By: Isett H.B. No. 1577

A BILL TO BE ENTITLED

AN ACT

relating to the pricing of certain health care goods and services and to the compensation of certain health insurance agents; providing an administrative penalty.

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

SECTION 1. Subtitle B, Title 4, Health and Safety Code, is amended by adding Chapter 254 to read as follows:

CHAPTER 254. PATIENT ACCESS TO PRICING INFORMATION

Sec. 254.001. DEFINITIONS. In this chapter:

(1) "Facility" means a facility that is subject to the authority of a licensing entity and at which a health care practitioner, as defined by Section 112.001, Occupations Code, engages in a health care profession. The term includes an abortion facility licensed under Chapter 245 and an end stage renal disease facility licensed under Chapter 251. The term does not include a facility subject to Chapter 324.

(2) "Licensing entity" means a department, commission, board, office, authority, or other agency of the state that regulates the activities of and licenses a facility.

Sec. 254.002. PRICE LIST REQUIRED; AVAILABILITY. (a) Each facility shall compile a list of the price charged by the facility for each product or service provided by the facility. If the facility bundles together prices for multiple products or services provided by the facility during one treatment by or visit to the

facility, the facility shall include any price bundles used by the facility in the list compiled under this subsection.

(b) A facility shall provide a copy of the price list described by Subsection (a) to any patient at the facility who requests a copy of the list.

Sec. 254.003. POSTING REQUIRED. (a) Each facility shall post in any general waiting area maintained by the facility, including any waiting areas of off-site or on-site registration, a clear and conspicuous notice that advises patients of the availability of the price list described by Section 254.002.

(b) If a facility maintains an Internet website, the facility shall post the price list described by Section 254.002 in a clear and conspicuous place on the facility's website.

Sec. 254.004. ITEMIZED BILLING REQUIRED. (a) A facility shall provide to a patient at the patient's request an itemized statement of the products and services for which the patient was billed, if the patient requests the statement not later than the first anniversary of the date the person receives the treatment to which the statement relates. The facility shall provide the itemized statement to the patient not later than the 10th business day after the date on which the itemized statement is requested.

(b) A facility shall provide an itemized statement of billed products and services to a third-party payor who is actually or potentially responsible for paying all or part of the billed services provided to a patient and who has received a claim for payment of those services. To be entitled to receive a statement, the third-party payor must request the statement from the facility

and must have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. The facility shall provide the statement to the payor not later than the 10th day after the date on which the payor requests the statement. If a third-party payor receives a claim for payment of part but not all of the billed services, the third-party payor may request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

(c) If a licensing entity rule or another law of this state requires a facility to provide an itemized statement described by Subsection (a) or (b) before the 10th day after the date a request for the statement is made, the facility shall comply with the time frame required by the licensing entity rule or other law.

Sec. 254.005. OVERPAYMENT REFUNDS. A facility that receives payment for products or services provided to a patient by the facility that exceeds the price of those products or services published in the price list described by Section 254.002 shall, not later than the 30th day after the date the overpayment is discovered by the facility, refund to the payor the amount of the overpayment. This section does not apply to an overpayment subject to Section 843.350 or 1301.132, Insurance Code.

Sec. 254.006. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTY. A violation of this chapter is grounds for disciplinary action or the imposition of an administrative penalty by the entity that licenses the facility or health care practitioner that violates this chapter.

SECTION 2. Section 324.101, Health and Safety Code, is amended by amending Subsections (c) and (f) and adding Subsection (c-1) to read as follows:

(c) Each facility shall post in the general waiting area and in the waiting areas of any off-site or on-site registration, admission, or business office a clear and conspicuous notice concerning:

(1) [~~of~~] the availability of the policies required by Subsection (a); and

(2) the price charged by the facility for a product or service, including any price bundles used by the facility if the facility bundles together prices for multiple products or services provided by the facility during one treatment by or visit to the facility.

(c-1) If a facility maintains an Internet website, the facility shall post the prices described by Subsection (c)(2) in a clear and conspicuous place on the facility's website.

