S.B. No. 1731

AN ACT

relating to consumer access to health care information and consumer protection for services provided by or through health benefit plans, hospitals, ambulatory surgical centers, birthing centers, and other health care facilities, and funding for health care information services; providing penalties.

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

SECTION 1. Subtitle G, Title 4, Health and Safety Code, is amended by adding Chapter 324 to read as follows:

CHAPTER 324. CONSUMER ACCESS TO HEALTH CARE INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 324.001. DEFINITIONS. In this chapter:

(1) "Average charge" means the mathematical average of facility charges for an inpatient admission or outpatient surgical procedure. The term does not include charges for a particular inpatient admission or outpatient surgical procedure that exceed the average by more than two standard deviations.

(2) "Billed charge" means the amount a facility charges for an inpatient admission, outpatient surgical procedure, or health care service or supply.

(3) "Costs" means the fixed and variable expenses incurred by a facility in the provision of a health care service.

(4) "Consumer" means any person who is considering receiving, is receiving, or has received a health care service or

supply as a patient from a facility. The term includes the personal representative of the patient.

(5) "Department" means the Department of State Health Services.

(6) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(7) "Facility" means:

(A) an ambulatory surgical center licensed under Chapter 243;

(B) a birthing center licensed under Chapter 244; or

(C) a hospital licensed under Chapter 241.

Sec. 324.002. RULES. The executive commissioner shall adopt and enforce rules to further the purposes of this chapter.

[Sections 324.003-324.050 reserved for expansion]

SUBCHAPTER B. CONSUMER GUIDE TO HEALTH CARE

Sec. 324.051. DEPARTMENT WEBSITE. (a) The department shall make available on the department's Internet website a consumer guide to health care. The department shall include information in the guide concerning facility pricing practices and the correlation between a facility's average charge for an inpatient admission or outpatient surgical procedure and the actual, billed charge for the admission or procedure, including notice that the average charge for a particular inpatient admission or outpatient surgical procedure will vary from the actual, billed charge for the admission or procedure based on:

(1) the person's medical condition;

(2) any unknown medical conditions of the person;

(3) the person's diagnosis and recommended treatment protocols ordered by the physician providing care to the person; and

(4) other factors associated with the inpatient admission or outpatient surgical procedure.

(b) The department shall include information in the guide to advise consumers that:

(1) the average charge for an inpatient admission or outpatient surgical procedure may vary between facilities depending on a facility's cost structure, the range and frequency of the services provided, intensity of care, and payor mix;

(2) the average charge by a facility for an inpatient admission or outpatient surgical procedure will vary from the facility's costs or the amount that the facility may be reimbursed by a health benefit plan for the admission or surgical procedure;

(3) the consumer may be personally liable for payment for an inpatient admission, outpatient surgical procedure, or health care service or supply depending on the consumer's health benefit plan coverage;

(4) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for an inpatient admission, outpatient surgical procedure, or health care service or supply; and

(5) the consumer, if uninsured, may be eligible for a

discount on facility charges based on a sliding fee scale or a written charity care policy established by the facility.

(c) The department shall include on the consumer guide to health care website:

(1) an Internet link for consumers to access quality of care data, including:

(A) the Texas Health Care Information Collection website;

(B) the Hospital Compare website within the United States Department of Health and Human Services website;

(C) the Joint Commission on Accreditation of Healthcare Organizations website; and

(D) the Texas Hospital Association's Texas PricePoint website; and

(2) a disclaimer noting the websites that are not provided by this state or an agency of this state.

(d) The department may accept gifts and grants to fund the consumer guide to health care. On the department's Internet website, the department may not identify, recognize, or acknowledge in any format the donors or grantors to the consumer guide to health care.

[Sections 324.052-324.100 reserved for expansion]

SUBCHAPTER C. BILLING OF FACILITY SERVICES AND SUPPLIES

Sec. 324.101. FACILITY POLICIES. (a) Each facility shall develop, implement, and enforce written policies for the billing of facility health care services and supplies. The policies must address:

(1) any discounting of facility charges to an uninsured consumer, subject to Chapter 552, Insurance Code;

(2) any discounting of facility charges provided to a financially or medically indigent consumer who qualifies for indigent services based on a sliding fee scale or a written charity care policy established by the facility and the documented income and other resources of the consumer;

(3) the providing of an itemized statement required by Subsection (e);

(4) whether interest will be applied to any billed service not covered by a third-party payor and the rate of any interest charged;

(5) the procedure for handling complaints; and

(6) the providing of a conspicuous written disclosure to a consumer at the time the consumer is first admitted to the facility or first receives services at the facility that:

(A) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided; and

(B) informs the consumer that a physician or other health care provider who may provide services to the consumer while in the facility may not be a participating provider with the same third-party payors as the facility.

