 confidential and not subject to disclosure under Chapter 552,
10 Government Code.

11 Sec. 38.357. PUBLICATION OF AGGREGATE HEALTH CARE
12 REIMBURSEMENT RATE INFORMATION. The department shall provide to
13 the Department of State Health Services for publication, for
14 identified regions of this state, aggregate health care
15 reimbursement rate information derived from the data collected
16 under this subchapter. The published information may not reveal
17 the name of any health care provider or health benefit plan issuer.
18 The department may make the aggregate health care reimbursement
19 rate information available through the department's Internet
20 website.

21 Sec. 38.358. PENALTIES. A health benefit plan issuer that
22 fails to submit data as required in accordance with this subchapter
23 is subject to an administrative penalty under Chapter 84. For
24 purposes of penalty assessment, each day the health benefit plan
25 issuer fails to submit the data as required is a separate violation.

26 SECTION 8. Section 843.155, Insurance Code, is amended by
27 amending Subsection (b) and adding Subsection (d) to read as

1 follows:

2 (b) The report shall:

3 (1) be verified by at least two principal officers;

4 (2) be in a form prescribed by the commissioner; and

5 (3) include:

6 (A) a financial statement of the health
7 maintenance organization, including its balance sheet and receipts
8 and disbursements for the preceding calendar year, certified by an
9 independent public accountant;

10 (B) the number of individuals enrolled during the
11 preceding calendar year, the number of enrollees as of the end of
12 that year, and the number of enrollments terminated during that
13 year;

14 (C) a statement of:

15 (i) an evaluation of enrollee satisfaction;

16 (ii) an evaluation of quality of care;

17 (iii) coverage areas;

18 (iv) accreditation status;

19 (v) premium costs;

20 (vi) plan costs;

21 (vii) premium increases;

22 (viii) the range of benefits provided;

23 (ix) copayments and deductibles;

24 (x) the accuracy and speed of claims
25 payment by the organization;

26 (xi) the credentials of physicians of the
27 organization;

1 (xii) the number of providers;
2 (xiii) the names of network providers; and
3 (xiv) a list of the hospitals in the
4 network;

5 (D) updated financial projections for the next
6 calendar year of the type described in Section 843.078(e), until
7 the health maintenance organization has had a net income for 12
8 consecutive months; and

9 (E) [~~(D)~~] other information relating to the
10 performance of the health maintenance organization as necessary to
11 enable the commissioner to perform the commissioner's duties under
12 this chapter and Chapter 20A.

13 (d) The annual report filed by the health maintenance
14 organization shall be made publicly available on the department's
15 Internet website in a user-friendly format that allows consumers to
16 make direct comparisons of the financial and other data reported by
17 health maintenance organizations under this section.

18 SECTION 9. Subchapter A, Chapter 1301, Insurance Code, is
19 amended by adding Section 1301.009 to read as follows:

20 Sec. 1301.009. ANNUAL REPORT. (a) Not later than March 1
21 of each year, an insurer shall file with the commissioner a report
22 relating to the preferred provider benefit plan offered under this
23 chapter and covering the preceding calendar year.

24 (b) The report shall:

- 25 (1) be verified by at least two principal officers;
26 (2) be in a form prescribed by the commissioner; and
27 (3) include:

1 (A) a financial statement of the insurer,
2 including its balance sheet and receipts and disbursements for the
3 preceding calendar year, certified by an independent public
4 accountant;

5 (B) the number of individuals enrolled during the
6 preceding calendar year, the number of enrollees as of the end of
7 that year, and the number of enrollments terminated during that
8 year; and

9 (C) a statement of:

- 10 (i) an evaluation of enrollee satisfaction;
11 (ii) an evaluation of quality of care;
12 (iii) coverage areas;
13 (iv) accreditation status;
14 (v) premium costs;
15 (vi) plan costs;
16 (vii) premium increases;
17 (viii) the range of benefits provided;
18 (ix) copayments and deductibles;
19 (x) the accuracy and speed of claims
20 payment by the insurer for the plan;
21 (xi) the credentials of physicians who are
22 preferred providers;
23 (xii) the number of preferred providers;
24 (xiii) the names of preferred providers;
25 and
26 (xiv) a list of the hospitals that are
27 preferred providers.

1 (c) The annual report filed by the insurer shall be made
2 publicly available on the department's website in a user-friendly
3 format that allows consumers to make direct comparisons of the
4 financial and other data reported by insurers under this section.

5 (d) An insurer providing group coverage of \$10 million or
6 less in premiums or individual coverage of \$2 million or less in
7 premiums is not required to report the data required under
8 Subsection (b)(3)(C).

9 SECTION 10. Subtitle F, Title 8, Insurance Code, is amended
10 by adding Chapter 1456 to read as follows:

11 CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

12 Sec. 1456.001. DEFINITIONS. In this chapter:

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

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

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

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

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

1 (4) "Health care facility" means a hospital, emergency
2 clinic, outpatient clinic, birthing center, ambulatory surgical
3 center, or other facility providing health care services.

