By: Burrows H.B. No. 307

A BILL TO BE ENTITLED

AN ACT

relating to disclosure of certain health care costs and shared savings between certain health benefit plans and enrollees.

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

SECTION 1. Title 2, Health and Safety Code, is amended by adding Subtitle J to read as follows:

SUBTITLE J. HEALTH CARE PRICE DISCLOSURES

CHAPTER 185. HEALTH CARE PRICE DISCLOSURES

Sec. 185.001. DEFINITIONS. In this chapter:

(1) "Facility" means a hospital, outpatient clinic, birthing center, ambulatory surgical center, or other licensed facility providing health care services. The term does not include an emergency clinic, a freestanding emergency medical care facility, or other facility providing only emergency care.

(2) "Patient" includes a prospective patient and a personal representative of the patient.

(3) "Practitioner" means an individual who is licensed to provide and provides medical or other health care services.

Sec. 185.002. PRICE DISCLOSURE OR ESTIMATE. (a) Before providing a nonemergency health care service offered to the patient by the facility or practitioner, a facility or practitioner shall provide a price disclosure described by Subsection (b) or an estimate described by Subsection (c), as applicable, unless declined by the patient.

(b) Except as provided by Subsection (c), a facility or practitioner required to provide a price disclosure under Subsection (a) shall disclose to the patient the amount, including facility fees, that:

(1) the patient's health benefit plan will reimburse the facility or practitioner for the service, if the facility or practitioner is a participating provider under the patient's health benefit plan; or

(2) the facility or practitioner will charge for the service, if the facility or practitioner is not a participating provider under the patient's health benefit plan.

(c) If a facility or practitioner is unable to quote a specific amount under Subsection (b) because of the facility's or practitioner's inability to predict the specific service the patient will need, the facility or practitioner shall provide an estimate of the amount, including facility fees, that:

(1) the patient's health benefit plan will reimburse the facility or practitioner for the predicted service, if the facility or practitioner is a participating provider under the patient's health benefit plan; or

(2) the facility or practitioner will charge for the predicted service, if the facility or practitioner is not a participating provider under the patient's health benefit plan.

(d) A facility or practitioner that provides an estimate described by Subsection (c) shall:

(1) disclose the incomplete nature of the estimate; and

(2) inform the patient that the facility or practitioner may be able to provide an updated estimate after the facility or practitioner obtains additional information.

(e) Notwithstanding any other law, a facility or practitioner that does not provide the price disclosure or estimate required by this section before providing a health care service for which the price disclosure or estimate is required may not bill the patient or the patient's health benefit plan for the service.

Sec. 185.003. EFFECT OF OTHER LAW. A facility that provides an estimate under Section 324.101(d) is not relieved of the obligation to provide a price disclosure or estimate under Section 185.002.

Sec. 185.004. PATIENT INFORMATION. On request, a facility or practitioner shall provide a patient with sufficient information about a proposed nonemergency health care service to enable the patient to determine the amount for which the patient will be personally liable by using the patient's health benefit plan's toll-free telephone number or Internet website. The facility or practitioner shall provide the information to the patient based on the information that is available to the facility or practitioner at the time of the request. The facility or practitioner may assist the patient in using the telephone number or website.

SECTION 2. Section 324.101, Health and Safety Code, is amended by adding Subsection (d-1) and amending Subsection (e) to read as follows:

(d-1) A facility that provides a price disclosure or estimate under Section 185.002 is not relieved of the obligation to

provide an estimate under Subsection (d).

(e) A facility shall provide to the consumer at the consumer's request an itemized statement in plain language 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.

SECTION 3. The heading to Chapter 1456, Insurance Code, is amended to read as follows:

CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS AND COSTS OF HEALTH CARE SERVICES; SHARED SAVINGS

SECTION 4. Section 1456.003, Insurance Code, is amended by amending Subsection (a) and adding Subsection (a-1) to read as follows:

(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) subject to Chapter 185, Health and Safety Code, a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan.