(b) For services provided in an emergency department of a hospital or as a result of an emergent direct admission, the

hospital shall provide the written disclosure required by Subsection (a)(6) before discharging the patient from the emergency department or hospital, as appropriate.

(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 of the availability of the policies required by Subsection (a).

(d) The facility shall provide an estimate of the facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service. The estimate must be provided not later than the 10th business day after the date on which the estimate is requested. The facility must advise the consumer that:

(1) the request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure, or other service;

(2) the actual charges for an inpatient admission, outpatient surgical procedure, or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service;

(3) the actual charges for an inpatient admission, outpatient surgical procedure, or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor;

(4) the consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure, or

other service depending on the consumer's health benefit plan coverage; and

(5) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure, or other service.

(e) A facility shall provide to the consumer at the consumer's request an itemized statement of the billed services if the consumer requests the statement not later than the first anniversary of the date the person is discharged from the facility. The facility shall provide the statement to the consumer not later than the 10th business day after the date on which the statement is requested.

(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 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.

(g) A facility in violation of this section is subject to enforcement action by the appropriate licensing agency.

(h) If a consumer or a third-party payor requests more than two copies of the statement, the facility may charge a reasonable fee for the third and subsequent copies provided. The fee may not exceed the 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;

(2) a charge for each page of:

(A) $1 for the 11th through the 60th page of the provided copies;

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

(C) 25 cents for any remaining pages of the provided copies; and

(3) the actual cost of mailing, shipping, or otherwise delivering the provided copies.

(i) If a consumer overpays a facility, the facility must refund the amount of the overpayment not later than the 30th day after the date the facility 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.

Sec. 324.102. COMPLAINT PROCESS. A facility shall

establish and implement a procedure for handling consumer complaints, and must make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the complaint cannot be resolved informally, the facility shall advise the consumer that a complaint may be filed with the department and shall provide the consumer with the mailing address and telephone number of the department.

Sec. 324.103. CONSUMER WAIVER PROHIBITED. The provisions of this chapter may not be waived, voided, or nullified by a contract or an agreement between a facility and a consumer.

SECTION 2. Subdivision (10), Section 108.002, Health and Safety Code, is amended to read as follows:

(10) "Health care facility" means:

(A) a hospital;

(B) an ambulatory surgical center licensed under Chapter 243;

(C) a chemical dependency treatment facility licensed under Chapter 464;

(D) a renal dialysis facility;

(E) a birthing center;

(F) a rural health clinic; [~~or~~]

(G) a federally qualified health center as defined by 42 U.S.C. Section 1396d(l)(2)(B); or

(H) a free-standing imaging center.

SECTION 3. Subsection (k), Section 108.009, Health and Safety Code, is amended to read as follows:

(k) The council shall collect health care data elements

relating to payer type, the racial and ethnic background of patients, and the use of health care services by consumers. The council shall prioritize data collection efforts on inpatient and outpatient surgical and radiological procedures from hospitals, ambulatory surgical centers, and free-standing radiology centers.

SECTION 4. Section 241.025, Health and Safety Code, is amended by adding Subsection (e) to read as follows:

(e) Notwithstanding Subsection (d), to the extent that money received from the fees collected under this chapter exceeds the costs to the department to conduct the activity for which the fee is imposed, the department may use the money to administer Chapter 324 and similar laws that require the department to provide information related to hospital care to the public. The department may not consider the costs of administering Chapter 324 or similar laws in adopting a fee imposed under this section.

SECTION 5. Subsection (h), Section 311.002, Health and Safety Code, is amended to read as follows:

(h) In this section, "hospital" includes:

(1) [~~a hospital licensed under Chapter 241;~~

[~~(2)~~] a treatment facility licensed under Chapter 464; and

(2) [~~(3)~~] a mental health facility licensed under Chapter 577.

