BILL ANALYSIS

Senate Research Center

S.B. 1221
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State Affairs
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1221 requires that a health plan obtain a health care provider's written consent prior to using a Medicaid-based fee schedule for reimbursement for services covered under a commercial health insurance plan. This bill is necessary to ensure that health care providers are made aware of and have the opportunity to consent to the use of Medicaid-based fee schedules for services provided to patients not covered under Medicaid.

Medicaid has historically paid lower reimbursement rates for provider services than rates paid through commercial insurance plans. Significant changes in health care scheduled to occur in 2014 have created uncertainty about the impact on providers' compensation for health care services. While providers may agree to accept a low reimbursement rate for Medicaid patients, they may or may not be willing to provide services at that rate for patients covered under commercial health plans. S.B. 1221 will ensure that, as health care changes take place, providers are made aware of and consent to accept Medicaid rates for patients not covered under the Medicaid program.

S.B. 1221 amends current law relating to use of a Medicaid-based fee schedule for reimbursement of services under a contract between a health care provider and certain health benefit plans.

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 Chapter 1451, Insurance Code, by adding Subchapter J as follows:

SUBCHAPTER J. REIMBURSEMENT OF HEALTH CARE PROVIDERS

Sec. 1451.451. REIMBURSEMENT UNDER MEDICAID-BASED FEE SCHEDULE. (a) Prohibits an insurance company, health maintenance organization, or preferred provider organization that contracts with a health care provider to provide services in connection with Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code, or Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, from requiring the health care provider to provide access to or transfer the provider's name and contracted discounted fee for use with health benefit plans issued to individuals and groups under Chapter 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges) or 1301 (Preferred Provider Benefit Plans).

(b) Authorizes an insurance company, health maintenance organization, or preferred provider organization to provide access to or transfer a provider's name and discounted fee described by Subsection (a) only if:

(1) the insurance company, health maintenance organization, or preferred provider organization provides written notice to the provider that is printed

in conspicuous boldface type near a separate signature line and includes a statement substantially similar to the following: "By signing on this line, you may be agreeing to apply this company's Medicaid or CHIP fee schedule to services you provide to commercial insurance or HMO enrollees."; and

(2) the provider authorizes the access or transfer and agrees to accept the contracted discounted fee by signing the notice described in Subdivision (1).

SECTION 2. Makes application of the change in law made by this Act prospective.

SECTION 3. Effective date: upon passage or September 1, 2013.