BILL ANALYSIS

H.B. 1406
By: Smithee
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Interested parties assert that many insurance providers do not share information with policyholders or health care providers regarding plan reimbursement amounts for out-of-network health care services. Additionally, there is concern that this lack of information leaves patients unable to determine their anticipated financial responsibility for health care treatment and unable to make an informed decision about whether or not they can financially afford the treatment. H.B. 1406 seeks to create a more transparent environment in which patients and physicians can make more informed decisions about health care treatment by requiring certain payment information to be shared with certain plan participants.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

H.B. 1406 amends the Insurance Code to require a health maintenance organization (HMO) to disclose to each enrollee and, if applicable, each group contract holder the methodology used by the HMO to calculate payment under the health plan for health care services provided by a physician or provider that does not participate in the HMO's delivery network. The bill requires such a disclosure to express the payment amount in terms of a percentage of the usual charge for out-of-network health care services that will be paid to the physician or provider and to include examples of the anticipated out-of-pocket payment responsibility for frequently billed health care services provided by physicians or providers that do not participate in the HMO's delivery network.

H.B. 1406 requires an HMO, at the request of an enrollee, to provide the enrollee with information, in writing or through publication on an Internet website, that allows the enrollee to determine the anticipated out-of-pocket payment responsibility for a specific health care service provided by a physician or provider that does not participate in the HMO's delivery network based on the methodology used by the HMO to calculate payment under the health plan for health care services provided by physicians and providers that do not participate in the HMO's delivery network and based on the usual charge for out-of-network health care services.

H.B. 1406 establishes comparable disclosure requirements for an insurer offering a preferred provider benefit plan with respect to health care services provided by nonpreferred providers. The bill's provisions apply only to a health plan contract or health insurance policy that is delivered, issued for delivery, or renewed on or after January 1, 2014.

EFFECTIVE DATE

September 1, 2013.