By: Davis of Harris H.B. No. 1889

A BILL TO BE ENTITLED

AN ACT

relating to the electronic transmission of certain information by and to health benefit plan issuers.

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

SECTION 1. Section 1213.002, Insurance Code, is amended to read as follows:

Sec. 1213.002. ELECTRONIC SUBMISSION OF CLAIMS AND OTHER INFORMATION. (a) The issuer of a health benefit plan by contract may require that a health care professional licensed or registered under the Occupations Code or a health care facility licensed under the Health and Safety Code:

(1) electronically submit a health care claim or equivalent encounter information, a referral certification, or an authorization or eligibility transaction; and

(2) communicate electronically with the health benefit plan issuer concerning information not otherwise described by Subdivision (1).

(a-1) The health benefit plan issuer shall comply with the standards for electronic transactions required by this section and established by the commissioner by rule.

(b) The issuer of a health benefit plan by contract shall establish a default method to submit claims and other information in a nonelectronic format if there is a system failure or failures or a catastrophic event substantially interferes with the normal

business operations of the physician, provider, or health benefit plan or its agents. The health benefit plan issuer shall comply with the standards for nonelectronic transactions established by the commissioner by rule.

SECTION 2. Chapter 1274, Insurance Code, is amended to read as follows:

CHAPTER 1274. ELECTRONIC TRANSMISSION OF CERTAIN HEALTH BENEFIT PLAN INFORMATION [~~ELIGIBILITY AND PAYMENT STATUS~~]

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1274.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible for coverage under a health benefit plan, including a covered dependent.

(2) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage only for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation insurance coverage or similar insurance coverage;

(L) automobile medical payment insurance coverage;

(M) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance coverage;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) liability insurance coverage, including general liability insurance and automobile liability insurance

coverage; or

(Q) coverage that provides other limited benefits specified by federal regulations.

(3) "Health benefit plan issuer" means a health maintenance organization operating under Chapter 843, a preferred provider organization operating under Chapter 1301, an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, and any other entity that issues a health benefit plan, including:

(A) an insurance company;

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

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

(D) a stipulated premium company operating under Chapter 884.

(4) "Health care provider" means:

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a pharmacist or dentist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by

one or more hospitals and physicians, including a physician-hospital organization.

(5) "Participating provider" means:

(A) a physician or health care provider who contracts with a health benefit plan issuer to provide medical care or health care to enrollees in a health benefit plan; or

(B) a physician or health care provider who accepts and treats a patient on a referral from a physician or provider described by Paragraph (A).

(6) "Physician" means:

(A) an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

(C) a nonprofit health corporation certified under Chapter 162, Occupations Code;

(D) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) another entity wholly owned by physicians.

Sec. 1274.002. RULES. (a) The commissioner shall adopt rules as necessary to implement this chapter.

(b) Before adopting rules under this section, the commissioner shall consult and receive advice from the technical

advisory committee on claims processing established under Chapter 1212.

SUBCHAPTER B. ELIGIBILITY AND PAYMENT STATUS INFORMATION FOR HEALTH CARE PROVIDERS

Sec. 1274.051 [~~1274.0015~~]. EXEMPTION. This subchapter [~~chapter~~] does not apply to a single-service health maintenance organization that provides coverage only for dental or vision benefits.

Sec. 1274.052 [~~1274.002~~]. TRANSMISSION OF ENROLLEE ELIGIBILITY AND PAYMENT STATUS. (a) Each health benefit plan issuer shall, upon the participating provider's submission of the patient's name, relationship to the primary enrollee, and birth date, make available telephonically, electronically, or by an Internet website portal to each participating provider information maintained in the ordinary course of business and sufficient for the provider to determine at the time of the enrollee's visit information concerning:

(1) the enrollee, including:

(A) the enrollee's identification number assigned by the health benefit plan issuer;

(B) the name of the enrollee and all covered dependents, if appropriate;

(C) the birth date of the enrollee and the birth dates of all covered dependents, if appropriate;

(D) the gender of the enrollee and the gender of each covered dependent, if appropriate; and

(E) the current enrollment and eligibility

status of the enrollee under the health benefit plan;

(2) the enrollee's benefits, including:

(A) whether a specific type or category of service is a covered benefit; and

(B) excluded benefits or limitations, both group and individual; and

(3) the enrollee's financial information, including:

(A) copayment requirements, if any; and

(B) the unmet amount of the enrollee's deductible or enrollee financial responsibility.

(b) Information required to be made available under this section may be made available only to a participating provider who is authorized under state and federal law to receive personally identifiable information on an enrollee or dependent.

Sec. 1274.053 [~~1274.003~~]. CERTAIN CHARGES PROHIBITED. A health benefit plan issuer may not directly or indirectly charge or hold a physician, health care provider, or enrollee responsible for a fee for making available or accessing information under this subchapter [~~chapter~~].

Sec. 1274.054 [~~1274.004. RULES. (a) The commissioner shall adopt rules as necessary to implement this chapter.~~

[~~(b) Before adopting rules under this section, the commissioner shall consult and receive advice from the technical advisory committee on claims processing established under Chapter 1212.~~

[~~Sec. 1274.005~~]. WAIVER OF CERTAIN PROVISIONS FOR CERTAIN FEDERAL PLANS. If the commissioner, in consultation with the

executive commissioner of health and human services, determines that a provision of Section 1274.052 [~~1274.002~~] will cause a negative fiscal impact on the state with respect to providing benefits or services under Subchapter XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), or Subchapter XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), the commissioner [~~of insurance~~] by rule shall waive the application of that provision to the providing of those benefits or services.

SUBCHAPTER C. COMMUNICATIONS WITH ENROLLEES

Sec. 1274.101. ELECTRONIC TRANSMISSION OF ENROLLEE DOCUMENTS AUTHORIZED. (a) Except as provided by Subsection (b), a health benefit plan issuer may electronically provide an enrollee with any document to which the enrollee is entitled.

(b) A health benefit plan issuer must provide an enrollee with a paper copy of any document to which the enrollee is entitled, if the enrollee requests in writing that documents be provided to the enrollee in paper form.

SECTION 3. Section 1213.003, Insurance Code, is repealed.

SECTION 4. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2010. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2010, is covered by the law in effect at the time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2009.