

HEALTH AND SAFETY CODE CHAPTER 324. CONSUMER ACCESS TO HEALTH CARE INFORMATION

HEALTH AND SAFETY CODE

TITLE 4. HEALTH FACILITIES

SUBTITLE G. PROVISION OF SERVICES IN CERTAIN FACILITIES

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 1, eff. September 1, 2007.

Sec. 324.002. RULES. The executive commissioner shall

adopt and enforce rules to further the purposes of this chapter.
Added by Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 1, eff. September
1, 2007.

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 1, eff. September 1, 2007.

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 1, eff. September 1, 2007.

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 1, eff. September 1, 2007.

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 1, eff. September 1, 2007.