By: Bonnen H.B. No. 4012

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" means non-emergent and able to be scheduled at least 24 hours in advance.

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

(3) "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.

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

(b) A health maintenance organization that preauthorizes an

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

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

(2) is elective; and

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

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

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

(2) an itemized estimate of:

(A) the payments that the health maintenance organization will make to:

(i) each facility-based provider for the preauthorized service and any services associated with the preauthorized service; and

(ii) the licensed medical facility for the preauthorized service and any services associated with the preauthorized service; and

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

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

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

(5) 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.

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

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" means non-emergent and able to be scheduled at least 24 hours in advance.

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

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

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

(2) is elective; and

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

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

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

preauthorized service;

(2) an itemized estimate of:

(A) the payment that the insurer will make to:

(i) each facility-based provider for the preauthorized service and any services associated with the preauthorized service; and

(ii) the licensed medical facility for the preauthorized service and any services associated with the preauthorized service; and

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

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

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

and

(5) 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.

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

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, 2022.

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