SECTION 6. Chapter 101, Occupations Code, is amended by adding Subchapter H, transferring Section 101.202 to Subchapter H redesignated as Section 101.351 and further amending that section, and adding Section 101.352 to read as follows:

SUBCHAPTER H. BILLING

Sec. 101.351 [~~101.202~~]. FAILURE TO PROVIDE BILLING INFORMATION. On the written request of a patient, a health care professional shall provide, in plain language, a written explanation of the charges for professional services previously made on a bill or statement for the patient. This section does not apply to a physician subject to Section 101.352.

Sec. 101.352. BILLING POLICIES AND INFORMATION; PHYSICIANS. (a) A physician shall develop, implement, and enforce written policies for the billing of health care services and supplies. The policies must address:

(1) any discounting of charges for health care services or supplies provided to an uninsured patient that is not covered by a patient's third-party payor, subject to Chapter 552, Insurance Code;

(2) any discounting of charges for health care services or supplies provided to an indigent patient who qualifies for services or supplies based on a sliding fee scale or a written charity care policy established by the physician;

(3) whether interest will be applied to any billed health care service or supply not covered by a third-party payor and the rate of any interest charged; and

(4) the procedure for handling complaints relating to billed charges for health care services or supplies.

(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.

(c) On the request of a patient who is seeking services that are to be provided on an out-of-network basis or who does not have coverage under a government program, health insurance policy, or health maintenance organization evidence of coverage, a physician shall provide an estimate of the charges for any health care services or supplies. The estimate must be provided not later than the 10th business day after the date of the request. A physician must advise the consumer that:

(1) the request for an estimate of charges may result in a delay in the scheduling and provision of the services;

(2) the actual charges for the services or supplies will vary based on the patient's medical condition and other factors associated with performance of the services;

(3) the actual charges for the services or supplies may differ from the amount to be paid by the patient or the patient's third-party payor; and

(4) the patient may be personally liable for payment for the services or supplies depending on the patient's health benefit plan coverage.

(d) For services provided in an emergency department of a hospital or as a result of an emergent direct admission, the physician shall provide the estimate of charges required by Subsection (c) not later than the 10th business day after the request or before discharging the patient from the emergency department or hospital, whichever is later, as appropriate.

(e) A physician shall provide a patient 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 requests the statement not later than the first anniversary of the date on which the health care services or supplies were provided.

(f) If a patient requests more than two copies of the statement, a physician may charge a reasonable fee for the third and subsequent copies provided. The Texas Medical Board shall by rule set the permissible fee a physician may charge for copying, processing, and delivering a copy of the statement.

(g) On the request of a patient, a physician shall provide, in plain language, a written explanation of the charges for services or supplies previously made on a bill or statement for the patient.

(h) If a patient overpays a physician, the physician must refund the amount of the overpayment not later than the 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.

(i) In this section, "physician" means a person licensed to practice in this state.

SECTION 7. Section 154.002, Occupations Code, is amended by adding Subsection (c) to read as follows:

(c) The board shall make available on the board's Internet website a consumer guide to health care. The board shall include information in the guide concerning the billing and reimbursement

of health care services provided by physicians, including information that advises consumers that:

(1) the charge for a health care service or supply will vary based on:

(A) the person's medical condition;

(B) any unknown medical conditions of the person;

(C) the person's diagnosis and recommended treatment protocols; and

(D) other factors associated with performance of the health care service;

(2) the charge for a health care service or supply may differ from the amount to be paid by the consumer or the consumer's third-party payor;

(3) the consumer may be personally liable for payment for the health care service or supply depending on the consumer's health benefit plan coverage; and

(4) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the health care services or supplies.

SECTION 8. Chapter 38, Insurance Code, is amended by adding Subchapter H to read as follows:

SUBCHAPTER H. HEALTH CARE REIMBURSEMENT RATE INFORMATION

Sec. 38.351. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to authorize the department to:

(1) collect data concerning health benefit plan

reimbursement rates in a uniform format; and

(2) disseminate, on an aggregate basis for geographical regions in this state, information concerning health care reimbursement rates derived from the data.

Sec. 38.352. DEFINITION. In this subchapter, "group health benefit plan" means a preferred provider benefit plan as defined by Section 1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by Section 843.002.

Sec. 38.353. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to the issuer of a group health benefit plan, including:

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; or

(6) a health maintenance organization.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, and except as provided by Subsection (e), this subchapter 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) basic coverage under Chapter 1601.

