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.

(5-a)  "Estimate" means a written statement outlining a consumer's total expected billed charges for a nonemergency elective medical service or procedure.

(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;

(C)  a hospital licensed under Chapter 241; or

(D)  a freestanding emergency medical care facility, as defined in Section 254.001, including a freestanding emergency medical care facility that is exempt from the licensing requirements of Chapter 254 under Section 254.052(8).

(8)  "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](http://capitol.texas.gov/tlodocs/80R/billtext/html/SB01731F.HTM)), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. [2256](http://capitol.texas.gov/tlodocs/81R/billtext/html/HB02256F.HTM)), Sec. 4, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 185 (S.B. [425](http://capitol.texas.gov/tlodocs/84R/billtext/html/SB00425F.HTM)), Sec. 4, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. [481](http://capitol.texas.gov/tlodocs/84R/billtext/html/SB00481F.HTM)), Sec. 1, eff. September 1, 2015.

Acts 2025, 89th Leg., R.S., Ch. 935 (H.B. [1314](http://capitol.texas.gov/tlodocs/89R/billtext/html/HB01314F.HTM)), Sec. 1, eff. September 1, 2025.

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 (S.B. [1731](http://capitol.texas.gov/tlodocs/80R/billtext/html/SB01731F.HTM)), 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;

(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;

(B)  informs consumers that a facility-based physician who may provide services to the consumer while the consumer is in the facility may not be a participating provider with the same third-party payors as the facility;

(C)  informs consumers that the consumer may receive a bill for medical services from a facility-based physician for the amount unpaid by the consumer's health benefit plan;

(D)  informs consumers that the consumer  may request a listing of facility-based physicians who have been granted medical staff  privileges to provide medical services at the facility; and

(E)  informs consumers that the consumer may request information from a facility-based physician on whether the physician has a contract with the consumer's health benefit plan and under what circumstances the consumer may be responsible for payment of any amounts not paid by the consumer's health benefit plan;

(7)  the requirement that a facility provide a list, on request, to a consumer to be admitted to, or who is expected to receive services from, the facility, that contains the name and contact information for each facility-based physician or facility-based physician group that has been granted medical staff privileges to provide medical services at the facility; and

(8)  if the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, the posting on the facility's website of a list that contains the name and contact information for each facility-based physician or facility-based physician group that has been granted medical staff privileges to provide medical services at the facility and the updating of the list in any calendar quarter in which there are any changes to the list.

(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)  A consumer is entitled to receive and a facility shall provide to a consumer an estimate of the facility's billed charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on the consumer's request and before the scheduling of the admission, procedure, or service.  Not later than five business days after receiving a request for an estimate under this subsection, the facility shall provide the estimate to the requesting consumer by e-mail.  The facility must advise the consumer that:

(1)  the request for an estimate of billed 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.

(d-1)  A facility shall include in the estimate provided under Subsection (d) information regarding the manner in which an eligible consumer may dispute final billed charges that exceed the amount specified in the estimate by $400 or more, as provided by 45 C.F.R. Section 149.620.

(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 that violates this section:

(1)  may not:

(A)  take or facilitate the taking of any third-party collection action against a consumer;

(B)  report the consumer to a credit bureau; or

(C)  pursue an action against the consumer; and

(2)  is subject to an 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 (S.B. [1731](http://capitol.texas.gov/tlodocs/80R/billtext/html/SB01731F.HTM)), Sec. 1, eff. September 1, 2007.

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Acts 2025, 89th Leg., R.S., Ch. 935 (H.B. [1314](http://capitol.texas.gov/tlodocs/89R/billtext/html/HB01314F.HTM)), Sec. 2, eff. September 1, 2025.

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 (S.B. [1731](http://capitol.texas.gov/tlodocs/80R/billtext/html/SB01731F.HTM)), 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 (S.B. [1731](http://capitol.texas.gov/tlodocs/80R/billtext/html/SB01731F.HTM)), Sec. 1, eff. September 1, 2007.