SUBJECT: Requiring health plans to disclose certain preauthorization information

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Oliverson, Vo, J. González, Hull, Israel, Middleton, Sanford

2 nays — Paul, Romero

WITNESSES: For — Ezequiel Silva, Texas Medical Association; Lillian Timon, Texas MGMA; (*Registered, but did not testify*: Allison Greer, CHCS; Kyle Frazier, Patient Choice Coalition of Texas; David Reynolds, Texas Chapter of the American College of Physicians; Kaden Norton, Texas Chiropractic Association; Clayton Stewart, Texas Medical Association; Bobby Hillert, Texas Orthopaedic Association; Michael Grimes, Texas Radiological Society; Khrystal Davis, Texas Rare Alliance; Bonnie Bruce and Michael Warner, Texas Society of Anesthesiologists; Price Ashley, Texas Society of Pathologists)

Against — Jamie Dudensing, Texas Association of Health Plans; (*Registered, but did not testify*: Patricia Kolodzey, Blue Cross Blue Shield of Texas; Eric Glenn, Superior Health Plan; Shannon Meroney, Texas Association of Health Underwriters; Calvin Tillman)

On — (*Registered, but did not testify*: Kenisha Schuster, Texas Department of Insurance)

BACKGROUND: Insurance Code sec. 843.348 governs the preauthorization process used by health maintenance organizations for health care services.

Sec. 1301.135 governs the preauthorization process used by insurers of preferred provider benefit plans for medical care and health care services.

DIGEST: CSHB 4012 would require a health maintenance organization (HMO) and a preferred provider benefit plan insurer that preauthorized an enrollee's health care service to disclose certain information to the enrollee.

Disclosure. The bill would require an HMO or insurer to provide a disclosure to the enrollee at the time the HMO or insurer issued a determination preauthorizing the service if the service:

- would be provided at a licensed medical facility;
- was elective; and
- was required to be preauthorized as a condition of payment by the HMO or insurer for the service.

Under the bill, "licensed medical facility" would mean a licensed hospital, ambulatory surgical center, or a birthing center. "Elective" would mean non-emergent and able to be scheduled at least 24 hours in advance.

The required disclosure would have to include certain information, including:

- 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 would provide and bill for the preauthorized services;
- a statement that the actual charges and payment for the services and the enrollee's financial responsibility for the services could vary; and
- a statement that the enrollee could be personally liable for the amount charged for services provided to the enrollee depending on the enrollee's health benefit plan coverage.

The disclosure also would have to include an itemized estimate of the payments that the HMO or insurer would make to the licensed medical facility and to each facility-based provider for the preauthorized service; and the enrollee's cost-sharing responsibility for the preauthorized service.

Including a general statement in the required disclosure that some facility-based providers could be out-of-network would not satisfy the bill's requirements.

The bill would take effect January 1, 2022, and would apply only to a health benefit plan issued or renewed on or after the effective date.

SUPPORTERS SAY:

CSHB 4012 would improve price transparency and could reduce surprise medical bills for consumers by requiring health plans to disclose certain health care cost information for preauthorized services in addition to the network status of a provider and facility.

Currently, preauthorization requirements are burdensome for health care providers and can delay patients' access to health care services they need. Additionally, health care prices often are opaque, leaving consumers without sufficient information to make decisions on health care services. The bill would increase a patient's access to health care cost information, empowering them to make more informed decisions about their health care for preauthorized services.

CRITICS SAY:

CSHB 4012 could duplicate existing transparency requirements of certain federal regulations. Also, preauthorizations are unrelated to cost, and instead, evaluate whether a requested health care service is medically necessary and appropriate for a particular patient. Preauthorizations should not be used for price transparency efforts.