

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

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, an emergency department physician, a neonatologist, or an assistant surgeon:

(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, birthing center, ambulatory surgical center, 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.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 11,

eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 2, eff. September 1, 2015.

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.

(c) This chapter does not apply to:

(1) Medicaid managed care programs operated under Chapter 533, Government Code;

(2) Medicaid programs operated under Chapter 32, Human Resources Code; or

(3) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11, eff. September 1, 2007.

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 unless the health care or medical service or supply provided to the enrollee is subject to a law prohibiting balance billing.

(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.

(c) A health benefit plan must clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the health benefit plan's provider network. Health care facilities identified under this subsection

must be identified in a separate and conspicuous manner in any provider network directory or website directory.

(d) Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 11, eff. September 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.01, eff. September 1, 2019.

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.

(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.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(1), eff. September 1, 2019.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 3, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 3, eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(1), eff. September 1, 2019.

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 Texas Medical Board.

(c) The Texas Medical Board shall:

(1) notify a facility-based physician of a finding by the Texas Medical Board 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 without penalty or reprimand.  
Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11,  
eff. September 1, 2007.

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 PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11,  
eff. September 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.02,  
eff. September 1, 2019.

Sec. 1456.007. HEALTH BENEFIT PLAN ESTIMATE OF CHARGES. A health benefit plan that must comply with this chapter under Section 1456.002 shall, on the request of an enrollee, provide 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. 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 will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and

(2) the enrollee may be personally liable for the

payment of services or supplies based upon the enrollee's health benefit plan coverage.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 11, eff. September 1, 2007.