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

6 (6) "Provider network" means a health benefit plan
7 under which health care services are provided to enrollees through
8 contracts with health care providers and that requires those
9 enrollees to use health care providers participating in the plan
10 and procedures covered by the plan. The term includes a network
11 operated by:

12 (A) a health maintenance organization;

13 (B) a preferred provider benefit plan issuer; or

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

16 Sec. 1456.002. APPLICABILITY OF CHAPTER. (a) This chapter
17 applies to any health benefit plan that:

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

23 (A) an insurance company;

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

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

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

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

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

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

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

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

17 (b) This chapter applies to a person to whom a health
18 benefit plan contracts to:

19 (1) processor pay claims;

20 (2) obtain the services of physicians or other
21 providers to provide health care services to enrollees; or

22 (3) issue verifications or preauthorizations.

23 (c) This chapter does not apply to:

24 (1) Medicaid managed care programs operated under
25 Chapter 533, Government Code;

26 (2) Medicaid programs operated under Chapter 32, Human
27 Resources Code; or

1 (3) the state child health plan operated under Chapter
2 62 or 63, Health and Safety Code.

3 Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN.

4 (a) Each health benefit plan that provides health care through a
5 provider network shall provide notice to its enrollees that:

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

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

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

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

17 (2) in an explanation of payment summary provided to
18 the enrollee or in any other analogous document that describes the
19 enrollee's benefits under the plan; and

20 (3) conspicuously displayed, on any health benefit
21 plan website that an enrollee is reasonably expected to access.

22 (c) A health benefit plan must clearly identify any health
23 care facilities within the provider network in which facility-based
24 physicians do not participate in the health benefit plan's provider
25 network. Health care facilities identified under this subsection
26 must be identified in a separate and conspicuous manner in any
27 provider network directory or website directory.

1 (d) Any explanation of benefits sent to an enrollee that
2 contains a remark code indicating a payment made to a non-network
3 physician has been paid at the health benefit plan's allowable or
4 usual and customary amount shall also include the number for the
5 department's consumer protection division for complaints regarding
6 payment.

7 Sec. 1456.004. REQUIRED DISCLOSURE: FACILITY-BASED
8 PHYSICIANS. (a) If a facility-based physician bills a patient who
9 is covered by a health benefit plan described in Section 1456.002
10 that does not have a contract with the facility-based physician,
11 the facility-based physician shall send a billing statement that:

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

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

17 (A) the facility-based physician is not within
18 the health plan provider network; and

19 (B) the health benefit plan has paid a rate, as
20 determined by the health benefit plan, which is below the
21 facility-based physician billed amount;

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

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

27 (5) contains a notice that the patient may file

1 complaints with the Texas Medical Board and includes the Texas
2 Medical Board mailing address and complaint telephone number; and

3 (6) for billing statements that total an amount
4 greater than \$200, over any applicable copayments or deductibles,
5 states, in plain language, that if the patient finalizes a payment
6 plan agreement within 45 days of receiving the first billing
7 statement and substantially complies with the agreement, the
8 facility-based physician may not furnish adverse information to a
9 consumer reporting agency regarding an amount owed by the patient
10 for the receipt of medical treatment.

11 (b) A patient may be considered by the facility-based
12 physician to be out of substantial compliance with the payment plan
13 agreement if payments are not made in compliance with the agreement
14 for a period of 90 days.

15 Sec. 1456.005. DISCIPLINARY ACTION AND ADMINISTRATIVE
16 PENALTY. (a) The commissioner may take disciplinary action
17 against a licensee that violates this chapter, in accordance with
18 Chapter 84.

19 (b) A violation of this chapter by a facility-based
20 physician is grounds for disciplinary action and imposition of an
21 administrative penalty by the Texas Medical Board.

22 (c) The Texas Medical Board shall:

23 (1) notify a facility-based physician of a finding by
24 the Texas Medical Board that the facility-based physician is
25 violating or has violated this chapter or a rule adopted under this
26 chapter; and

27 (2) provide the facility-based physician with an

1 opportunity to correct the violation without penalty or reprimand.

2 Sec. 1456.006. COMMISSIONER RULES; FORM OF DISCLOSURE. The
3 commissioner by rule may prescribe specific requirements for the
4 disclosure required under Section 1456.003. The form of the
5 disclosure must be substantially as follows:

6 NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN
7 PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE
8 PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER
9 PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE
10 FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE
11 NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF
12 ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT
13 PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN."

14 Sec. 1456.0065. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF
15 HEALTH PLANS. (a) In this section:

16 (1) "Commissioner" means the commissioner of
17 insurance.

18 (2) "Health benefit plan" means an insurance policy or
19 a contract or evidence of coverage issued by a health maintenance
20 organization or an employer or employee sponsored health plan.

21 (b) The commissioner shall appoint an advisory committee to
22 study facility-based provider network adequacy of health benefit
23 plans.

24 (c) The advisory committee shall be composed of:

25 (1) one or more physician representatives;

26 (2) one or more hospital representatives;

27 (3) one or more health benefit plan representatives,

1 to equal the total number of physician and hospital
2 representatives; and

3 (4) one representative each from associations
4 representing physicians, hospitals, and health benefit plans.

