BILL ANALYSIS

Senate Research Center
81R30571 PMO-D

C.S.H.B. 1342
By: Menendez, Thompson (Harris)
State Affairs
5/5/2009
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Current law does not address information technology use by health benefit plan providers. The lack of instant or real-time coverage information creates confusion and frustration for both patients and physicians.

This bill requires health benefit plan providers to use information technology to provide physicians, hospitals, or other health care providers with real-time information at the point of service. The bill also requires health benefit plan providers to use information technology to provide enrollees with information concerning the enrollee's copayment and coinsurance, deductibles, covered benefits and services and estimated financial responsibility.

C.S.H.B. 1342 amends current law relating to adoption of certain information technology.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1661.008 and 1661.009, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle J, Title 8, Insurance Code, by adding Chapter 1661, as follows:

CHAPTER 1661. INFORMATION TECHNOLOGY

Sec. 1661.001. DEFINITIONS. Defines "health benefit plan," "health benefit plan issuer," "health care provider," and "participating provider."

Sec. 1661.002. USE OF CERTAIN INFORMATION TECHNOLOGY REQUIRED. (a) Requires a health benefit plan issuer to use information technology that provides a participating provider with real-time information at the point of care concerning the enrollee's copayment and coinsurance, applicable deductibles, and covered benefits and services; and the enrollee's estimated total financial responsibility for the care.

(b) Requires a health benefit plan issuer to use information technology that provides an enrollee with information concerning the enrollee's copayment and coinsurance, applicable deductibles, covered benefits and services, and estimated financial responsibility for the health care provided to the enrollee.

(c) Provides that nothing in this section may be interpreted as a guarantee of payment for health care services.

(d) Authorizes a health benefit plan issuer's Internet website to be used to meet the information technology requirements of this chapter.

Sec. 1661.003. EXCEPTIONS. Sets forth certain health benefit plans or insurance coverage policies or programs to which this chapter does not apply.

Sec. 1661.004. REQUIRED USE OF TECHNOLOGY BY PROVIDERS. Requires a physician, hospital, or other health care provider to use information technology as required under this chapter beginning not later than September 1, 2013.

Sec. 1661.005. REFUND OF OVERPAYMENT. Requires a physician, hospital, or other health care provider that receives an overpayment from an enrollee to refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. Provides that this section does not apply to an overpayment subject to Section 843.350 (Overpayment) or 1301.132 (Overpayment).

Sec. 1661.006. HEALTH BENEFIT PLAN ISSUER CONDUCT. Prohibits a contract between a health benefit plan issuer and a physician, hospital, or other health care provider from prohibiting the physician, hospital, or health care provider from collecting, at the time of care, the estimated amount for which the enrollee may be financially responsible.

Sec. 1661.007. CERTAIN FEES PROHIBITED. Prohibits a health benefit plan issuer from directly charging or collecting from an enrollee or a physician, or other health care provider, a fee to cover the costs incurred by the health benefit plan issuer in complying with this chapter.

Sec. 1661.008. WAIVER. (a) Authorizes a health benefit plan issuer to apply to the commissioner of insurance (commissioner) for a waiver of the requirement under this chapter to use information technology.

(b) Requires the commissioner by rule to identify circumstances that justify a waiver, including undue hardship, including financial or operational hardship; the geographical area in which the health benefit plan issuer operates; the number of enrollees covered by a health benefit plan issuer; and other special circumstances.

(c) Requires the commissioner to approve or deny a waiver application under this section not later than the 60th day after the date of receipt of the application.

(d) Provides that this section expires January 1, 2012.

Sec. 1661.009. RULES. (a) Requires the commissioner to adopt rules as necessary to implement this chapter, including rules that ensure that the information technology used by a health benefit plan issuer does not have legal or technical restrictions for encoding, displaying, exchanging, reading, printing, transmitting, or storing information or data in electronic form.

(b) Requires that rules adopted by the commissioner be consistent with national standards established by the Workgroup for Electronic Data Interchange or by other similar organizations recognized by the commissioner.

SECTION 2. Effective date: upon passage or January 1, 2010.