BILL ANALYSIS

C.S.H.B. 1236
By: Oliverson
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Emergency care is commonly defined as health care services provided to evaluate and stabilize a medical condition that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that failure to get immediate medical care could result in a serious threat to the person's health. This is known as the "prudent layperson standard." It is fundamental that the prudent layperson standard look at a patient's health based on the patient's presenting symptoms, rather than their diagnosis. Despite clear guidance, insurance plans have implemented policies that condition payment for emergency care on the patient's ultimate diagnosis, rather than the patient's presenting symptoms. This is unsafe for patients and is inconsistent with current state and federal law. The federal Emergency Medical Treatment and Labor Act (EMTALA) prohibits a hospital from seeking or directing an individual to seek insurer authorization for screening or stabilization services until after the hospital has provided a medical screening examination and initiated stabilizing treatment. Using a diagnosis to retroactively define an emergency condition also disregards the resources, time, and clinical decision-making required to screen and stabilize patients under EMTALA. Most importantly, these policies can dissuade patients from seeking care when they believe they have an emergency condition and can lead to balance billing of patients. C.S.H.B. 1236 seeks to address this issue by upholding the definition of "emergency care" in certain Insurance Code provisions regardless of the final diagnosis of the condition for which the care was sought.

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. 1236 amends the Insurance Code to clarify that the health care services provided in certain settings to evaluate and stabilize recently onset and severe medical conditions are defined as "emergency care" if they meet the prudent layperson standard based on presenting symptoms regardless of the final diagnosis of the conditions. The bill makes this clarification for purposes of health benefit plans issued by health maintenance organizations, preferred provider and exclusive provider benefit plans, and statutory provisions governing utilization review agents.

C.S.H.B. 1236 establishes that a utilization review of emergency care provided in a freestanding emergency medical care facility may consider diagnosis codes, relevant documentation, and presenting symptoms.

C.S.H.B. 1236 applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 1236 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

Whereas the introduced specified that the system for review of the medical necessity and appropriateness of health care services constituting a "utilization review" under statutory provisions governing utilization review agents included a determination that the services do not meet the definition of emergency care, the substitute removes that language and instead includes a provision absent from the introduced establishing that a utilization review of emergency care provided in a freestanding emergency medical care facility may consider diagnosis codes, relevant documentation, and presenting symptoms.