5 (d) The advisory committee shall advise the commissioner
6 periodically of its findings not later than December 1, 2008.

7 (e) Members of the advisory committee serve without
8 compensation.

9 (f) The advisory committee is abolished and this section
10 expires January 1, 2009.

11 Sec. 1456.007. HEALTH BENEFIT PLAN ESTIMATE OF CHARGES. A
12 health benefit plan that must comply with this chapter under
13 Section 1456.002 shall, on the request of an enrollee, provide an
14 estimate of payments that will be made for any health care service
15 or supply and shall also specify any deductibles, copayments,
16 coinsurance, or other amounts for which the enrollee is
17 responsible. The estimate must be provided not later than the 10th
18 business day after the date on which the estimate was requested. A
19 health benefit plan must advise the enrollee that:

20 (1) the actual payment and charges for the services or
21 supplies will vary based upon the enrollee's actual medical
22 condition and other factors associated with performance of medical
23 services; and

24 (2) the enrollee may be personally liable for the
25 payment of services or supplies based upon the enrollee's health
26 benefit plan coverage.

27 SECTION 11. Section 843.201, Insurance Code, is amended by

1 adding Subsection (d) to read as follows:

2 (d) A health maintenance organization shall provide to an
3 enrollee on request information on:

4 (1) whether a physician or other health care provider
5 is a participating provider in the health maintenance
6 organization's network;

7 (2) whether proposed health care services are covered
8 by the health plan; and

9 (3) what the enrollee's personal responsibility will
10 be for payment of applicable copayment or deductible amounts.

11 SECTION 12. Subchapter F, Chapter 843, Insurance Code, is
12 amended by adding Section 843.211 to read as follows:

13 Sec. 843.211. APPLICABILITY OF SUBCHAPTER TO ENTITIES
14 CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter
15 applies to a person to whom a health maintenance organization
16 contracts to:

17 (1) process or pay claims;

18 (2) obtain the services of physicians or other
19 providers to provide health care services to enrollees; or

20 (3) issue verifications or preauthorizations.

21 SECTION 13. Section 1301.158, Insurance Code, is amended by
22 adding Subsection (d) to read as follows:

23 (d) An insurer shall provide to an insured on request
24 information on:

25 (1) whether a physician or other health care provider
26 is a participating provider in the insurer's preferred provider
27 network;

1 (2) whether proposed health care services are covered
2 by the health insurance policy;

3 (3) what the insured's personal responsibility will be
4 for payment of applicable copayment or deductible amounts; and

5 (4) coinsurance amounts owed based on the provider's
6 contracted rate for in-network services or the insurer's usual and
7 customary reimbursement rate for out-of-network services.

8 SECTION 14. Subchapter D, Chapter 1301, Insurance Code, is
9 amended by adding Section 1301.163 to read as follows:

10 Sec. 1301.163. APPLICABILITY OF SUBCHAPTER TO ENTITIES
11 CONTRACTING WITH INSURER. This subchapter applies to a person to
12 whom an insurer contracts to:

13 (1) process or pay claims;

14 (2) obtain the services of physicians or other
15 providers to provide health care services to enrollees; or

16 (3) issue verifications or preauthorizations.

17 SECTION 15. This Act applies to an insurance policy,
18 certificate, or contract or an evidence of coverage delivered,
19 issued for delivery, or renewed on or after the effective date of
20 this Act. A policy, certificate, or contract or evidence of
21 coverage delivered, issued for delivery, or renewed before the
22 effective date of this Act is governed by the law as it existed
23 immediately before the effective date of this Act, and that law is
24 continued in effect for that purpose.

25 SECTION 16. Except as provided by Section 17 of this Act,
26 the Department of State Health Services, Texas Medical Board, and
27 Texas Department of Insurance shall adopt rules as necessary to

1 implement this Act not later than May 1, 2008.

2 SECTION 17. Not later than December 31, 2007, the
3 commissioner of insurance shall adopt rules as necessary to
4 implement Subchapter H, Chapter 38, Insurance Code, as added by
5 this Act. The rules must require that each health benefit plan
6 issuer subject to that subchapter make the initial submission of
7 data under that subchapter not later than the 60th day after the
8 effective date of the rules.

9 SECTION 18. (a) The commissioner of insurance by rule
10 shall require each health benefit plan issuer subject to Chapter
11 1456, Insurance Code, as added by this Act, to submit information to
12 the Texas Department of Insurance concerning the use of non-network
13 providers by health benefit plan enrollees and the payments made to
14 those providers. The information collected must cover a 12-month
15 period specified by the commissioner of insurance. The
16 commissioner of insurance shall work with the network adequacy
17 study group to develop the data collection and evaluate the
18 information collected.

19 (b) A health benefit plan issuer that fails to submit data
20 as required in accordance with this section is subject to an
21 administrative penalty under Chapter 84, Insurance Code. For
22 purposes of penalty assessment, each day the health benefit plan
23 issuer fails to submit the data as required is a separate violation.

24 SECTION 19. This Act takes effect September 1, 2007.