By: Phelan H.B. No. 4855

A BILL TO BE ENTITLED

AN ACT

relating to a patient's access to health records and access to and exchange of certain health benefit plan information; authorizing a civil penalty; authorizing fees.

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

SECTION 1. Section 15.05, Business & Commerce Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) It is unlawful for a person to place a restraint on trade or commerce by intentionally violating federal laws regulating information blocking, as that term is defined by 45 C.F.R. Section 171.103.

SECTION 2. Section 181.001(b), Health and Safety Code, is amended by adding Subdivision (3-a) to read as follows:

(3-a) "Information blocking" has the meaning assigned by 45 C.F.R. Section 171.103.

SECTION 3. Section 181.004(a), Health and Safety Code, is amended to read as follows:

(a) A covered entity, as that term is defined by 45 C.F.R. Section 160.103, shall comply with:

(1) the Health Insurance Portability and Accountability Act and Privacy Standards; and

(2) federal laws regulating information blocking.

SECTION 4. Section 181.102, Health and Safety Code, is amended to read as follows:

Sec. 181.102. CONSUMER ACCESS TO [~~ELECTRONIC~~] HEALTH RECORDS. (a) Subject to the payment of fees required under this section, a patient or the patient's legally authorized representative on request is entitled to copies of the patient's physical or electronic health records.

(b) Except as provided by Subsection (d) [~~(b)~~], if a health care provider is using an electronic health records system that is capable of fulfilling the request, the health care provider, as soon as practicable but not later than the 15th business day after the date the health care provider receives a written request from a person for the person's electronic health record, shall provide the requested record to the person in electronic form unless the person agrees to accept the record in another form.

(c) Except as provided by Subsection (d) and Section 181.105, a health care provider's violation of federal laws regulating information blocking constitutes a violation of this section.

(d) [~~(b)~~] A health care provider is not required to provide access to a person's protected health information that is excepted from access, or to which access may be denied, under 45 C.F.R. Section 164.524.

(e) [~~(c)~~] For purposes of this section [~~Subsection (a)~~], the executive commissioner, in consultation with the department, the Texas Medical Board, and the Texas Department of Insurance, by rule may recommend a standard electronic format for the release of requested health records. The standard electronic format recommended under this section must be consistent, if feasible,

with federal law regarding the release of electronic health records.

(f) A covered entity that receives a request from a patient or the patient's legally authorized representative for a copy of the patient's health records may charge a fee to produce those records in an amount consistent with the requirements under 45 C.F.R. Section 164.524, except a covered entity may not charge an aggregate amount that exceeds $100 to produce the records if:

(1) the patient is a Medicaid recipient; or

(2) the patient's household income is at or below 200 percent of the federal poverty level.

(g) A covered entity shall post in a conspicuous location for patients requesting health records notice of the option to obtain a copy of the patient's health records under Subsection (f).

(h) A covered entity may require a patient or the patient's legally authorized representative to submit a written or electronic request for copies of the patient's health records but may not require a patient or the patient's legally authorized representative to submit a request by facsimile.

(i) Unless explicitly authorized by state or federal law, a covered entity may not enter into a contract with terms restricting a patient or the patient's legally authorized representative from accessing the patient's health records. Any contract clause or provision that restricts a patient or the patient's legally authorized representative from accessing the patient's health records is unenforceable.

SECTION 5. Subchapter C, Chapter 181, Health and Safety

Code, is amended by adding Section 181.105 to read as follows:

Sec. 181.105. DISCLOSURE OF SENSITIVE TEST RESULT. (a) In this section, "sensitive test result" means a:

(1) pathology or radiology report reasonably likely to show a malignancy;

(2) test result revealing a genetic marker;

(3) positive test for the human immunodeficiency virus if the patient has not been previously informed of a positive test result for the virus; or

(4) result showing a presence of antigens indicating a hepatitis infection.

(b) A health care provider may not electronically disclose a sensitive test result to a patient before the third day after the date the results are finalized unless the provider directs the release of the results before that date.

SECTION 6. Section 181.201, Health and Safety Code, is amended by amending Subsections (b) and (d) and adding Subsections (g) and (h) to read as follows:

(b) In addition to the injunctive relief provided by Subsection (a), the attorney general may institute an action for civil penalties against a covered entity for a violation of this chapter, other than a violation of Section 181.102. A civil penalty assessed under this section may not exceed:

(1) $5,000 for each violation that occurs in one year, regardless of how long the violation continues during that year, committed negligently;

(2) $25,000 for each violation that occurs in one

year, regardless of how long the violation continues during that year, committed knowingly or intentionally; or

(3) $250,000 for each violation in which the covered entity knowingly or intentionally used protected health information for financial gain.

