

By: Bonnen

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:

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

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

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

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

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

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

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

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

26 Sec. 1301.1355. DISCLOSURES CONCERNING CERTAIN
27 PREAUTHORIZED SERVICES. (a) In this section:

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

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

7 (3) "Licensed medical facility" means:

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

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

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

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

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

19 (2) is elective; and

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

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

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

1 preauthorized service;

2 (2) an itemized estimate of:

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

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

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

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

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

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

1 and

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

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

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

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