By: Bonnen of Galveston H.B. No. 3727

A BILL TO BE ENTITLED

AN ACT

relating to the provision of health care payment information and related information for health care services, supplies, and procedures; authorizing enforcement and penalties.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1470 to read as follows:

CHAPTER 1470. DISCLOSURE OF PAYMENT AND COMPENSATION METHODOLOGY

Sec. 1470.001. DEFINITIONS. In this chapter, unless the context otherwise requires:

(1) "Edit" means a practice or procedure under which an adjustment is made regarding procedure codes that results in:

(A) payment for some, but not all, of the health care procedures performed under a procedure code;

(B) payment made under a different procedure code;

(C) a reduced payment as a result of services provided to a patient that are claimed under more than one procedure code on the same service date;

(D) a reduced payment related to a modifier used with a procedure code; or

(E) a reduced payment based on multiple units of the same procedure code billed for a single date of service.

(2) "Health benefit plan issuer" means:

(A) an insurance company, association, organization, group hospital service corporation, health maintenance organization, or pharmacy benefit manager that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits and includes:

(i) a life, health, or accident insurance company operating under Chapter 841 or 982;

(ii) a general casualty insurance company operating under Chapter 861;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a mutual life insurance company operating under Chapter 882;

(v) a local mutual aid association operating under Chapter 886;

(vi) a statewide mutual assessment company operating under Chapter 881;

(vii) a mutual assessment company or mutual assessment life, health, and accident association operating under Chapter 887;

(viii) a mutual insurance company operating under Chapter 883 that writes coverage other than life insurance;

(ix) a Lloyd's plan operating under Chapter 941;

(x) a reciprocal exchange operating under Chapter 942;

(xi) a stipulated premium insurance company operating under Chapter 884;

(xii) an exchange operating under Chapter 942;

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

(xiv) a Medicaid managed care program operated under Chapter 533, Government Code;

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

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

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

(B) the state Medicaid program operated under Chapter 32, Human Resources Code, or the state child health plan or health benefits plan for children under Chapter 62 or 63, Health and Safety Code;

(C) the Employees Retirement System of Texas or another entity issuing or administering a basic coverage plan under Chapter 1551;

(D) the Teacher Retirement System of Texas or

another entity issuing or administering a basic plan under Chapter 1575 or a primary care coverage plan under Chapter 1579;

(E) The Texas A&M University System or The University of Texas System or another entity issuing or administering basic coverage under Chapter 1601; and

(F) an entity issuing or administering medical benefits provided under a workers' compensation insurance policy or otherwise under Title 5, Labor Code.

(3) "Health care contract" means a contract entered into or renewed between a health care contractor and a physician or health care provider for the delivery of health care services to others.

(4) "Health care contractor" means an individual or entity that has as a business purpose contracting with physicians or health care providers for the delivery of health care services. The term includes a health benefit plan issuer, an administrator regulated under Chapter 4151, and a pharmacy benefit manager that administers or manages prescription drug benefits.

(5) "Health care provider" means an individual or entity that furnishes goods or services under a license, certificate, registration, or other authority issued by this state to diagnose, prevent, alleviate, or cure a human illness or injury. The term includes a physician or a hospital or other health care facility.

(6) "Physician" means:

(A) an individual licensed to engage in the practice of medicine in this state; or

(B) an entity organized under Subchapter B, Chapter 162, Occupations Code.

(7) "Procedure code" means an alphanumeric code used to identify a specific health procedure performed by a health care provider. The term includes:

(A) the American Medical Association's Current Procedural Terminology code, also known as the "CPT code";

(B) the Centers for Medicare and Medicaid Services Health Care Common Procedure Coding System; and

(C) other analogous codes published by national organizations and recognized by the commissioner.

Sec. 1470.002. DEFINITION OF MATERIAL CHANGE. For purposes of this chapter, "material change" means a change to a contract that decreases the health care provider's payment or compensation.

Sec. 1470.003. APPLICABILITY OF CHAPTER. This chapter does not apply to an employment contract or arrangement between health care providers.

Sec. 1470.004. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of this chapter.

Sec. 1470.005. REQUIRED DISCLOSURE OF PAYMENT AND COMPENSATION TERMS. (a) Each health care contract must include a disclosure form that states, in plain language, payment and compensation terms for the provision of health care services, supplies or procedures. The form must include information sufficient for a health care provider to determine the compensation or payment for the provider's services.

(b) The disclosure form under Subsection (a) must include:

(1) the manner of payment, such as fee-for-service, capitation, or risk sharing;

(2) the methodology used to compute any fee schedule, such as the use of a relative value unit system and conversion factor, percentage of Medicare payment system, or percentage of billed charges;

(3) the fee schedule for procedure codes reasonably expected to be billed by the health care provider for services provided under the contract and, on request, the fee schedule for other procedure codes used by, or that may be used by, the health care provider; and

(4) the effect of edits, if any, on payment or compensation.

(c) As applicable, the methodology disclosure under Subsection (b)(2) must include:

(1) the name of any relative value system used;

(2) the version, edition, or publication date of that system;

(3) any applicable conversion or geographic factors; and

(4) the date by which compensation or fee schedules may be changed by the methodology, if allowed under the contract.

(d) The fee schedule described by Subsection (b)(3) must include, as applicable, service or procedure codes and the associated payment or compensation for each code. The fee schedule may be provided electronically.

(e) A health care contractor shall provide the fee schedule described by Subsection (b)(3) to an affected health care provider when a material change related to payment or compensation occurs. Additionally, a health care provider may request that a written fee schedule be provided up to twice annually, and the health care contractor must provide the written fee schedule within 10 business days.

(f) A health care contractor may satisfy the requirement under Subsection (b)(4) regarding the effect of edits by providing a clearly understandable, readily available mechanism that allows a health care provider to determine the effect of an edit on payment or compensation before a service is provided or a claim is submitted.

Sec. 1470.006. ENFORCEMENT. (a) The commissioner shall adopt rules as necessary to enforce the provisions of this chapter, including the imposition of administrative penalties.

(b) A violation of Section 1470.005 is a deceptive act or practice in insurance under Subchapter B, Chapter 541.

SECTION 2. Chapter 1470, Insurance Code, as added by this Act, applies only to a health care contract that is entered into or renewed on or after January 1, 2016. A health care contract entered into before January 1, 2014, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2015.