(d) In determining the amount of a penalty imposed under Subsections [~~Subsection~~] (b) and (g), the court shall consider:

(1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the disclosure or information blocking;

(2) the covered entity's compliance history;

(3) whether the violation poses a significant risk of financial, reputational, or other harm to an individual whose protected health information is involved in the violation;

(4) whether the covered entity was certified at the time of the violation as described by Section 182.108;

(5) the amount necessary to deter a future violation; [~~and~~]

(6) the covered entity's efforts to correct the violation;

(7) the size and geographic location of the covered entity; and

(8) the financial impact of the penalty on the covered entity's financial viability and ability to adequately serve an underserved community or population.

(g) In addition to the injunctive relief provided by Subsection (a), the attorney general may institute an action for

civil penalties against a covered entity for a violation of Section 181.102. A civil penalty assessed under this subsection may not exceed:

(1) $10,000 for each negligent violation, regardless of the time the violation continues during any year; or

(2) $250,000 for each intentional violation committed for the purpose of financial gain, regardless of the time the violation continues during any year.

(h) If the court in a pending action under Subsection (g) finds the violations occurred with a frequency constituting a pattern or practice, the court may assess additional civil penalties for each violation.

SECTION 7. Section 241.154(b), Health and Safety Code, is amended to read as follows:

(b) Except as provided by Subsection (d), the hospital or its agent may charge a reasonable fee for providing the health care information except payment information and is not required to permit the examination, copying, or release of the information requested until the fee is paid unless there is a medical emergency. The fee may not exceed the aggregate amount specified under Section 181.102(f) and [~~sum of:~~

[~~(1) a basic retrieval or processing fee, which must include the fee for providing the first 10 pages of the copies and which may not exceed $30; and~~

[~~(A) a charge for each page of:~~

[~~(i) $1 for the 11th through the 60th page of the provided copies;~~

[~~(ii) 50 cents for the 61st through the 400th page of the provided copies; and~~

[~~(iii) 25 cents for any remaining pages of the provided copies; and~~

[~~(B) the actual cost of mailing, shipping, or otherwise delivering the provided copies;~~

[~~(2) if the requested records are stored on microform, a retrieval or processing fee, which must include the fee for providing the first 10 pages of the copies and which may not exceed $45; and~~

[~~(A) $1 per page thereafter; and~~

[~~(B) the actual cost of mailing, shipping, or otherwise delivering the provided copies; or~~

[~~(3) if the requested records are provided on a digital or other electronic medium and the requesting party requests delivery in a digital or electronic medium, including electronic mail:~~

[~~(A) a retrieval or processing fee, which may not exceed $75; and~~

[~~(B)~~] the actual cost of mailing, shipping, or otherwise delivering the provided copies.

SECTION 8. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1212 to read as follows:

CHAPTER 1212. ELECTRONIC ACCESS TO AND EXCHANGE OF CERTAIN HEALTH BENEFIT PLAN INFORMATION

Sec. 1212.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit 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 or similar coverage document that is issued by:

(1) an insurance company;

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

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

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

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

(6) a stipulated premium company operating under Chapter 884;

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) a plan providing basic coverage under Chapter 1601.

Sec. 1212.002. CONSTRUCTION OF CHAPTER. This chapter may not be construed to limit the requirements of Chapter 181, Health and Safety Code.

Sec. 1212.003. RULEMAKING. The commissioner may adopt rules necessary to implement this chapter.

Sec. 1212.004. REQUIRED APPLICATION PROGRAMMING INTERFACES. (a) To facilitate patient and health care provider access to health information, a health benefit plan issuer shall establish and maintain the following application programming interfaces for the benefit of all enrollees and contracted health care providers, as applicable, as if the issuer were a Medicare advantage organization:

(1) a patient access interface described by 42 C.F.R. Sections 422.119(a)-(e);

(2) a provider directory interface described by 42 C.F.R. Section 422.120; and

(3) a payer-to-payer data exchange interface described by 42 C.F.R. Section 422.121(b).

(b) In addition to the application programming interfaces described by Subsection (a) and subject to Subsection (c), the commissioner by rule may require a health benefit plan issuer to establish and maintain the following application programming interfaces after the date final rules associated with the interfaces are published by the federal Centers for Medicare and Medicaid Services:

(1) a provider access interface; and

(2) a prior authorization support interface.

(c) In implementing the requirements described by Subsection (b), the commissioner shall adopt rules that conform to:

(1) any associated standard published in a final rule issued by the Centers for Medicare and Medicaid Services; and

(2) federal effective dates, including enforcement delays and suspension, issued by the Centers for Medicare and Medicaid Services.

SECTION 9. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 10. (a) The changes in law made by this Act to the Business & Commerce Code and the Health and Safety Code apply only to a violation of law that occurs on or after the effective date of this Act. A violation that occurs before the effective date of this Act is governed by the law in effect on the date the violation occurred, and the former law is continued in effect for that purpose. For purposes of this section, a violation of law occurred before the effective date of this Act if any element of the violation occurred before that date.

(b) Chapter 1212, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2026.

SECTION 11. This Act takes effect September 1, 2025.