By: J. Johnson of Dallas H.B. No. 2520

A BILL TO BE ENTITLED

AN ACT

relating to disclosures by certain health benefit plans to enrollees regarding certain preauthorized medical care and health care services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter F, Chapter 843, Insurance Code, is amended by adding Section 843.2025 to read as follows:

Sec. 843.2025. DISCLOSURES CONCERNING CERTAIN PREAUTHORIZED SERVICES. (a) In this section:

(1) "Elective health care service" means a covered health care service that is scheduled in advance.

(2) "Licensed medical facility" means:

(A) a hospital licensed under Chapter 241, Health and Safety Code;

(B) an ambulatory surgical center licensed under Chapter 243, Health and Safety Code; or

(C) a birthing center licensed under Chapter 244, Health and Safety Code.

(3) "Preauthorization" has the meaning assigned by Section 843.348.

(b) If a health maintenance organization preauthorizes an elective health care service to be provided at a licensed medical facility, the health maintenance organization shall, within a reasonable period before the date the health care service is

scheduled to be performed, provide to the enrollee:

(1) a statement of the name and network status of any facility-based physician or provider that the health maintenance organization reasonably expects will provide and charge for the preauthorized service;

(2) an estimate of:

(A) the payment that will be made for the preauthorized service; and

(B) the enrollee's financial responsibility for the preauthorized service, including any copayment or other out-of-pocket amount for which the enrollee is responsible;

(3) a statement that the actual charges and payment for the health care service and the enrollee's financial responsibility for the health care service may vary from the estimate provided by the health maintenance organization based on the enrollee's medical condition and other factors associated with the performance of the health care service; and

(4) a statement that the enrollee may be personally liable for the amount charged for health care services provided to the enrollee depending on the enrollee's health benefit plan coverage.

(c) A general statement that some facility-based physicians or providers may be out-of-network does not satisfy the notice requirement of Subsection (b).

SECTION 2. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Section 1301.1355 to read as follows:

Sec. 1301.1355. DISCLOSURES CONCERNING CERTAIN

PREAUTHORIZED SERVICES. (a) In this section:

(1) "Elective medical care or health care service" means a covered medical care or health care service that is scheduled in advance.

(2) "Licensed medical facility" means:

(A) a hospital licensed under Chapter 241, Health and Safety Code;

(B) an ambulatory surgical center licensed under Chapter 243, Health and Safety Code; or

(C) a birthing center licensed under Chapter 244, Health and Safety Code.

(b) If an insurer preauthorizes an elective medical care or health care service to be provided at a licensed medical facility, the insurer shall, within a reasonable period before the date the medical care or health care service is scheduled to be performed, provide to the insured:

(1) a statement of the name and network status of any facility-based physician or health care provider that the insurer reasonably expects will provide and charge for the preauthorized service;

(2) an estimate of:

(A) the payment that will be made for the preauthorized service; and

(B) the insured's financial responsibility for the preauthorized service, including any copayment, coinsurance, deductible, or other out-of-pocket amount for which the insured is responsible;

(3) a statement that the actual charges and payment for the medical care or health care service and the insured's financial responsibility for the medical care or health care service may vary from the estimate provided by the insurer based on the insured's medical condition and other factors associated with the performance of the medical care or health care service; and

(4) a statement that the insured may be personally liable for the amount charged for medical care or health care services provided to the insured depending on the insured's health benefit plan coverage.

(c) A general statement that some facility-based physicians or health care providers may be out-of-network does not satisfy the notice requirement of Subsection (b).

SECTION 3. The changes in law made by this Act apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020.

SECTION 4. This Act takes effect January 1, 2020.