SUBJECT: Consumer access to health care information, including costs and service

COMMITTEE: Public Health — favorable, without amendment

VOTE: 8 ayes — Delisi, Jackson, Cohen, Coleman, Gonzales, S. King, Olivo, Truitt

0 nays

1 absent — Laubenberg

SENATE VOTE: On final passage, April 30 — 31-0

WITNESSES: For — Jenny Fowler, Humana; Bill Hinchey, Texas Medical Association; Patricia Kolodzey, Texas Hospital Association; Stephen Norwood, Texas Ambulatory Surgery Center Society, Texas Orthopaedic Association; Will Schlotter, Capitol Anesthesiology Association, Texas Medical Group Management Association; Jared Wolfe, Texas Association of Health Plans; (*Registered, but did not testify*: Joel Ballew, Texas Health Resources; Jaime Capelo, Texas Ambulatory Surgery Center Society, Texas Society of Anesthesiologists; Jennifer Cutrer, Parkland Health and Hospital System; Shelton Green, Texas Association of Business; Michele O'Brien, CHRISTUS Santa Rosa Healthcare; John Pike, Texas Ambulatory Surgery Center Society; JR Ruiz, CHRISTUS Health)

Against — None

On — Nance Stearman, Department of State Health Services

DIGEST: SB 1731 would require the Department of State Health Services (DSHS) to create a "Consumer Guide to Health Care" on the DSHS web site that would contain information about billing policies, estimated charges, and personal liability for payment. The bill also would require the Texas Department of Insurance (TDI) to collect information about reimbursement rates that health plans pay to insurers. TDI also would be required to evaluate information collected.

Consumer Guide to Health Care web site. SB 1731 would require DSHS to make available on its website a consumer guide to health care.

The guide would include information about facility pricing practices and the correlation between a facility's average charge for a service and the actual billed charge for the service, including notice that:

- the average charge for a service varies based on the particular medical condition and recommended course of treatment;
- the average charge for a procedure or service could vary between facilities;
- the average charge by a facility for a procedure or service would vary from the facility's costs;
- the consumer could be personally liable for payment for a procedure or service;
- the consumer should contact his or her health plan regarding accurate information about plan provisions that could impact the consumer's liability for payment; and
- the consumer, if uninsured, could be eligible for a discount on facility charges based on a sliding fee scale.

The web site also would include links to other sites that provide information about quality of care data. DSHS could accept gifts and grants to fund the creation and maintenance of the website. SB 1731 also would require the Texas Medical Board (TMB) to make a consumer guide to health care available on its web site.

Requirements for health care providers. Health care providers, including health care facilities and physicians, would be required to develop, implement, and enforce written policies in plain language for the billing of services and procedures. The policies would address:

- discounting of charges to uninsured consumers;
- discounting of charges to a financially or medically indigent consumer who qualified for indigent services based on a sliding fee scale;
- providing an itemized statement;
- whether interest would be applied to any billed service not covered by a third party payor;
- the procedure for handling complaints; and
- the requirement to provide conspicuous written disclosure to the consumer about whether the health care provider participated in the consumer's health plan at the time the consumer was first admitted.

Each health care provider would post in its waiting area a clear and conspicuous notice of the availability of these policies.

Each health care provider would be required to provide an estimate of the charges for any elective service or procedure before a procedure was scheduled. The estimate would have to be provided no later than 10 days after it was requested. Each health care provider would have to advise the consumer that:

- the request for an estimate could result in a delay in the scheduling and provision of the services or procedure;
- the actual charges for the services or procedure would vary based on the person's medical condition;
- the actual charges for a service or admission could differ from the amount paid by the consumer or the consumer's health plan;
- the consumer could personally be liable for payment for the services or procedure; and
- the consumer should contact his or her health plan for accurate information regarding payment and consumer liability for payment.

A health care provider would provide to the consumer, upon request, an itemized statement of the billed services within 10 business days of the request if the request occurred within one year of the date of discharge. For services provided through an emergency room or emergency department, the health care facility would have to provide written disclosure before discharging the patient. If a consumer overpaid a health care provider, the provider would have to refund the amount of the overpayment within 30 days of its discovery.

The health care provider would provide an itemized statement of billed services to a third-party payor, including a health plan, that was or could be responsible for paying all or part of the billed services. The request would have to be made not later than one year after the date on which the payor received the claim for payment. A third-party payor could request an itemized statement of only the billed services.

Complaint procedures. A health care provider would establish and implement complaint procedures and make a good faith effort to resolve the complaint in an informal manner. If a complaint could not be resolved through the provider's complaint process, the provider would inform the consumer that he or she could file a complaint with DSHS. The provider

also would be required to provide the consumer with the contact information for DSHS.

Texas Health Care Information Council. As part of the council's duties to collect and provide data to enable Texas consumers and health plan purchasers to make informed health care decisions, SB 1731 would require the Texas Health Care Information Council to prioritize its data collection efforts on inpatient and outpatient surgical and radiological procedures from health care facilities.

