By: Isett H.B. No. 3530

A BILL TO BE ENTITLED

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, and birthing centers; 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 a health care service or supply. The term does not include charges that exceed the average by more than two standard deviations.

(2) "Billed charge" means the amount a facility charges for a health care service or supply.

(3) "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.

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

(5) "Executive commissioner" means the executive

commissioner of the Health and Human Services Commission.

(6) "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 a health care service or supply and the actual, billed charge for the service or supply, including notice that the average charge for a particular health care service or supply will vary from the actual, billed charge for the service or supply 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 performance of the procedure.

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

(1) the average charge for a health care service or supply may vary between facilities depending on a facility's cost structure, the range and frequency of the services provided, intensity of care, and payors;

(2) the average 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, and other plan provisions that may impact the consumer's liability for payment for the health care service or supply.

(c) The department shall include on the consumer guide to health care website an Internet link for consumers to access quality of care data, including:

(1) the Texas Health Care Information Collection website;

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

(3) the Joint Commission on Accreditation of Healthcare Organizations website.

(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 for a health care service or supply provided to an uninsured consumer or for a service or supply that is not covered by a consumer's third-party payor, subject to Chapter 552, Insurance Code;

(2) any discounting of facility charges for a health care service or supply 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;

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

(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 relating to billed services or supplies; 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; 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) Each facility shall post in the general waiting area and in the waiting areas of any off-site or onsite registration, admission, or business office a clear and conspicuous notice of the availability of the policies required by Subsection (a).

(c) The facility shall provide an estimate of the facility's charges for any health care service or supply on request and before the scheduling of an elective admission or scheduling of nonemergency outpatient procedures or services. The estimate must be provided within a reasonable time based on the number of charge estimates requested and whether the request was made during normal operating hours of the facility's business office. 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 health care service or supply;

(2) the actual charges for a health care service or supply will vary based on the person's medical condition and other factors associated with performance of the service or provision of

the supply;

(3) the actual charges 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;

(4) 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

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

(d) 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 day after the date on which the statement is requested.

(e) If a consumer 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 facility's cost to copy, process, and deliver the copy to the consumer.

(f) 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 relating to the charges for health care services and supplies. If a consumer objects to the billed amount for a particular service or supply, the facility must make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures.

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

SUBCHAPTER H. BILLING

Sec. 101.351 [~~101.202~~]. [~~FAILURE TO PROVIDE~~] BILLING POLICIES AND INFORMATION. (a) A health care professional 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 health care professional;

(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;

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

(5) the providing of a conspicuous written disclosure to a patient at the time the patient first receives health care services that provides confirmation whether the health care professional is a participating provider under the patient's third-party payor coverage on the date services are to be rendered.

(b) Each health care professional shall post in the general waiting area and in the waiting areas of any registration, admission, or business office a clear and conspicuous notice of the availability of the policies required by Subsection (a).

(c) On the request of a patient, a health care professional shall provide an estimate of the charges for any health care services or supplies. The estimate must be provided within a reasonable time based on the number of charge estimates requested and whether the request was made during normal operating hours of the health care professional's business office. A health care professional 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;

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

(5) the patient should contact the patient's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, and other plan provisions that may impact the patient's liability for payment for the services.

(d) A health care professional shall provide a patient with an itemized statement of the charges for professional services or supplies not later than the 10th 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.

(e) If a patient requests more than two copies of the statement, a health care professional may charge a reasonable fee for the third and subsequent copies provided. The fee may not exceed the health care professional's cost to copy, process, and deliver the copy to the patient.

(f) On the [~~written~~] request of a patient, a health care professional shall provide, in plain language, a written explanation of the charges for health care [~~professional~~] services or supplies previously made on a bill or statement for the patient.

(g) If a patient overpays a health care professional, the health care professional must refund the amount of the overpayment not later than the 30th day after the date the health care professional 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.

SECTION 3. 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, and other plan provisions that may impact the consumer's liability for payment for the health care services or supplies.

SECTION 4. Chapter 38, Insurance Code, is amended by adding Subchapter H to read as follows:

SUBCHAPTER H. HEALTH CARE COST 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 costs that is derived from the data to enable consumers to compare and evaluate health care costs.

Sec. 38.352. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to the issuer of a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, 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) This chapter applies to the issuer of a group health

benefit plan that is a preferred provider benefit plan.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, and except as provided by Subsection (f), 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.

(d) Except as provided by Subsection (f), this subchapter applies to a small employer health benefit plan provided under Chapter 1501.

(e) This subchapter does not apply to a standard health benefit plan provided under Chapter 1507 or a children's health benefit plan provided under Chapter 1502. This subchapter does not apply to health care benefits provided under a workers' compensation insurance policy.

(f) 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. 38.353. RULES. The commissioner may adopt rules as provided by Subchapter A, Chapter 36, to implement this subchapter.

Sec. 38.354. 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:

(1) reimbursement rates paid by the health benefit plan issuer for health care services; and

(2) any supporting information, including decoding and unbundling support and documentation, required by the department.