(f) A facility shall provide an itemized statement of billed services to a third-party payor who is actually or potentially responsible for paying all or part of the billed services provided to a patient and who has received a claim for payment of those services. To be entitled to receive a statement, the third-party payor must request the statement from the facility and must have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. The facility shall provide the statement to the payor not later than the 10th [~~30th~~] day after the date on which the payor

requests the statement. If a third-party payor receives a claim for payment of part but not all of the billed services, the third-party payor may request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

SECTION 3. Chapter 550, Insurance Code, is amended by adding Section 550.003 to read as follows:

Sec. 550.003. DISCLOSURE OF CERTAIN AGENT COMPENSATION REQUIRED. (a) An insurer or an affiliate of the insurer may not pay to an insurance agent, and an insurance agent may not receive from an insurer or an affiliate of the insurer, compensation for an insurance transaction that violates the disclosure requirements adopted under Section 4005.056.

(b) For purposes of this section, "affiliate" means a person or entity classified as an affiliate under Section 823.003.

SECTION 4. Chapter 552, Insurance Code, is amended to read as follows:

CHAPTER 552. PRACTICES RELATED TO [~~ILLEGAL~~] PRICING AND DISCOUNTING OF HEALTH CARE GOODS AND SERVICES [~~PRACTICES~~]

SUBCHAPTER A. PRICING PRACTICES

Sec. 552.001. APPLICABILITY OF SUBCHAPTER [~~CHAPTER~~]. (a) This subchapter [~~chapter~~] does not apply to the provision of a health care service to a:

(1) patient for which a health care provider has accepted assignment for the health care service from Medicaid or Medicare or any other [~~patient or a patient who is covered by a~~] federal, state, or local government-sponsored indigent health care

program;

(2) financially or medically indigent person who qualifies for indigent health care services based on:

(A) a sliding fee scale; or

(B) a written charity care policy established by a health care provider; or

(3) person who is not covered by a health insurance policy or other health benefit plan that provides benefits for the services and qualifies for services for the uninsured based on a written policy established by a health care provider.

(b) This subchapter [~~chapter~~] does not permit the establishment of health care provider policies or contracts that violate any other state or federal law.

[~~(c) This chapter does not prohibit a health care provider from entering into a contract to provide services covered by a health insurance policy or other health benefit plan with:~~

[~~(1) the issuer of the health insurance policy or other health benefit plan; or~~

[~~(2) a preferred provider organization that contracts with the issuer of the health insurance policy or other health benefit plan.~~]

Sec. 552.002. FRAUDULENT INSURANCE ACT. An offense under Section 552.003 is a fraudulent insurance act under Chapter 701.

Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A person commits an offense if[~~:~~

[~~(1)~~] the person knowingly, [~~or~~] intentionally, recklessly, or negligently charges two different prices for

providing the same product or service[~~; and~~

[~~(2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service~~].

(b) An offense under this section is a Class B misdemeanor.

SUBCHAPTER B. DISCOUNTS

Sec. 552.051. DEFINITION. In this subchapter, "health care provider" means an individual licensed or certified in this state to practice medicine, pharmacy, chiropractic, nursing, physical therapy, podiatry, dentistry, optometry, occupational therapy, or another healing art.

Sec. 552.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a facility subject to Chapter 254 or 324, Health and Safety Code; and

(2) a health care provider.

Sec. 552.053. ALLOWED DISCOUNTS. A facility or health care provider may provide a discount to an individual, including an individual described by Section 552.001(a)(1), (2), or (3), only if the discount is applied to that portion of the facility's or provider's bill that is the patient's responsibility after the facility or provider receives any payment to which the facility or provider is entitled from a third-party payor.

Sec. 552.054. PROHIBITED DISCOUNTS. Except as provided by Section 552.053, a facility or health care provider may not discount the price the facility or provider charges for a product or service based on whether a third-party payor, including an insurer,

will pay all or part of the price of the product or service.

Sec. 552.055. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTIES. A violation of this subchapter is grounds for disciplinary action or the imposition of an administrative penalty by the entity that licenses the facility or health care provider that violates this subchapter.

SECTION 5. Subchapter B, Chapter 4005, Insurance Code, is amended by adding Sections 4005.056 and 4005.057 to read as follows:

Sec. 4005.056. DISCLOSURE OF CERTAIN COMPENSATION REQUIRED. (a) In this section:

(1) "Affiliate" means a person or entity classified as an affiliate under Section 823.003.

(2) "Compensation" means remuneration for services rendered. The term includes payment of a salary, a fee, or a commission.

