**BILL ANALYSIS**

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| Senate Research Center | C.S.S.B. 1232 |
| 89R24127 MPF-F | By: Hancock |
|  | Health & Human Services |
|  | 5/8/2025 |
|  | Committee Report (Substituted) |

**AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

In health care, there are often charges on a patient's bill that are mysterious or do not make sense to the person who received the care. This is specifically happening when patients see a doctor who is working in an office or clinic owned by a hospital. Hospitals are permitted by law to charge an extra "facility fee" in order to pay for the equipment and other supplies to offer the needed care in a hospital setting.

More recently, hospital systems have begun acquiring physician clinics and other outpatient services, and oftentimes these systems have begun billing for clinic services as if they were provided at the hospital. These added "facility fees" do not identify that the service was in fact not provided at a hospital.

S.B. 1232 addresses facility fees to ensure clarity around when and how they are used, protecting patients from the added cost and ensuring accurate billing to enable payers to process claims fairly and protect patients.

Bill Analysis

Key provisions of S.B. 1232 include amending Section 328.002 of the Health and Safety Code to prohibit a facility fee for most telehealth health services. It also includes a 90-day advance notice requirement to payers about newly imposed facility fees or acquisitions, so insurers may be able to adjust networks or negotiate facility fees. It also requires 10-day advance notice to patients of a service outside of a hospital where a facility fee will be added.

S.B. 1232 also creates a phased-in process to improve health claim form accuracy regarding facility fees. Improved claim accuracy is designed to resolve many of the problems that consumers have been experiencing.  First, Section 328.003 of the Health and Safety Code requires claim forms to include a "place of service code modifier" that enables payers to know what kind of facility the service was performed in. Second, Section 328.004 requires each facility to obtain a unique national provider identifier (NPI) and requires that unique NPI be used on a health care claim to specify the exact location where a patient received care and ensure appropriate billing. These NPI requirements will have delayed effective dates, starting in 2031, to allow hospitals and HHSC to work out technical implementation issues that may arise.

In Summary

During the 88th Legislative Session, S.B. 1275/H.B. 1692 included a complete ban on facility fees off a hospital's campus, as well as a provision to allow the executive commissioner of the Health and Human Services Commission to identify services at a hospital that also should not have facility fees.

This refiled bill is more narrowly tailored. It prohibits facility fees only for telehealth services, increases transparency around the imposition of facility fees for both patients and insurers, and fixes the inaccurate billing issues by requiring the use of a unique NPI for every facility to enable accurate claims processing.

C.S.S.B. 1232 amends current law relating to certain health care transaction fees and payment claims and provides an administrative penalty.

**RULEMAKING AUTHORITY**

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 328.006, Health and Safety Code) of this bill.

Rulemaking authority is expressly granted to the executive head of a state regulatory authority with jurisdiction over a health care provider in SECTION 1 (Section 328.006, Health and Safety Code) of this bill.

**SECTION BY SECTION ANALYSIS**

SECTION 1. Amends Subtitle G, Title 4, Health and Safety Code, by adding Chapter 328, as follows:

CHAPTER 328. FACILITY FEES

Sec. 328.001. DEFINITIONS. Defines "commission," "executive commissioner," "facility fee," "health care provider," "health care provider campus," "hospital," "hospital-owned facility," "independent physician or physician group," "place of service code," "provider-based outpatient facility," "telehealth service," "telemedicine medical service," and "third party payor."

Sec. 328.002. PROHIBITED FACILITY FEES. Prohibits a health care provider from charging a facility fee for telehealth services or telemedicine medical services.

Sec. 328.003. REQUIRED PLACE OF SERVICE CODE. Requires a health care provider to include a valid place of service code for the setting where a health care service was provided on each claim for reimbursement submitted for the health care service provided by the provider.

Sec. 328.004. NOTICE OF FACILITY FEE. (a) Requires a health care provider to provide to a patient written notice of a facility fee charged for a health care service or supply provided to the patient at, if the provider is a hospital, a hospital-owned facility or a provider-based outpatient facility that meets certain criteria.

(b) Requires that the written notice required under Subsection (a), except as provided by Subsection (c), be provided to the patient not later than the 10th day before the date scheduled for provision of the health care service or supply or in accordance with Section 324.101 or 45 C.F.R. Section 149.610, as applicable.

(c) Requires a health care provider to provide the written notice required under Subsection (a) on the date the health care service or supply is provided if the provision of the health care service or supply is scheduled less than 10 days before that date or in accordance with Section 324.101 or 45 C.F.R. Section 149.610, as applicable.

(d) Requires that the written notice required under Subsection (a) include the amount of the facility fee or, if the exact health care service or supply to be provided is not known, an explanation that the patient may incur a cost-share or coinsurance expense unless the service or supply is provided by an independent physician or physician group, the purpose of the facility fee, and if the third party payor of a patient's health benefit plan provides the information to a health care provider before the date the notice is required, information on whether the health benefit plan covers the facility fee.

(e) Requires a health care provider, before the provider is authorized to begin charging a facility fee for provision of a health care service or supply at a newly built provider-based outpatient facility, at a provider-based outpatient facility or hospital-owned facility that did not previously charge a facility fee, or for a health care service or supply that did not previously include a facility fee charge, to notify all contracted third party payors of the provider's intent to begin charging facility fees not later than the 90th day before the date the provider begins charging the facility fee.

(f) Prohibits a health care provider from charging a patient or third party payor a facility fee at a provider-based outpatient facility or hospital-owned facility unless the provider provides notice as required by this section.

Sec. 328.005. ENFORCEMENT. (a) Requires the Health and Human Services Commission (HHSC) or appropriate state regulatory authority with jurisdiction over a health care provider to assess an administrative penalty in an amount not to exceed $1,000 for each violation against a health care provider that violates this chapter or a rule adopted under this chapter.

(b) Provides that this section does not create a private cause of action against a provider for legal or equitable relief.

Sec. 328.006. RULES. (a) Authorizes the executive commissioner of HHSC to adopt rules to implement this chapter.

(b) Authorizes the executive head of a state regulatory authority with jurisdiction over a health care provider to adopt rules regarding the duties of a health care provider under this chapter and disciplinary action to be taken against a health care provider that violates this chapter.

SECTION 2. (a) Defines "third party payor" and "independent physician or physician group."

(b) Requires The University of Texas Health Science Center at Houston, using the Texas All Payor Claims Database established under Subchapter I (Texas All Payor Claims Database), Chapter 38 (Data Collection and Reports), Insurance Code, and in cooperation with HHSC and the Department of State Health Services, to conduct a study on health care facility fees charged in this state.

(c) Requires that the study include certain elements.

(d) Requires The University of Texas Health Science Center at Houston, not later than December 1, 2026, to submit to the legislature a written report on the findings of the study conducted under this section.

(e) Provides that this section expires September 1, 2027.

SECTION 3. Provides that The University of Texas Health Science Center at Houston is required to conduct the study and make the report required by Section 2 of this Act only if the legislature appropriates money specifically for that purpose. Provides that if the legislature does not appropriate money specifically for that purpose, the center is authorized to, but is not required to, implement those requirements using other money available to the center for that purpose.

SECTION 4. Effective date, except as provided by Subsection (b) of this section: September 1, 2025.

(b) Effective date, Section 328.004, Health and Safety Code, as added by this Act: January 1, 2026.