BILL ANALYSIS

C.S.H.B. 2520
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been suggested that health maintenance organizations (HMO) and insurers do too little to use prior authorization to the benefit of an enrollee or insured, as applicable, and prevent surprise medical bills. C.S.H.B. 2520 seeks to address this issue by requiring an HMO or insurer, under specified conditions, to provide certain disclosures and statements to the enrollee or insured at the time the HMO or insurer issues a determination preauthorizing an applicable service.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

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

C.S.H.B. 2520 amends the Insurance Code to require a health maintenance organization (HMO) or an insurer that preauthorizes an elective medical care or health care service to provide a disclosure to the enrollee or insured, as applicable, at the time the HMO or insurer issues a determination preauthorizing the service if the service will be provided at a licensed medical facility, is elective, and must be preauthorized as a condition of payment by the HMO or insurer.

C.S.H.B. 2520 requires the disclosure to include:

- a statement of the name and network status of any facility-based provider that the HMO or insurer reasonably expects will provide and bill for the preauthorized service or any anesthesia, pathology, or radiology services associated with the preauthorized service;
- an estimate of the payment that the HMO or insurer will make for the preauthorized service and any anesthesia, pathology, or radiology services associated with the preauthorized service and the enrollee's or insured's financial responsibility for such services;
- a statement that the actual charges and payment for the preauthorized service and the enrollee's or insured's financial responsibility for the service may vary from the estimate provided by the HMO or insurer based on certain factors;
- a certain statement that the notice may not reflect all the physicians and health care providers who may be involved in and bill for the enrollee's or insured's care; and
- a statement that the enrollee or insured may be personally liable for the amount charged for the care or services provided to the enrollee or insured depending on the enrollee's or insured's health benefit plan coverage.

C.S.H.B. 2520 establishes that a general statement that some facility-based physicians or providers may be out-of-network does not satisfy the notice requirement.

C.S.H.B. 2520 applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020.

EFFECTIVE DATE

January 1, 2020.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2520 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute changes the time at which the requisite information must be provided from a statement made within a reasonable period before the date the health care service is scheduled to be performed to a disclosure that is made on issuance of the preauthorization determination.

The substitute includes as one of the underlying conditions giving rise to required disclosure the condition that the service must be preauthorized as a condition of payment by the HMO or insurer for the service.

The substitute includes provisions requiring the disclosure statement to include a certain prescribed statement and requiring among the bill's other requisite disclosures and statements:

- the name and network status of any facility-based provider expected to provide and bill for any anesthesia, pathology, or radiology services associated with the preauthorized service;
- an estimate of the payment that will be made for such associated services; and
- an estimate of an enrollee's or insured's financial responsibility, including any copayment or other out-of-pocket amount for such associated services.