BILL ANALYSIS

Senate Research Center
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S.B. 481
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities for a procedure or an emergency is ultimately responsible for an unexpected bill.

Prior to the passage of H.B. 2256, 81st Legislature, Regular Session, 2009, there was no remedy for this unexpected bill other than the patient attempting to set up a payment plan with the facility-based physician. H.B. 2256 established a new mediation process for consumers who are balanced billed.

Mediation is working for consumers when it is available. In the past year, mediations have saved consumers millions and virtually all claims have been settled.

Despite the success of mediation, balance billing continues to be common practice and it has become increasingly difficult for consumers to avoid being balance billed in emergency care situations.

S.B. 481 seeks to further protect consumers from the balance billing process. The bill expands the options for consumers to go to mediation when they are balance billed by simply eliminating the current $1,000 threshold for claims eligible for mediation.

As proposed, S.B. 481 amends current law relating to notice and availability of mediation for balance billing by a facility-based physician.

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 Section 324.001(8), Health and Safety Code, to redefine "facility-based physician" to include an assistant surgeon.

SECTION 2. Amends Section 1456.001(3), Insurance Code, to redefine "facility-based physician" to include an assistant surgeon.

SECTION 3. Amends Section 1456.004(c), Insurance Code, as follows:

> (c) Requires a facility-based physician who bills a patient covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551 (Texas Employees Group Benefits Act) that does not have a contract with the facility-based physician to send a billing statement to the patient that contains a conspicuous, plain-language explanation of the mandatory mediation process available under Chapter 1467 (Out-of-Network Claim Dispute Resolution) if the enrollee is responsible to the physician, after copayments, deductibles, and coinsurance, for an amount unpaid by the administrator or

insurer, rather than requires a facility-based physician who bills a patient covered by such a plan under Chapter 1551 that does not have a contract with the facility-based physician to send a billing statement to the patient with information sufficient to notify the patient of the mandatory mediation process available under Chapter 1467 if the amount for which the enrollee is responsible, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000.

SECTION 4. Amends Section 1467.001(4), Insurance Code, to redefine "facility-based physician" to include an assistant surgeon.

SECTION 5. Amends Section 1467.051(a), Insurance Code, as follows:

(a) Deletes existing text authorizing 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 facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000.

SECTION 6. Makes application of Sections 1456.004(c) and 1467.051(a), Insurance Code, as amended by this Act, prospective.

SECTION 7. Effective date: September 1, 2015.