

By: Bonnen

H.B. No. 4012

Substitute the following for H.B. No. 4012:

By: Oliverson

C.S.H.B. No. 4012

A BILL TO BE ENTITLED

1 AN ACT

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

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

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

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

10 (1) "Elective" means non-emergent and able to be
11 scheduled at least 24 hours in advance.

12 (2) "Facility-based provider" means a physician or
13 provider who provides a health care service to a patient of a
14 licensed medical facility and bills for the service provided.

15 (3) "Licensed medical facility" means:

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

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

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

22 (4) "Preauthorization" has the meaning assigned by
23 Section 843.348.

24 (b) A health maintenance organization that preauthorizes an

1 enrollee's health care service shall provide a disclosure to the
2 enrollee at the time the health maintenance organization issues a
3 determination preauthorizing the service if the service:

4 (1) will be provided at a licensed medical facility;

5 (2) is elective; and

6 (3) must be preauthorized as a condition of payment by
7 the health maintenance organization for the service.

8 (c) The disclosure provided to an enrollee under Subsection
9 (b) must include:

10 (1) a statement of the name and network status of the
11 licensed medical facility and any facility-based provider that the
12 health maintenance organization reasonably expects will provide
13 and bill for the preauthorized service or any services associated
14 with the preauthorized service;

15 (2) an itemized estimate of:

16 (A) the payments that the health maintenance
17 organization will make to the licensed medical facility and to each
18 facility-based provider for the preauthorized service and for any
19 services associated with the preauthorized service; and

20 (B) the enrollee's financial responsibility,
21 including any copayment, coinsurance, deductible, or other
22 out-of-pocket amount, for the preauthorized service and any
23 services associated with the preauthorized service;

24 (3) a statement that the actual charges and payment
25 for the services and the enrollee's financial responsibility for
26 the services may vary from the estimate provided by the health
27 maintenance organization based on the enrollee's actual medical

1 condition and other factors associated with the performance of the
2 services;

3 (4) a statement substantially similar to the
4 following: "This notice may not reflect all the physicians and
5 health care providers who may be involved in and bill for your care.
6 Despite your health maintenance organization's best efforts to
7 disclose all physicians and health care providers who we reasonably
8 expect to participate in your care, circumstances, including
9 facility scheduling, staff changes, or complications, or other
10 factors associated with your care, may result in different or
11 additional physicians or health care providers providing and
12 billing for care provided to you."; and

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

17 (d) A general statement that some facility-based providers
18 may be out-of-network does not satisfy the requirement in
19 Subsection (c)(1).

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

22 Sec. 1301.1355. DISCLOSURES CONCERNING CERTAIN
23 PREAUTHORIZED SERVICES. (a) In this section:

24 (1) "Elective" means non-emergent and able to be
25 scheduled at least 24 hours in advance.

26 (2) "Facility-based provider" means a physician or
27 health care provider who provides a medical care or health care

1 service to a patient of a licensed medical facility and bills for
2 the service provided.

3 (3) "Licensed medical facility" means:

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

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

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

10 (b) An insurer that preauthorizes an insured's medical care
11 or health care service shall provide a disclosure to the insured at
12 the time the insurer issues a determination preauthorizing the
13 service if the service:

14 (1) will be provided at a licensed medical facility;

15 (2) is elective; and

16 (3) must be preauthorized as a condition of payment by
17 the insurer for the service.

18 (c) The disclosure provided to an insured under Subsection
19 (b) must include:

20 (1) a statement of the name and network status of the
21 licensed medical facility and any facility-based provider that the
22 insurer reasonably expects will provide and bill for the
23 preauthorized service or any services associated with the
24 preauthorized service;

25 (2) an itemized estimate of:

26 (A) the payments that the insurer will make to
27 the licensed medical facility and to each facility-based provider

1 for the preauthorized service and for any services associated with
2 the preauthorized service; and

3 (B) the insured's financial responsibility,
4 including any copayment, coinsurance, deductible, or other
5 out-of-pocket amount, for the preauthorized service and any
6 services associated with the preauthorized service;

7 (3) a statement that the actual charges and payment
8 for the services and the insured's financial responsibility for the
9 services may vary from the estimate provided by the insurer based on
10 the insured's actual medical condition and other factors associated
11 with the performance of the services;

12 (4) a statement substantially similar to the
13 following: "This notice may not reflect all the physicians and
14 health care providers who may be involved in and bill for your care.
15 Despite your insurer's best efforts to disclose all physicians and
16 health care providers who we reasonably expect to participate in
17 your care, circumstances, including facility scheduling, staff
18 changes, or complications, or other factors associated with your
19 care, may result in different or additional physicians or health
20 care providers providing and billing for care provided to you.";
21 and

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

26 (d) A general statement that some facility-based providers
27 may be out-of-network does not satisfy the requirement in

1 Subsection (c)(1).

2 SECTION 3. The changes in law made by this Act apply only to
3 a health benefit plan that is delivered, issued for delivery, or
4 renewed on or after January 1, 2022.

5 SECTION 4. This Act takes effect January 1, 2022.