TDI collection of information. SB 1731 would authorize TDI to collect data about health plan reimbursement rates and to distribute information about reimbursement rates to different geographical regions of the state. The bill would require health plans to submit information to TDI about reimbursement rates by region. TDI could require the data to be submitted in a standardized format to permit comparison. TDI could make information about reimbursement rates available on its web site and could contract with a third party to obtain this data. The bill would specify that data collected under the bill would be confidential and not subject to disclosure under the Public Information Act, and TDI would prohibit the third party contractor from selling, leasing, or publishing the data.

Requirements for health plans. A health plan that provided group coverage of more than $10 million in premiums or individual coverage of more than $2 million in premiums would be required to submit an annual report to TDI about plan costs, premiums, copayments, range of benefits, coverage areas, number of providers in the network, and other plan details. The bill would apply to health plans that provide more than $20 million in group coverage premiums. The report would be verified by two principal officers of the health plan and include pertinent plan details financial and operational, as well as benefits coverage. Annual reports would be published on TDI's web site. A health plan that failed to submit data to facilitate TDI's collection of information would be assessed an administrative penalty.

The provisions that applied to health plans also would apply to persons or entities that contracted with health plans.

Health plan required disclosures. A health plan would be required to provide notice to its enrollees about:

- the fact that a facility-based physician might not operate within the plan's network;
- facilities within provider networks in which facility-based physicians did not participate in the network; and
- the ability of a physician to balance bill the enrollee for any costs not fully reimbursed by the plan.

A health plan would be required to provide notice to its enrollees, similar to that provided by health care facilities and physicians, as to its policies for the billing of services and procedures. A health plan also would provide to an enrollee upon request, information about:

- whether a physician was a participating provider;
- whether certain health care services were covered;
- what the enrollee's personal responsibility would be for payment; and
- coinsurance amounts owed.

Form of disclosure. The commissioner of insurance would promulgate rules regarding specific disclosure requirements for health plans. The form of the disclosure would 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."

Physician required disclosures. SB 1731 would require a facility-based physician who billed a patient in a plan that did not have a contract with the physician to send a billing statement that included:

- an itemized statement of services provided;
- a conspicuous, plain language explanation that the physician was not in the health plan's network; and the health plan had paid a rate

below the billed amount;

- that the patient could file a complaint with TMB;
- that patients could discuss alternative payment arrangements;
- a telephone number to call to discuss the statement; and
- a statement that, for a bill containing an amount more than $200 above the costs paid by copayments or deductibles, that a physician could not report a patient to a debt collection agency if the patient finalized a payment plan agreement within 45 days of receiving the first billing statement.

Study of health plan networks. SB 1731 would authorize the commissioner of insurance to appoint an advisory committee to study the adequacy of the networks of health plans. The committee would be composed of physicians, hospital representatives, health plan representatives, members from associations that represent physicians, hospitals, and health plans. The members serve without compensation. The committee shall advise TDI of its findings by December 1, 2008. The advisory committee would be abolished by January 1, 2009.

Penalties and waiver. A health care provider that violated this bill would be subject to an enforcement action by the appropriate licensing agency. The provisions involving notification to consumers regarding billing, estimated charges, complaints, and refunds could not be waived, voided, or nullified by contract or agreement between the consumer and the provider. The commissioner of insurance could take disciplinary action against a licensee who violated these provisions. A violation by a physician would be grounds for an administrative penalty by TMB.

The commissioner of the Health and Human Services Commission would adopt rules to implement the bill by December 31, 2007. DSHS, TMB, and TDI would adopt rules to implement the bill by May 1, 2008.

The bill would take effect September 1, 2007, and would apply to an insurance policy issued or renewed on or after that date.

SUPPORTERS SAY:

SB 1731 would help promote transparency in the health care system. The bill represents a beneficial step in providing information to improve patient care and the patient-physician relationship. It would better educate consumers of health care about the actual costs and payment obligations for health care. Patients need accurate, current, and honest information on co-pays, deductibles, and health plan networks to make decisions in

today's health care market, especially as health savings accounts become more prevalent. In addition, the bill would help employers by providing information to help their covered employees more responsibly utilize their health care options.

Concerns that consumers would have difficulty accessing or using this information are exaggerated. The minority of consumers who did not have access to the Internet still could call a hospital, health plan, or physician to get the same information that would be available online. Furthermore, this bill would require extensive posting of information in the offices of health care providers to inform them of their rights under the bill.

The bill also would formalize complaint procedures so that consumers would first go through the facility complaint process. Once those were exhausted, the consumer could go to DSHS. SB 1731 would not foreclose any previously available complaint option.

OPPONENTS SAY:

SB 1731 would not adequately provide health care information to all consumers. Some consumers do not have computers or web access, and many do not speak English. In addition, while in theory the information provided by the bill should help keep consumers informed about the intricacies of their health plans, shopping for an in-network physician during a health care crisis is an unrealistic proposition. The bill also would grant too much discretion to facilities to create complaint procedures that could penalize consumers by requiring too many steps and requirements, thus making it difficult for consumers to progress farther in the complaint process.

NOTES:

According to the Legislative Budget Board, the bill would have no net impact to general revenue-related funds in fiscal 2008-09. However, it is estimated that TMB would require additional staff at a cost of nearly $100,000 per fiscal year, which likely would be offset with higher license fees. In addition, TDI is expected to require $1.5 million in fiscal 2008 and approximately $562,000 in each subsequent year to pay for required staff and technology. These costs likely would be offset by increased maintenance taxes.