(a-1) A health benefit plan shall provide notice to its enrollees that an enrollee may be eligible for a cost-sharing payment to the enrollee if the enrollee elects to receive a health

care service that costs less than the average amount quoted for that service by the health benefit plan's telephone number or website established for that purpose.

SECTION 5. Sections 1456.006 and 1456.007, Insurance Code, are amended to read as follows:

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 under Section 1456.003(a) 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. 1456.007. HEALTH BENEFIT PLAN ESTIMATE OF CHARGES. (a) A health benefit plan that must comply with this chapter under Section 1456.002 shall, on the request of an enrollee, provide a binding [~~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, based on the information available to the health benefit plan at the time the estimate was requested. 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 may [~~will~~] vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services, including any factors unknown to or unforeseeable by the health benefit plan or provider at the time the estimate was requested; and

(2) subject to Subsection (b) and Chapter 185, Health and Safety Code, the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.

(b) Except as provided by Subsection (c), a health benefit plan may not require an enrollee to pay more than the amount estimated under Subsection (a) for a health care service or supply that was actually provided.

(c) A health benefit plan may require an enrollee to pay any deductibles, copayments, coinsurance, or other amounts disclosed in the enrollee's policy, certificate of coverage, or evidence of coverage for an unforeseen health care service or supply that arises out of the provision of the proposed health care service or supply.

SECTION 6. Chapter 1456, Insurance Code, is amended by adding Sections 1456.008, 1456.009, and 1456.010 to read as follows:

Sec. 1456.008. PRICE DISCLOSURE TELEPHONE NUMBER AND WEBSITE. (a) A health benefit plan shall establish and operate a

toll-free telephone number and publicly accessible Internet website for an enrollee to:

(1) request and obtain the average amount paid under the health benefit plan to a provider in the health benefit plan provider network for a particular health care service or supply in the preceding 12 months in the enrollee's geographic rating area; and

(2) request an estimate described by Section 1456.007.

(b) A health benefit plan shall maintain a written record of the average amount quoted to an enrollee under Subsection (a)(1).

Sec. 1456.009. SHARED SAVINGS. (a) Except as provided by Subsection (b), if an enrollee elects and receives a health care service or supply the total cost of which is less than the average amount quoted under Section 1456.008, a health benefit plan shall pay to the enrollee the lesser of:

(1) 50 percent of the difference between the average amount and the actual cost, minus any applicable deductible, copayment, or coinsurance; or

(2) $7,500.

(b) A health benefit plan is not required to pay an enrollee under Subsection (a) if the plan's saved cost is $50 or less.

(c) A health benefit plan shall pay an enrollee not later than the 30th day after the day on which the enrollee submits a claim for shared savings under this section.

(d) If an enrollee elects and receives a health care service or supply from a provider outside the health benefit plan provider network the total cost of which is less than the average amount

quoted under Section 1456.008, a health benefit plan may hold the enrollee responsible only for any deductible, copayment, or coinsurance that would be due if the service were provided by a provider in the health benefit plan provider network.

Sec. 1456.010. SHARED SAVINGS REPORTING. Not later than February 1 of each year, a health benefit plan shall submit to the commissioner a report for the preceding calendar year stating:

(1) the total number of requests for a binding estimate received for the plan under Section 1456.007;

(2) the total number of health care services or supplies for which an enrollee is eligible for a payment under Section 1456.009 and the average cost of each service or supply by category;

(3) the difference between the average cost of health care services or supplies for which an enrollee is eligible for a payment under Section 1456.009 and the average amount for the same service or supply quoted under Section 1456.008;

(4) the total payments made under Section 1456.009 to enrollees; and

(5) the total number and percentage of the health benefit plan's enrollees who received a payment under Section 1456.009.

SECTION 7. (a) Chapter 185, Health and Safety Code, as added by this Act, and Section 324.101(e), Health and Safety Code, as amended by this Act, apply only to a service provided by a facility or practitioner on or after January 1, 2018. A service provided before January 1, 2018, 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.

(b) Chapter 1456, Insurance Code, as amended by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2018, 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 8. This Act takes effect September 1, 2017.