By: Menendez, Thompson (Senate Sponsor - Harris) H.B. No. 1342
(In the Senate - Received from the House April 29, 2009; May 1, 2009, read first time and referred to Committee on State Affairs; May 7, 2009, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; May 7, 2009, sent to printer.)

COMMITTEE SUBSTITUTE FOR H.B. No. 1342 By: Van de Putte

A BILL TO BE ENTITLED
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:

2-1 (1) copayment and coinsurance;
2-2 (2) applicable deductibles;
2-3 (3) covered benefits and services; and
2-4 (4) estimated financial responsibility for the health
2-5 care provided to the enrollee.
2-6 (c) Nothing in this section may be interpreted as a
2-7 guarantee of payment for health care services.
2-8 (d) A health benefit plan issuer's Internet website may be
2-9 used to meet the information technology requirements of this
2-10 chapter.
2-11 Sec. 1661.003. EXCEPTIONS. This chapter does not apply to:
2-12 (1) a health benefit plan that provides coverage only:
2-13 (A) for a specified disease or diseases or under
2-14 a limited benefit policy;
2-15 (B) for accidental death or dismemberment;
2-16 (C) as a supplement to a liability insurance
2-17 policy; or
2-18 (D) for dental or vision care;
2-19 (2) disability income insurance coverage;
2-20 (3) credit insurance coverage;
2-21 (4) a hospital confinement indemnity policy;
2-22 (5) a Medicare supplemental policy as defined by
2-23 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
2-24 (6) a workers' compensation insurance policy;
2-25 (7) medical payment insurance coverage provided under
2-26 a motor vehicle insurance policy;
2-27 (8) a long-term care insurance policy, including a
2-28 nursing home fixed indemnity policy, unless the commissioner
2-29 determines that the policy provides benefits so comprehensive that
2-30 the policy is a health benefit plan and should not be subject to the
2-31 exemption provided under this section;
2-32 (9) the child health plan program under Chapter 62,
2-33 Health and Safety Code, or the health benefits plan for children
2-34 under Chapter 63, Health and Safety Code; or
2-35 (10) a Medicaid managed care program operated under
2-36 Chapter 533, Government Code, or a Medicaid program operated under
2-37 Chapter 32, Human Resources Code.
2-38 Sec. 1661.004. REQUIRED USE OF TECHNOLOGY BY PROVIDERS. A
2-39 physician, hospital, or other health care provider shall use
2-40 information technology as required under this chapter beginning not
2-41 later than September 1, 2013.
2-42 Sec. 1661.005. REFUND OF OVERPAYMENT. A physician,
2-43 hospital, or other health care provider that receives an
2-44 overpayment from an enrollee must refund the amount of the
2-45 overpayment to the enrollee not later than the 30th day after the
2-46 date the physician, hospital, or health care provider determines
2-47 that an overpayment has been made. This section does not apply to an
2-48 overpayment subject to Section 843.350 or 1301.132.
2-49 Sec. 1661.006. HEALTH BENEFIT PLAN ISSUER CONDUCT. A
2-50 contract between a health benefit plan issuer and a physician,
2-51 hospital, or other health care provider may not prohibit the
2-52 physician, hospital, or health care provider from collecting, at
2-53 the time of care, the estimated amount for which the enrollee may be
2-54 financially responsible.
2-55 Sec. 1661.007. CERTAIN FEES PROHIBITED. A health benefit
2-56 plan issuer may not directly charge or collect from an enrollee or a
2-57 physician, or other health care provider, a fee to cover the costs
2-58 incurred by the health benefit plan issuer in complying with this
2-59 chapter.
2-60 Sec. 1661.008. WAIVER. (a) A health benefit plan issuer
2-61 may apply to the commissioner for a waiver of the requirement under
2-62 this chapter to use information technology.
2-63 (b) The commissioner by rule shall identify circumstances
2-64 that justify a waiver, including:
2-65 (1) undue hardship, including financial or
2-66 operational hardship;
2-67 (2) the geographical area in which the health benefit
2-68 plan issuer operates;
2-69 (3) the number of enrollees covered by a health

3-1 benefit plan issuer; and
3-2 (4) other special circumstances.
3-3 (c) The commissioner shall approve or deny a waiver
3-4 application under this section not later than the 60th day after the
3-5 date of receipt of the application.
3-6 (d) This section expires January 1, 2012.
3-7 Sec. 1661.009. RULES. (a) The commissioner shall adopt
3-8 rules as necessary to implement this chapter, including rules that
3-9 ensure that the information technology used by a health benefit
3-10 plan issuer does not have legal or technical restrictions for
3-11 encoding, displaying, exchanging, reading, printing, transmitting,
3-12 or storing information or data in electronic form.
3-13 (b) Rules adopted by the commissioner must be consistent
3-14 with national standards established by the Workgroup for Electronic
3-15 Data Interchange or by other similar organizations recognized by
3-16 the commissioner.
3-17 SECTION 2. This Act takes effect immediately if it receives
3-18 a vote of two-thirds of all the members elected to each house, as
3-19 provided by Section 39, Article III, Texas Constitution. If this
3-20 Act does not receive the vote necessary for immediate effect, this
3-21 Act takes effect January 1, 2010.

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