(3) "Contingent compensation" means any commission or other compensation an insurer, or an affiliate or vendor of the insurer, pays to an agent that is contingent on:

(A) the writing or procurement of an insurance product in the insurer;

(B) the procurement of an application for an insurance product in the insurer;

(C) the payment of a renewal premium; or

(D) the assumption of an insurance risk by the insurer.

(4) "Vendor of insurance" has the meaning assigned to

that term by rule by the commissioner.

(b) An agent may not accept or receive any compensation, including a commission, from an insurer, or an affiliate or vendor of the insurer, unless the agent has, before the purchase of an insurance product by a client, disclosed to the client in writing the amount of compensation to be received by the agent from the insurer, or an affiliate or vendor of the insurer, and the method of computing that compensation, including any contingent compensation.

(c) If the amount of contingent compensation is not known at the time of the disclosure required under Subsection (b), the agent must disclose:

(1) a reasonable estimate of the amount of the contingent compensation; and

(2) the method under which the contingent compensation will be computed.

(d) An agent must disclose in writing to a client before the purchase of an insurance product by the client that:

(1) the agent will receive compensation from the insurer for the sale of the insurance product by the agent to the client;

(2) the compensation received by the agent may vary depending on the insurance product and the insurer; and

(3) the agent may receive additional compensation from the insurer based on other factors, such as premium volume or persistency of business placed with a particular insurer and loss or claims experience.

(e) In addition to the information described by Subsection (d), an agent must disclose to a client before the purchase of an insurance product by the client a good faith estimate of the amount of any compensation described by Subsection (d) that the agent may receive as a result of the sale of the insurance product.

(f) An agent who violates this section is subject to disciplinary action as provided by Subchapter C.

Sec. 4005.057. DISCLOSURE OF OFFER OF COVERAGE REQUIRED. (a) An agent shall disclose all proposals or offers of coverage requested and received by the agent on behalf of a client or potential client to the client or potential client as soon as possible after receiving each proposal or offer.

(b) An agent shall make the disclosures required under Sections 4005.056(d) and (e) at the same time the agent makes the disclosure required by this section.

(c) An agent who violates this section is subject to disciplinary action as provided by Subchapter C.

SECTION 6. Section 101.352, Occupations Code, is amended by amending Subsections (b), (e), and (h) and adding Subsection (b-1) to read as follows:

(b) Each physician who maintains a waiting area shall post [~~a clear and conspicuous notice of the availability of the policies required by Subsection (a)~~] in the waiting area and in any registration, admission, or business office in which patients are reasonably expected to seek service a clear and conspicuous notice concerning:

(1) the availability of the policies required by

Subsection (a); and

(2) the price charged by the physician for a product or service, including any price bundles used by the physician if the physician bundles together prices for multiple products or services provided by the physician during one treatment by or visit to the physician.

(b-1) A physician shall make a list of prices described by Subsection (b)(2) available to any patient or third-party payor who requests a copy of the list. If a physician maintains an Internet website, the physician shall post the prices described by Subsection (b)(2) in a clear and conspicuous place on the physician's website.

(e) A physician shall provide a patient or a third-party payor who is actually or potentially responsible for paying all or part of the billed products or services with an itemized statement of the charges for professional services or supplies not later than the 10th business day after the date on which the statement is requested if the patient or third-party payor requests the statement not later than the first anniversary of the date on which the health care services or supplies were provided.

(h) If a patient overpays a physician, the physician must refund the amount of the overpayment not later than the 10th [~~30th~~] day after the date the physician determines that an overpayment has been made. This subsection does not apply to an overpayment subject to Section 1301.132 or 843.350, Insurance Code.

SECTION 7. Chapter 112, Occupations Code, is amended to read as follows:

CHAPTER 112. GENERAL [~~LICENSING~~] REQUIREMENTS APPLICABLE TO MULTIPLE HEALTH CARE PRACTITIONERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 112.001. DEFINITIONS. In this chapter:

(1) "Health care practitioner" means an individual issued a license, certificate, registration, title, permit, or other authorization to engage in a health care profession.

(2) "Licensing entity" means a department, commission, board, office, authority, or other agency of the state that regulates activities and persons under this title.

