AN ACT

relating to adoption of certain information technology.

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

SECTION 1. Subtitle J, Title 8, Insurance Code, is amended by adding Chapter 1661 to read as follows:

CHAPTER 1661. INFORMATION TECHNOLOGY

Sec. 1661.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan" means a plan that 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 Lloyd's plan operating under Chapter 941;

(F) an exchange operating under Chapter 942;

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

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

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

(J) 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.

(2) "Health benefit plan issuer" means an entity authorized to issue a health benefit plan in this state.

(3) "Health care provider" means:

(A) an individual who is licensed, certified, or otherwise authorized to provide health care services; or

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

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

Sec. 1661.002. USE OF CERTAIN INFORMATION TECHNOLOGY REQUIRED. (a) A health benefit plan issuer shall use information technology that provides a participating provider with real-time information at the point of care concerning:

(1) the enrollee's:

(A) copayment and coinsurance;

(B) applicable deductibles; and

(C) covered benefits and services; and

(2) the enrollee's estimated total financial

responsibility for the care.

(b) A health benefit plan issuer shall use information technology that provides an enrollee with information concerning the enrollee's:

(1) copayment and coinsurance;

(2) applicable deductibles;

(3) covered benefits and services; and

(4) estimated financial responsibility for the health care provided to the enrollee.

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

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

Sec. 1661.003. EXCEPTIONS. This chapter does not apply to:

(1) a health benefit plan that provides coverage only:

(A) for a specified disease or diseases or under a limited benefit policy;

(B) for accidental death or dismemberment;

(C) as a supplement to a liability insurance policy; or

(D) for dental or vision care;

(2) disability income insurance coverage;

(3) credit insurance coverage;

(4) a hospital confinement indemnity policy;

(5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(6) a workers' compensation insurance policy;

(7) medical payment insurance coverage provided under a motor vehicle insurance policy;

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section;

(9) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(10) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

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

Sec. 1661.005. REFUND OF OVERPAYMENT. A physician, hospital, or other health care provider that receives an overpayment from an enrollee must 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. This section does not apply to an overpayment subject to Section 843.350 or 1301.132.

Sec. 1661.0055. USE OF TECHNOLOGY: WAIVER. (a) Notwithstanding Section 1661.004, physicians or health care

providers with fewer than five full-time-equivalent employees are not required to use information technology as required under this chapter.

(b) A health benefit plan issuer may not require, through contract or otherwise, physicians or health care providers with fewer than five full-time-equivalent employees to use information technology as required under this chapter.

(c) A contract between the issuer of a health benefit plan and a physician or health care provider must provide for a waiver of any requirement for the use of information technology as established or required under this chapter.

(d) The commissioner shall establish the circumstances under which the requirements of this chapter do not apply to a physician or health care provider including:

(1) undue hardship, including fiscal or operational hardship; or

(2) any other special circumstance that would justify an exclusion.

(e) The commissioner shall establish circumstances under which a waiver under Subsection (c) is required, including:

(1) undue hardship, including fiscal or operational hardship; or

(2) any other special circumstance that would justify a waiver.

(f) Any physician or health care provider that is denied a waiver by a health benefit plan issuer may appeal the denial to the commissioner. The commissioner shall determine whether a waiver

must be granted.

(g) A health benefit plan issuer may not refuse to contract or renew a contract with a physician or health care provider based in whole or in part on the physician or provider requesting or receiving a waiver or appealing a waiver determination. A health benefit plan issuer may not refuse to contract or renew a contract with a physician or health care provider based in whole or in part on the physician or provider meeting the exemptions contained in Subsections (a) and (b).

(h) A waiver approved under this section expires September 1, 2013.

Sec. 1661.006. HEALTH BENEFIT PLAN ISSUER CONDUCT. A contract between a health benefit plan issuer and a physician, hospital, or other health care provider may not prohibit 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. A health benefit plan issuer may not directly charge or collect 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) A health benefit plan issuer may apply to the commissioner for a waiver of the requirement under this chapter to use information technology.

(b) The commissioner by rule shall identify circumstances that justify a waiver, including:

(1) undue hardship, including financial or operational hardship;

(2) the geographical area in which the health benefit plan issuer operates;

(3) the number of enrollees covered by a health benefit plan issuer; and

(4) other special circumstances.

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

(d) This section expires January 1, 2012.

(e) A waiver approved under this section expires September 1, 2013.

Sec. 1661.009. RULES. (a) The commissioner shall 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) Rules adopted by the commissioner must be consistent with national standards established by the Workgroup for Electronic Data Interchange or by other similar organizations recognized by the commissioner.

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 January 1, 2010.

President of the Senate

Speaker of the House

I certify that H.B. No. 1342 was passed by the House on April 28, 2009, by the following vote: Yeas 149, Nays 0, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 1342 on May 18, 2009, by the following vote: Yeas 139, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 1342 was passed by the Senate, with amendments, on May 14, 2009, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor