BILL ANALYSIS

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S.B. 425
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Freestanding emergency medical care facilities, also known as freestanding ERs (FSERs), are medical facilities that provide emergency care but are structurally separate from a hospital and can resemble urgent care clinics. Often times, an individual seeking urgent care is unable to discern between an FSER and an urgent care clinic. Issues arise when a person walks into a FSER, thinking it to be an urgent care clinic, and are then stuck with a bill similar to that of a regular emergency room visit. FSERs are more expensive than urgent care clinics because they are allowed to charge a "facility fee" to cover overhead expenses, similar to fees charged by hospital ERs.

S.B. 425 seeks to increase price transparency for consumers by requiring FSERs to post a sign containing:

- information so that an individual is fully aware that they are seeking services in a FSER, not an urgent care clinic;
- whether the facility participates in a provider network, and the providers working in the facility that do not participate in each network;
- a statement that out of network providers may bill separately from the facility; and
- the minimum and maximum amounts the physician charges and the facility fee are likely to be per visit.

S.B. 425 also grants consumers of FSERs the same opportunity to seek mediation if they are balanced billed for a facility fee in an amount greater than $1,000. This mediation option is currently available to patients of hospital ERs.

As proposed, S.B. 425 amends current law relating to health care information provided by and notice of facility fees charged by certain freestanding emergency medical care facilities and the availability of mediation.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission for the Department of State Health Services in SECTION 6 (Section 1467.003, Insurance Code) and SECTION 17 (Section 1476.101, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 241, Health and Safety Code, by adding Subchapter J, as follows:

SUBCHAPTER J. NOTICE OF FACILITY FEES IN CERTAIN FREESTANDING EMERGENCY MEDICAL CARE FACILITIES

Sec. 241.251. APPLICABILITY. Provides that this subchapter applies only to a freestanding emergency medical care facility, as that term is defined by Section 254.001, that is exempt from the licensing requirements of Chapter 254 under Section 254.052(8) (relating to a facility that is owned or operated by a certain hospital).

Sec. 241.252. NOTICE OF FEES. (a) Defines "provider network."

(b) Requires a facility described by Section 241.251 to post notice that states:

(1) that the facility is a freestanding emergency medical care facility and not an urgent care center;

(2) either that the facility does not participate in a provider network, or that the facility participates in a provider network; and

(3) any facility fee charged by the facility, including the minimum and maximum facility fee amounts charged per visit.

(c) Requires that the notice required under Subsection (b)(2)(B) (providing that the facility participates in a provider network):

(1) identify the provider network;

(2) identify each physician providing medical care at the facility who is excluded from the provider network; and

(3) for each physician described by Subdivision (2), state that the physician is authorized to bill separately from the facility for the medical care provided to a patient and provide the minimum and maximum amounts the physician charges for each patient visit.

(d) Requires that the notices required by this section be posted prominently and conspicuously at the primary entrance to the facility, in each patient treatment room, and at each location within the facility at which a person pays for health care services.

(e) Authorizes a facility that is required to post notice under this section and Section 241.183 (Rules), as added by Chapter 917 (H.B. 1376), Acts of the 83rd Legislature, Regular Session, 2013, to post the required notices on the same sign.

Sec. 241.253. REQUIRED DISCLOSURE FOR CERTAIN ENROLLEES. (a) Defines "administrator" and "enrollee."

(b) Requires a facility that bills an enrollee covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551 (Texas Employees Group Benefits Act), Insurance Code, to make a disclosure to the enrollee under this section if the facility is not a network provider for the enrollee's plan, and the facility fee amount for which the enrollee is responsible is greater than $1,000 after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer.

(c) Requires that the disclosure required under this section be made in the billing statement provided to the enrollee and include information sufficient to notify the patient of the mandatory mediation process available under Chapter 1467 (Out-of-Network Claim Dispute Resolution), Insurance Code.

SECTION 2. Amends Section 254.001, Health and Safety Code, by adding Subdivision (6) to define "provider network."

SECTION 3. Amends Subchapter D, Chapter 254, Health and Safety Code, by adding Sections 254.155 and 254.156, as follows:

Sec. 254.155. NOTICE OF FEES. (a) Requires a facility to post notice that states:

(1) that the facility is a freestanding emergency medical care facility and not an urgent care center;

(2) either that the facility does not participate in a provider network, or that the facility participates in a provider network; and

(3) any facility fee charged by the facility, including the minimum and maximum facility fee amounts charged per visit.

(b) Requires that the notice required under Subsection (a)(2)(B) (providing that the facility participates in a provider network) to:

(1) identify the provider network;

(2) identify each physician providing medical care at the facility who is excluded from the provider network; and

(3) for each physician described by Subdivision (2), state that the physician is authorized to bill separately from the facility for the medical care provided to a patient and provide the minimum and maximum amounts the physician charges for each patient visit.

(c) Requires that the notices required by this section be posted prominently and conspicuously at the primary entrance to the facility, in each patient treatment room, and at each location within the facility at which a person pays for health care services.

(d) Authorizes a facility that is required to post notice under this section to post the required notices on the same sign.

Sec. 254.156. REQUIRED DISCLOSURE FOR CERTAIN ENROLLEES. (a) Defines "administrator" and "enrollee."

(b) Requires a facility that bills an enrollee covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551, Insurance Code, to make a disclosure to the enrollee under this section if:

(1) the facility is not a network provider for the enrollee's plan; and

(2) the facility fee amount for which the enrollee is responsible is greater than $1,000 after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer.

(c) Requires that the disclosure required under this section be made in the billing statement provided to the enrollee and include information sufficient to notify the patient of the mandatory mediation process available under Chapter 1467, Insurance Code.

SECTION 4. Amends Section 324.001(7), Health and Safety Code, to redefine "facility."

SECTION 5. Amends Section 1467.001, Insurance Code, by amending Subdivisions (4), (5), and (7) to redefine "facility-based physician," "mediation," and "party" and adding Subdivision (4-a) to define "freestanding emergency medical care facility."

SECTION 6. Amends Section 1467.003, Insurance Code, to require adoption of rules by the executive commissioner of the Health and Human Services Commission (executive commissioner) (HHSC) for the Department of State Health Services (DSHS).

SECTION 7. Amends Section 1467.005, Insurance Code, as follows:

Sec. 1467.005. REFORM. Provides that this chapter may not be construed to prohibit a facility-based physician or a freestanding emergency medical care facility from offering a reformed charge for medical services or a facility fee.

SECTION 8. Amends Section 1467.051, Insurance Code, as follows:

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION; EXCEPTION. (a) Authorizes an enrollee to request mediation of a settlement of an out-of-network health benefit claim if the amount for which the enrollee is responsible to a freestanding emergency medical care facility for a facility fee, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000. Makes nonsubstantive changes.

(b) Requires the facility-based physician, the freestanding medical care facility, or the physician's or facility's representative and the insurer or the administrator to participate in the mediation, except as provided by Subsections (c) and (d).

(c) Requires, except in the case of an emergency and if requested by the enrollee, to provide a complete disclosure, as set forth, to an enrollee.

(d) Includes a facility-based physician or a freestanding medical care facility in the provision under this subsection not requiring the facility to mediate under certain circumstances.

SECTION 9. Amends Section 1467.053(d), Insurance Code, to require the mediator's fees to be split evenly and paid by the insurer or administrator, and the facility-based physician or freestanding emergency medical care facility.

SECTION 10. Amends Sections 1467.054(b) and (c), Insurance Code, as follows:

(b) Requires that a request for mandatory mediation include certain information, including the name of the freestanding emergency medical care facility.

(c) Requires the Texas Department of Insurance (TDI) to notify certain persons or freestanding emergency medical care facilities, as applicable.

SECTION 11. Amends Sections 1467.055(d), (h), and (i), Insurance Code, as follows:

(d) Requires the mediator to inform the enrollee that if the enrollee is not satisfied with the mediated agreement, the enrollee is authorized to, as applicable, file a complaint with certain entities and DSHS against the freestanding emergency medical care facility for improper billing; makes nonsubstantive changes.

(h) and (i) Includes the facility-based physician or freestanding emergency medical care facility in these subsections regarding collection efforts and services provided.

SECTION 12. Amends Sections 1467.056(a), (b), and (d), Insurance Code, by including the facility-based physician or freestanding emergency medical care facility and facility fee in the provisions of these subsections regarding certain requirements in a mediation.

SECTION 13. Amends Section 1467.057(a), Insurance Code, to require the mediator of an unsuccessful mediation under this chapter to report the outcome of the mediation to TDI, the Texas Medical Board (TMB) when the mediation involves a facility-based physician, DSHS when the mediation involves a freestanding emergency medical care facility, and the chief administrative judge, and makes nonsubstantive changes.

SECTION 14. Amends Section 1467.058, Insurance Code, to authorize the facility-based physician or the freestanding emergency medical care facility and the insurer or administrator, as applicable, to elect to continue the mediation to further determine their responsibilities.

SECTION 15. Amends Section 1467.059, Insurance Code, to require the mediator to prepare a confidential mediation agreement and order that states the total amount for which the enrollee will be responsible to the facility-based physician or freestanding emergency medical care facility, after copayments, deductibles, and coinsurance, and any agreement reached by the parties under Section 1467.058 (Continuation of Mediation).

SECTION 16. Amends Section 1467.060, Insurance Code, as follows:

> Sec. 1467.060. REPORT OF MEDIATOR. Requires the mediator to report to the commissioner of insurance and, as applicable, to TMB when the mediation involves a facility-based physician or DSHS when the mediation involves a freestanding emergency medical care facility certain information.

SECTION 17. Amends Section 1467.101(c), Insurance Code, to require a mediator to report bad faith mediation to the commissioner, the Texas Medical Board, or the Department of State Health Services, as appropriate, following the conclusion of the mediation.

SECTION 18. Amends Sections 1467.151(a), (b), and (c), Insurance Code, as follows:

> (a) Requires the commissioner, TMB, and the executive commissioner of HHSC for DSHS, as appropriate, to adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. Requires the rules adopted under this section to accomplish the criteria set forth in this subsection.
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> (b) Requires TDI, TMB, and DSHS to maintain information:
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> > (1) Makes no change to this subsection;
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> > (2) related to a claim that is the basis of an enrollee complaint, including:
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> > > (A) the type of services or fee that gave rise to the dispute;
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> > > (B) the type and specialty of the facility-based physician who provided the out-of-network service, if any;
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> > > (C) the county and metropolitan area in which the medical service or supply was provided or facility fee was charged, as applicable;
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> > > (D) whether the medical service or supply or facility fee was for emergency care; and
> > >
> > > (E) any other information about the insurer or administrator that the commissioner by rule requires, the physician that TMB by rule requires, or the freestanding emergency medical care facility that the executive commissioner by rule requires for DSHS.
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> (c) Provides that the information collected and maintained by TDI, TMB, and DSHS under Subsection (b)(2) is public information as defined by Section 552.002, Government Code, and is prohibited from including personally identifiable information or medical information.

SECTION 19. (a) Requires, not later than December 1, 2015, the executive commissioner of the Health and Human Services Commission to adopt the rules necessary to implement the changes in law made by this Act.

(b) Notwithstanding Subchapter J, Chapter 241 (Hospitals), Health and Safety Code, and Sections 254.155 and 254.156, Health and Safety Code, as added by this Act, a freestanding emergency medical care facility is not required to comply with those provisions until January 1, 2016.

(c) Provides that, notwithstanding Chapter 324 (Consumer Access to Health Care Information), Health and Safety Code, as amended by this Act, a freestanding emergency medical care facility is not required to comply with Chapter 324, Health and Safety Code, until January 1, 2016.

(d) Provides that, notwithstanding Chapter 1467 (Out-of-Network Claim Dispute Resolution), Insurance Code, as amended by this Act, a mandatory mediation applies only to a facility fee that is incurred on or after January 1, 2016. Provides that a facility fee incurred before January 1, 2016, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 20. Effective date: September 1, 2015.