BILL ANALYSIS

Senate Research Center

S.B. 1313
By: Van de Putte
State Affairs
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DIGEST AND PURPOSE

Currently, non-network physicians or providers charge patients the balance of fees not provided by the patient's insurers during hospital visits. This practice is called "balance billing." Many patients are required to use the non-network physicians during their hospital visits and then are sent bills for the balance not paid by their insurers. As proposed, S.B. 1313 eliminates the practice of "balance billing."

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Article 20A.09, Insurance Code, as amended by Chapter 837, Chapter 905 and Chapter 1023, Acts of the 75th Legislature, Regular Session, 1997, as follows:

> (f) Requires, if medically necessary covered services are not available through network physicians or providers, or if network facilities provide or arrange to provide services to enrollees through non-network physicians or providers, the health maintenance organization, on the request of a network physician or provider, within a reasonable period, to allow referral to a non-network physician or provider and requires full reimbursement to the non-network physician or provider at the usual and customary or an agreed rate. Requires the network provider to ensure through contract, indemnity or otherwise, that the enrollee is held harmless for the payment of the cost of covered services provided by the non-network physician or provider except for applicable copayments and deductibles. Requires the evidence of coverage to provide for a review by a specialist of the same specialty or a similar specialty as the type of physician or provider to whom a referral is requested before the health maintenance organization is authorized to deny a referral.

SECTION 2. Amends Article 20A.09, Insurance Code, as amended by Chapter 163, Chapter 837, Chapter 1023 and Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, to make conforming changes.

SECTION 3. Amends Article 20A.18A, Insurance Code, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, to require all contracts or other agreements between a health maintenance organization and a physician or provider to specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services in the event the health maintenance organization fails to pay the provider for health care services, and further specify that the provider require its subcontracted physicians and providers to honor such hold harmless agreement.

SECTION 4. Amends Article 20A.18F, Insurance Code, as amended by Chapter 550, Acts of the 77th Legislature, Regular Session, 2001, to require all contracts or other agreements between a health maintenance organization and a limited provider network provider network or delegated entity to specify that the physician or provider who holds a contract with the limited provider network or delegated entity hold an enrollee harmless for payment of the cost of covered health

care services in the event the health maintenance organization fails to pay the limited provider network or delegated entity for health care services and further specify that the limited provider network or delegated entity require its subcontracted physicians and providers to honor such hold harmless agreement.

SECTION 5. Amends Sec. 3, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by adding Subparagraph (p), as follows:

> (p) Requires a preferred provider contract between an insurer and a preferred provider to contain a provision that states if the preferred provider provides or arranges to provide services to insureds through non-network physicians or providers, then the preferred provider is required to ensure through contract, indemnity or otherwise, that the insured is held harmless for the payment of the cost of covered services provided by the non-network physician or non-network provider except for applicable copayments, coinsurance and deductibles.

SECTION 6. Effective date: upon passage or September 1, 2003.