(c) Except as provided by Subsection (d), this subchapter

applies to a small employer health benefit plan provided under Chapter 1501.

(d) This subchapter does not apply to:

(1) standard health benefit plans provided under Chapter 1507;

(2) children's health benefit plans provided under Chapter 1502;

(3) health care benefits provided under a workers' compensation insurance policy;

(4) Medicaid managed care programs operated under Chapter 533, Government Code;

(5) Medicaid programs operated under Chapter 32, Human Resources Code; or

(6) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

(e) The commissioner by rule may exclude a type of health benefit plan from the requirements of this subchapter if the commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of this subchapter.

Sec. 38.354. RULES. The commissioner may adopt rules as provided by Subchapter A, Chapter 36, to implement this subchapter.

Sec. 38.355. DATA CALL; STANDARDIZED FORMAT. (a) Each health benefit plan issuer shall submit to the department, at the time and in the form and manner required by the department, aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the department.

(b) The department shall require that data submitted under this section be submitted in a standardized format, established by rule, to permit comparison of health care reimbursement rates. To the extent feasible, the department shall develop the data submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates, such as Medicare reimbursement rates.

(c) The department shall specify the period for which reimbursement rates must be filed under this section.

(d) The department may contract with a private third party to obtain the data under this subchapter. If the department contracts with a third party, the department may determine the aggregate data to be collected and published under Section 38.357 if consistent with the purposes of this subchapter described in Section 38.351. The department shall prohibit the third party contractor from selling, leasing, or publishing the data obtained by the contractor under this subchapter.

Sec. 38.356. CONFIDENTIALITY OF DATA. Except as provided by Section 38.357, data collected under this subchapter is confidential and not subject to disclosure under Chapter 552, Government Code.

Sec. 38.357. PUBLICATION OF AGGREGATE HEALTH CARE REIMBURSEMENT RATE INFORMATION. The department shall provide to the Department of State Health Services for publication, for identified regions of this state, aggregate health care reimbursement rate information derived from the data collected

under this subchapter. The published information may not reveal the name of any health care provider or health benefit plan issuer. The department may make the aggregate health care reimbursement rate information available through the department's Internet website.

Sec. 38.358. PENALTIES. A health benefit plan issuer that fails to submit data as required in accordance with this subchapter is subject to an administrative penalty under Chapter 84. For purposes of penalty assessment, each day the health benefit plan issuer fails to submit the data as required is a separate violation.

SECTION 9. Section 843.155, Insurance Code, is amended by amending Subsection (b) and adding Subsection (d) to read as follows:

(b) The report shall:

(1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the health maintenance organization, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year;

(C) a statement of:

(i) an evaluation of enrollee satisfaction;

(ii) an evaluation of quality of care;

(iii) coverage areas;

(iv) accreditation status;

(v) premium costs;

(vi) plan costs;

(vii) premium increases;

(viii) the range of benefits provided;

(ix) copayments and deductibles;

(x) the accuracy and speed of claims payment by the organization;

(xi) the credentials of physicians of the organization; and

(xii) the number of providers;

(D) updated financial projections for the next calendar year of the type described in Section 843.078(e), until the health maintenance organization has had a net income for 12 consecutive months; and

(E) [~~(D)~~] other information relating to the performance of the health maintenance organization as necessary to enable the commissioner to perform the commissioner's duties under this chapter and Chapter 20A.

(d) The annual report filed by the health maintenance organization shall be made publicly available on the department's Internet website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by health maintenance organizations under this section.

SECTION 10. Subchapter A, Chapter 1301, Insurance Code, is

amended by adding Section 1301.009 to read as follows:

Sec. 1301.009. ANNUAL REPORT. (a) Not later than March 1 of each year, an insurer shall file with the commissioner a report relating to the preferred provider benefit plan offered under this chapter and covering the preceding calendar year.

(b) The report shall:

(1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the insurer, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year; and

(C) a statement of:

(i) an evaluation of enrollee satisfaction;

(ii) an evaluation of quality of care;

(iii) coverage areas;

(iv) accreditation status;

(v) premium costs;

(vi) plan costs;

(vii) premium increases;

(viii) the range of benefits provided;

(ix) copayments and deductibles;

(x) the accuracy and speed of claims payment by the insurer for the plan;

(xi) the credentials of physicians who are preferred providers; and

(xii) the number of preferred providers.