SUBCHAPTER B. SERVICES PROVIDED TO CHARITIES

Sec. 112.051 [~~112.002~~]. APPLICABILITY. This subchapter [~~chapter~~] applies only to licensing entities and health care practitioners under Chapters 401, 453, and 454 and Subtitles B, C, D, E, F, and K.

[~~SUBCHAPTER B. SERVICES PROVIDED TO CHARITIES~~]

Sec. 112.052 [~~112.051~~]. REDUCED LICENSE REQUIREMENTS FOR RETIRED HEALTH CARE PRACTITIONERS PERFORMING CHARITY WORK. (a) Each licensing entity shall adopt rules providing for reduced fees and continuing education requirements for a retired health care practitioner whose only practice is voluntary charity care.

(b) The licensing entity by rule shall define voluntary charity care.

SUBCHAPTER C. AVAILABILITY OF PRICING INFORMATION

Sec. 112.101. PRICE LIST REQUIRED; AVAILABILITY. (a) Each health care practitioner shall compile a list of the price charged by the practitioner for each product or service provided by the

health care practitioner. If the health care practitioner bundles together prices for multiple products or services provided by the practitioner during one treatment by or visit to the practitioner, the practitioner shall include any price bundles used by the practitioner in the list compiled under this subsection.

(b) A health care practitioner shall provide a copy of the price list described by Subsection (a) to any patient of the health care practitioner who requests a copy of the list.

Sec. 112.102. POSTING REQUIRED. (a) Each health care practitioner shall post in any general waiting area maintained by the practitioner, including any waiting areas of off-site or on-site registration, a clear and conspicuous notice that advises patients of the availability of the price list described by Section 112.101.

(b) If a health care practitioner maintains an Internet website, the practitioner shall post the price list described by Section 112.101 on the practitioner's website.

Sec. 112.103. ITEMIZED BILLING REQUIRED. (a) A health care practitioner shall provide to a patient at the patient's request an itemized statement of the products and services for which the patient was billed, if the patient requests the statement not later than the first anniversary of the date the person receives the treatment to which the statement relates. The health care practitioner shall provide the itemized statement to the patient not later than the 10th business day after the date on which the itemized statement is requested.

(b) A health care practitioner shall provide an itemized

statement of billed products and services to a third-party payor who is actually or potentially responsible for paying all or part of the billed services provided to a patient and who has received a claim for payment of those services. To be entitled to receive a statement, the third-party payor must request the statement from the health care practitioner and must have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. The health care practitioner shall provide the statement to the payor not later than the 10th day after the date on which the payor requests the statement. If a third-party payor receives a claim for payment of part but not all of the billed services, the third-party payor may request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

(c) If an entity that licenses a health care practitioner or another law of this state requires the practitioner to provide an itemized statement described by Subsection (a) or (b) before the 10th day after the date a request for the statement is made, the health care practitioner shall comply with the time frame required by the licensing entity or other law.

Sec. 112.104. OVERPAYMENT REFUNDS. A health care practitioner that receives payment for products or services provided to a patient by the practitioner that exceeds the price of those products or services published in the price list described by Section 112.101 shall, not later than the 30th day after the date the overpayment is discovered by the practitioner, refund to the

payor the amount of the overpayment. This section does not apply to an overpayment subject to Section 843.350 or 1301.132, Insurance Code.

Sec. 112.105. DISCIPLINARY ACTIONS AND ADMINISTRATIVE PENALTY. A violation of this subchapter is grounds for disciplinary action or the imposition of an administrative penalty by the entity that licenses the health care practitioner that violates this subchapter.

SECTION 8. A facility, physician, or health care practitioner shall compile the price list and post the notice required by Chapter 254, Health and Safety Code, as added by this Act, and Section 324.101, Health and Safety Code, Section 101.352(b), Occupations Code, and Chapter 112, Occupations Code, as amended by this Act, as applicable, not later than January 1, 2010.

SECTION 9. The change in law made by Sections 550.003 and 4005.056, Insurance Code, as added by this Act, applies to compensation paid to an insurance agent regarding a policy or contract relating to an insurance product that is entered into on or after the effective date of this Act. Compensation paid before that date is governed by the law in effect on the date the compensation was paid, and the former law is continued in effect for that purpose.

SECTION 10. 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 September 1, 2009.