

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE A. HEALTH COVERAGE IN GENERAL

CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT
INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES.
This subchapter does not apply to indigent care or chronic disease care provided in or by an eleemosynary institution, sanitarium, sanitorium, mental health treatment facility, tuberculosis treatment facility, or cancer treatment facility that is owned or controlled by the state or by a unit of local government.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance policy providing hospital, nursing, medical, or surgical coverage that is issued or delivered in this state after August 27, 1973, may not include a provision that prevents the payment of benefits for expenses of a nonindigent patient incurred in a hospital facility that:

(1) is owned or controlled by the state or by a unit of local government; and

(2) regularly and customarily demands and collects from nonindigent persons payment for those expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

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) "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) "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) "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) "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) "Person" means an individual, association, partnership, corporation, or other legal entity.

(8) "Physician" means an individual licensed to practice medicine in this or another state of the United States.
Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS.
This subchapter applies to:

(1) an employee benefit plan, to the extent not preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) benefit programs under Chapters [1551](#) and [1601](#), to the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer may not deliver, renew, or issue for delivery in this state a health insurance policy that prohibits or restricts a covered person from making a written assignment of benefits to a physician or other health care provider who provides health care services to the person.

(b) This section does not:

(1) provide a coverage or benefit that is not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to:

(A) a person who is not legally entitled to receive such a direct payment; or

(B) another person if, under the health insurance policy or plan, the benefit must be provided to the covered person by a physician or other health care provider who is a contractor or preferred provider under the policy; or

(3) prohibit an insurer from verifying, through the insurer's normal process, the health care services the physician or other health care provider provides to the covered person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT. An insurer shall pay benefits directly to a physician or other health care provider, and the insurer is relieved of the obligation to pay, and of any liability for paying, those benefits to the covered person if:

(1) the covered person makes a written assignment of those benefits payable to the physician or other health care provider; and

(2) the assignment is obtained by or delivered to the insurer with the claim for benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES

AND COPAYMENTS. (a) The payment of benefits under an assignment does not relieve a covered person of a contractual obligation to pay a deductible or copayment.

(b) A physician or other health care provider may not waive a deductible or copayment by the acceptance of an assignment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

Sec. 1204.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

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

(3) "Provider" means a person who provides health care under a license issued by this state. The term includes a health care practitioner listed in Section 1451.001 and a nurse first assistant, as defined by Section 1451.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider who seeks payment or reimbursement under a health benefit plan and the health benefit plan issuer that issued the plan shall use uniform claim billing form UB-82/HCFR or HCFR 1500, or a successor to one of those forms, as developed by the National Uniform Billing

Committee or its successor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

Sec. 1204.151. DEFINITION. In this subchapter, "policy" means an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY TEXAS DEPARTMENT OF HUMAN SERVICES. Each policy delivered or issued for delivery in this state must provide for the repayment of the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for an insured person if, under the policy, the insured person is entitled to payment for the medical expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN SERVICES FOR CERTAIN CHILDREN. (a) This section applies only to a policy that is delivered, issued for delivery, or renewed in this state and that provides coverage for a child whose parent:

- (1) purchased the policy; or
- (2) is a member of the group covered under the policy.

(b) Each policy must include a requirement that, after written notice to the insurer or group hospital service corporation at the insurer's or group hospital service corporation's home office, benefits payable on behalf of a child must be paid to the Texas Department of Human Services if:

(1) the parent who purchased the policy or who is a group member is required to pay child support by a court order or court-approved agreement and:

(A) is a possessory conservator of the child under a court order issued in this state; or

(B) is not entitled to possession of or access to

the child;

(2) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and

(3) the insurer or group hospital service corporation is notified, through an attachment to the claim for benefits at the time the claim is first submitted to the insurer or group hospital service corporation, that the benefits must be paid directly to the Texas Department of Human Services.

(c) The commissioner and the Texas Department of Human Services may consult regarding implementation of this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner shall adopt uniform policy provisions, riders, and endorsements for the policy requirement of Section 1204.153.

(b) Before the commissioner adopts or makes a change to a provision, rider, or endorsement under Subsection (a), the commissioner shall present each provision, rider, or endorsement, and any amendment to a provision, rider, or endorsement, to the Texas Department of Human Services for comment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. EXCLUSIONARY CLAUSES

Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL ASSISTANCE BENEFITS. An individual or group accident and health insurance policy delivered or issued for delivery in this state, including a policy issued by a group hospital service corporation operating under Chapter 842, may not include a provision that excludes or limits the insurer's or group hospital service corporation's coverage from paying benefits covered by Chapter 32, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP MEMBER. (a) An insurer or group hospital service corporation operating under Chapter 842 that delivers, issues for delivery, or renews in this state a group accident and health insurance policy that provides coverage for a minor child who qualifies as a dependent of a group member may pay benefits on the child's behalf to a person who is not a group member if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in this or another state.

(b) A person who is not a group member is entitled to be paid benefits under this section only if the person presents to the insurer or group hospital service corporation, with the claim application:

(1) written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a) In accordance with the terms of the policy and this subchapter, an insurer or group hospital service corporation may be required to pay benefits under a group accident and health insurance policy to a person who is not a group member and who complies with:

(1) Section 1204.251;

(2) the insurer's or group hospital service corporation's claim application procedures; and

(3) department rules.

(b) Any requirement imposed on a possessory or managing conservator of a child under this subchapter does not apply with regard to:

(1) an unpaid medical bill for which an assignment of benefits has been exercised, whether in accordance with policy provisions or otherwise; or

(2) a claim presented by a group member for which the group member paid any portion of a medical bill that is covered under the policy's terms.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.253. RULES. The commissioner may adopt rules to ensure the effective implementation of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.