(c) The annual report filed by the insurer shall be made publicly available on the department's website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by insurers under this section.

(d) An insurer providing group coverage of $10 million or less in premiums or individual coverage of $2 million or less in premiums is not required to report the data required under Subsection (b)(3)(C).

SECTION 11. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1456 to read as follows:

CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

Sec. 1456.001. DEFINITIONS. In this chapter:

(1) "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

(2) "Enrollee" means an individual who is eligible to receive health care services through a health benefit plan.

(3) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department

physician, or a neonatologist:

(A) to whom the facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(4) "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.

(5) "Health care practitioner" means an individual who is licensed to provide and provides health care services.

(6) "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a network operated by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) another entity that issues a health benefit plan, including an insurance company.

Sec. 1456.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to any health benefit plan that:

(1) 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 that is offered by:

(A) an insurance company;

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

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

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

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

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

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

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This chapter applies to a person to whom a health benefit plan contracts to:

(1) process or pay claims;

(2) obtain the services of physicians or other providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

(c) This chapter does not apply to:

(1) Medicaid managed care programs operated under Chapter 533, Government Code;

(2) Medicaid programs operated under Chapter 32, Human Resources Code; or

(3) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN. (a) Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:

(1) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network; and

(2) a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan.

(b) The health benefit plan shall provide the disclosure in writing to each enrollee:

(1) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;

(2) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and

(3) conspicuously displayed, on any health benefit plan website that an enrollee is reasonably expected to access.

(c) A health benefit plan must clearly identify any health

care facilities within the provider network in which facility-based physicians do not participate in the health benefit plan's provider network. Health care facilities identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory.

(d) Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.

Sec. 1456.004. REQUIRED DISCLOSURE: FACILITY-BASED PHYSICIANS. (a) If a facility-based physician bills a patient who is covered by a health benefit plan described in Section 1456.002 that does not have a contract with the facility-based physician, the facility-based physician shall send a billing statement that:

(1) contains an itemized listing of the services and supplies provided along with the dates the services and supplies were provided;

(2) contains a conspicuous, plain-language explanation that:

(A) the facility-based physician is not within the health plan provider network; and

(B) the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based physician billed amount;

(3) contains a telephone number to call to discuss the

statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;

(4) contains a statement that the patient may call to discuss alternative payment arrangements;

(5) contains a notice that the patient may file complaints with the Texas Medical Board and includes the Texas Medical Board mailing address and complaint telephone number; and

(6) for billing statements that total an amount greater than $200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 45 days of receiving the first billing statement and substantially complies with the agreement, the facility-based physician may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment.

(b) A patient may be considered by the facility-based physician to be out of substantial compliance with the payment plan agreement if payments are not made in compliance with the agreement for a period of 90 days.

Sec. 1456.005. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTY. (a) The commissioner may take disciplinary action against a licensee that violates this chapter, in accordance with Chapter 84.

(b) A violation of this chapter by a facility-based physician is grounds for disciplinary action and imposition of an administrative penalty by the Texas Medical Board.

(c) The Texas Medical Board shall:

(1) notify a facility-based physician of a finding by the Texas Medical Board that the facility-based physician is violating or has violated this chapter or a rule adopted under this chapter; and

(2) provide the facility-based physician with an opportunity to correct the violation without penalty or reprimand.

Sec. 1456.006. COMMISSIONER RULES; FORM OF DISCLOSURE. The commissioner by rule may prescribe specific requirements for the disclosure required under Section 1456.003. The form of the disclosure must be substantially as follows:

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN."

Sec. 1456.0065. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF HEALTH PLANS. (a) In this section:

(1) "Commissioner" means the commissioner of insurance.

(2) "Health benefit plan" means an insurance policy or a contract or evidence of coverage issued by a health maintenance organization or an employer or employee sponsored health plan.

(b) The commissioner shall appoint an advisory committee to study facility-based provider network adequacy of health benefit

plans.

(c) The advisory committee shall be composed of:

(1) one or more physician representatives;

(2) one or more hospital representatives;

(3) one or more health benefit plan representatives, to equal the total number of physician and hospital representatives; and

(4) one representative each from associations representing physicians, hospitals, and health benefit plans.

(d) The advisory committee periodically and not later than December 1, 2008, shall advise the following of its findings:

(1) the governor;

(2) the lieutenant governor;

(3) the speaker of the house of representatives;

(4) the commissioner; and

(5) the chairs of the standing committees of the senate and house of representatives that have primary jurisdiction over health benefit plans.

