

BILL ANALYSIS

C.S.H.B. 4012
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been suggested that health maintenance organizations (HMO) and insurers do not effectively use prior authorization to benefit an enrollee or insured, as applicable, and prevent surprise medical bills. C.S.H.B. 4012 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. 4012 amends the Insurance Code to require a health maintenance organization (HMO) or an insurer that preauthorizes a 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. 4012 requires the disclosure to include the following information:

- a statement of the name and network status of the licensed medical facility and any facility-based provider that the HMO or insurer reasonably expects will provide and bill for the preauthorized service or any services associated with the preauthorized service;
- an itemized estimate of the following:
 - the payments that the HMO or insurer will make to the licensed medical facility and to each facility-based provider for the preauthorized service and any services associated with the preauthorized service; and
 - the enrollee's or insured's financial responsibility for such services;
- a statement that the actual charges, payment, and financial responsibility for the services 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 medical care or health care services provided to the enrollee or insured depending on the enrollee's or insured's health benefit plan coverage.

C.S.H.B. 4012 establishes that a general statement that some facility-based physicians or providers may be out-of-network does not satisfy the requirement to provide a statement of certain providers names and network status.

C.S.H.B. 4012 applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2022.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 4012 differs from the original in minor or nonsubstantive ways by conforming to certain bill drafting conventions.