(b) The department shall require that data submitted under this section be submitted in a standardized format, established by the department, to permit comparison of health care costs. To the extent feasible, the department shall develop the data submission requirements in a manner that allows:

(1) collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates, such as Medicare reimbursement rates;

(2) comparison of reimbursement rates paid under large and small employer health benefit plans;

(3) collection of average reimbursement rate information from large and small employer health benefit plans; and

(4) comparison of reimbursement rates paid for health care services provided by a network provider and an out-of-network provider.

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

Sec. 38.355. CONFIDENTIALITY OF DATA. Except as provided by Section 38.356, data collected under this subchapter is confidential and not subject to disclosure under Chapter 552, Government Code.

Sec. 38.356. PUBLICATION OF AGGREGATE HEALTH CARE COST INFORMATION. The department shall publish, for identified regions of this state, aggregate health care cost 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 shall make the aggregate health care cost information available through the department's Internet website.

Sec. 38.357. 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 5. 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, or an emergency department

physician:

(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, 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.

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.

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 for one calendar year from the first statement date.

(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 appropriate regulatory agency that issued a license, certification, or registration to the facility-based physician who committed the violation.

(c) The regulatory agency shall:

(1) notify a facility-based physician of a finding by the regulatory agency 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.

(d) The complaints brought under this section are not considered to require a determination of medical competency, and Section 154.058, Occupations Code, does not apply.

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 COVERED BY YOUR HEALTH BENEFIT PLAN."

Sec. 1456.007. STUDY OF NETWORK ADEQUACY AND CONTRACTS OF HEALTH PLANS. (a) In this section:

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

(2) "Health 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 direct the Technical Advisory Committee on Claim Processing to study facility-based provider network adequacy of health plans and the health plans' ability to contract with facility-based physicians.

(c) The advisory committee shall advise the commissioner periodically of its findings, no later than December, 2008.

(d) Members of the committee serve without compensation.

SECTION 6. 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 7. 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 8. Section 1204.051, Insurance Code, is amended to read as follows:

Sec. 1204.051. DEFINITIONS. In this subchapter:

(1) "Covered person" means a person who is insured or covered by a health insurance policy or is a participant in an employee benefit plan. The term includes:

(A) a person covered by a health insurance policy because the person is an eligible dependent; and

(B) an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that it provides, through the purchase of insurance or otherwise, health care

services to employees, participants, or the dependents of employees or participants.

(3) "Financially indigent" means a person who has an income level less than 200 percent of the federal poverty guidelines as established by the U.S. Department of Health and Human Services.

[~~(3)~~] (4) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.

[~~(4)~~] (5) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care provider.

[~~(5)~~] (6) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, or an insurance agreement, that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

[~~(6)~~] (7) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

[~~(7)~~] (8) "Person" means an individual, association, partnership, corporation, or other legal entity.

[~~(8)~~] (9) "Physician" means an individual licensed to practice medicine in this or another state of the United States.

(10) "Waiver of deductible or copayment" means an agreed reduction by a health care provider of all or a portion of the deductible or copayment amount owed by a covered person for health care services under an employee benefit plan or health insurance policy.

SECTION 9. Section 1204.055, Insurance Code, is amended by adding Subsections (c)-(g) to read as follows:

(c) A physician or health care provider shall make reasonable efforts to collect a deductible or copayment owed by a covered person.

(d) A physician or health care provider may waive a deductible or copayment owed by a consumer only if the consumer is:

(1) covered by the Medicare, Medicaid, or other governmental programs to the extent that a waiver is authorized by state or federal law; or

(2) covered by employee benefit plan or health insurance policy and who is financially indigent and does not have the financial resources to pay the applicable deductible or copayment amounts.

(e) A physician or health care provider who waives a deductible or copayment owed by a consumer pursuant to Subsection (d)(2) shall provide notice to the consumer's plan, insurer or third party administrator that all or part of the applicable deductible or copayment was waived and shall submit a report to the Texas Department of Insurance that includes information on each claim for which all or part of the deductible or copayment was waived, including:

(1) identification of the consumer, plan, insurer or third party administrator;

(2) date or dates health care services were provided;

(3) amount of the claim and the deductible or copayment amount that was waived; and

(4) documented proof of the consumer's financial indigency.

(f) A physician or health care provider in violation of this section is subject to enforcement action by the physician's or health care provider's licensing agency or action by the attorney general under Subsection (g) of this section.

(g) The attorney general may institute an action for an appropriate order to restrain the physician or health care provider from committing or continuing to commit a violation of this article. An action under this subsection shall be brought in a district court of Travis County or of a county in which any part of the violation is occurring, or is about to occur. The attorney general shall be entitled to recover its reasonable expenses incurred in obtaining injunctive relief, including court costs, reasonable attorney's fees, reasonable investigative costs, witness fees, and deposition expenses.

SECTION 10. 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 11. 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 12. The following laws are repealed:

(1) Sections 311.002 and 311.0025, Health and Safety Code; and

(2) Section 101.203, Occupations Code.

SECTION 13. 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 14. Except as provided by Section 14 of this Act, the Texas 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 15. 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 16. (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 evaluate the information collected under this section and, on the basis of that evaluation, adopt rules under Section 1456.007, Insurance Code, as added by this Act, to be effective not later than March 1, 2009.

(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 17. This Act takes effect September 1, 2007.