(e) Members of the advisory committee serve without compensation.

(f) The advisory committee is abolished and this section expires January 1, 2009.

Sec. 1456.007. HEALTH BENEFIT PLAN ESTIMATE OF CHARGES. A health benefit plan that must comply with this chapter under Section 1456.002 shall, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and shall also specify any deductibles, copayments,

coinsurance, or other amounts for which the enrollee is responsible. The estimate must be provided not later than the 10th business day after the date on which the estimate was requested. A health benefit plan must advise the enrollee that:

(1) the actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and

(2) the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.

SECTION 12. Section 843.201, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) A health maintenance organization shall provide to an enrollee on request information on:

(1) whether a physician or other health care provider is a participating provider in the health maintenance organization's network;

(2) whether proposed health care services are covered by the health plan; and

(3) what the enrollee's personal responsibility will be for payment of applicable copayment or deductible amounts.

SECTION 13. Subchapter F, Chapter 843, Insurance Code, is amended by adding Section 843.211 to read as follows:

Sec. 843.211. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person to whom a health maintenance organization

contracts to:

(1) process or pay claims;

(2) obtain the services of physicians or other providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

SECTION 14. Section 1301.158, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) An insurer shall provide to an insured on request information on:

(1) whether a physician or other health care provider is a participating provider in the insurer's preferred provider network;

(2) whether proposed health care services are covered by the health insurance policy;

(3) what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and

(4) coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services.

SECTION 15. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.163 to read as follows:

Sec. 1301.163. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person to whom an insurer contracts to:

(1) process or pay claims;

(2) obtain the services of physicians or other providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

SECTION 16. Section 1506.007, Insurance Code, is amended by adding Subsections (a-1) and (a-2) to read as follows:

(a-1) A health benefit plan issuer, employer, or other person who is required to provide notice to an individual of the individual's ability to continue coverage in accordance with Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), shall, at the time that that notice is required, also provide notice to the individual of the availability of coverage under the pool.

(a-2) A health benefit plan issuer who is providing coverage to an individual in accordance with Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), shall, not later than the 45th day before the date that coverage expires, notify the individual of the availability of coverage under the pool.

SECTION 17. This Act applies to an insurance policy, certificate, or contract or an evidence of coverage delivered, issued for delivery, or renewed on or after the effective date of this Act. A policy, certificate, or contract or evidence of coverage delivered, issued for delivery, or renewed before the effective date of this Act 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 18. Except as provided by Section 19 of this Act, the Department of State Health Services, Texas Medical Board, and Texas Department of Insurance shall adopt rules as necessary to

implement this Act not later than May 1, 2008.

SECTION 19. Not later than December 31, 2007, the commissioner of insurance shall adopt rules as necessary to implement Subchapter H, Chapter 38, Insurance Code, as added by this Act. The rules must require that each health benefit plan issuer subject to that subchapter make the initial submission of data under that subchapter not later than the 60th day after the effective date of the rules.

SECTION 20. (a) The commissioner of insurance by rule shall require each health benefit plan issuer subject to Chapter 1456, Insurance Code, as added by this Act, to submit information to the Texas Department of Insurance concerning the use of non-network providers by health benefit plan enrollees and the payments made to those providers. The information collected must cover a 12-month period specified by the commissioner of insurance. The commissioner of insurance shall work with the network adequacy study group to develop the data collection and evaluate the information collected.

(b) A health benefit plan issuer that fails to submit data as required in accordance with this section is subject to an administrative penalty under Chapter 84, Insurance Code. For purposes of penalty assessment, each day the health benefit plan issuer fails to submit the data as required is a separate violation.

SECTION 21. This Act takes effect September 1, 2007.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1731 passed the Senate on April 30, 2007, by the following vote: Yeas 31, Nays 0; May 25, 2007, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 26, 2007, House granted request of the Senate; May 27, 2007, Senate adopted Conference Committee Report by the following vote: Yeas 30, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1731 passed the House, with amendments, on May 23, 2007, by the following vote: Yeas 145, Nays 0, three present not voting; May 26, 2007, House granted request of the Senate for appointment of Conference Committee; May 27, 2007, House adopted Conference Committee Report by the following vote: Yeas 144, Nays 0, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor