BILL ANALYSIS

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S.B. 1747
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Third-party administrators assist businesses that self-fund their health insurance costs to control and contain health care spending. Often times, these third-party administrators perform an extensive review of a facility billing to ensure they are only paying for actual performed services and that there are no duplications or mistakes. This review process often takes time and can result in delayed payment to the facility.

As proposed, S.B. 1747 requires a facility to provide an itemized statement to a third-party payor for charges that exceed $20,000 and allows that statement to be provided in an electronic format. S.B. 1747 also restricts the length of time that a preferred provider can retrospectively require a third-party payor to repay inaccurately paid claims to 180 days.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 324.001, Health and Safety Code, by adding Subdivision (8), to define "preferred provider."

SECTION 2. Amends Section 324.101, Health and Safety Code, by amending Subsections (e) and (f) and adding Subsections (f-1)-(f-6), as follows:

(e) Requires a health care facility (facility) to provide to the consumer at the consumer's request an itemized statement of the billed charges, rather than services, if the consumer requests the statement not later than the first anniversary of the date the person is discharged from the facility. Authorizes the facility to provide the consumer with an electronic copy of the itemized statement.

(f) Requires the facility, if the billed charges exceed $20,000, to provide an itemized statement of the billed charges to a third-party payor who is actually or potentially responsible for paying all or part of the billed charges for providing services, rather than billed services provided, to a patient. Requires the facility to provide the statement to the payor with the facility's claim for payment. Deletes existing text requiring a facility to provide an itemized statement of billed services to a third-party payor who is actually or potentially responsible for paying all or part of the billed services provided to a patient and who has received a claim for payment of these services. Deletes existing text requiring the third-party payor, to be entitled to receive a statement, to request the statement from the facility and have received a claim for payment. Deletes existing text requiring that the request be made not later than one year after the date on which the payor received the claim for payment.

(f-1) Authorizes a third-party payor to request an itemized statement for billed charges of $20,000 or less.

(f-2) Authorizes a third-party payor, after receiving an itemized statement under Subsection (f) or (f-1), to request additional information, including medical records and operative reports.

(f-3) Requires the facility to provide the statement requested under Subsection (f-1) or information requested under Subsection (f-2) as soon as practicable. Authorizes the third-party payor and the facility to agree to allow the itemized statement and the additional information to be requested simultaneously to facilitate investigation and payment of billed charges. Prohibits the days between the date a third-party payor requests an itemized statement or additional information from the facility and the date the payor receives the statement or information from being counted in a payment period established by statute or under contract.

(f-4) Authorizes the facility to provide the third-party payor with an electronic copy of an itemized statement under this section. Deletes existing text requiring that the statement be provided not later than the 30th day after the date on which the payor requests the statement.

(f-5) Creates this subsection from existing text. Entitles the third-party payor, if a third-party payor receives a claim for payment of part of the billed services, to an itemized statement of only the billed charges for which payment is claimed or to which any deduction or copayment applies. Deletes existing text authorizing the third-party payor, if a third-party payor receives a claim for payment of part, but not all of the billed services, to request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

(f-6) Requires a third-party payor that requests an itemized statement or additional information under Subsection (f-1) or (f-2) to have evidence sufficient to prove the date the payor made the request, which may include a certified mail receipt or an electronic date stamp. Provides that, unless rebutted by sufficient evidence provided by a facility, the date the payor receives the statement or additional information, as shown in the payor's records, is presumed to be the date of receipt for purposes of Subsection (f-3).

SECTION 3. Amends Section 324.103, Health and Safety Code, as follows:

Sec. 324.103. New heading: WAIVER PROHIBITED. Prohibits the provisions of this chapter from being waived, voided, or nullified by a contract or an agreement between a facility and a consumer or third-party payor.

SECTION 4. Amends Subchapter C, Chapter 324, Health and Safety Code, by adding Sections 324.104-324.106, as follows:

Sec. 324.104. CLAIM FOR PAYMENT FROM PREFERRED PROVIDER. (a) Requires a preferred provider that directly or through its agent or assignee asserts that a claim for payment of a medical or health care service or supply provided to a consumer, including a claim for payment of the amount due for a disallowed discount on the service or supply provided, has not been timely or accurately paid to provide written notification of the nonpayment or inaccuracy to the third-party payor not later than the 180th day after the earlier of the date the preferred provider received payment from the payor or the date that payment was due. Provides that a preferred provider or agent that fails to provide the notification before the 180th day is barred from asserting the claim of nonpayment or inaccuracy.

(b) Requires the preferred provider on request of a third-party payor, if a patient is admitted to a preferred provider for more than 15 days, to provide an interim statement of the facility's billed charges to the third-party payor not later than the 10th day after the date the third-party payor submits the request.

Sec. 324.105. OVERPAYMENT AND REIMBURSEMENT. (a) Requires the preferred provider, not later than the 45th day after the date a preferred provider receives a written notice of overpayment and request for reimbursement from a third-party payor or the preferred provider makes a determination that it has received an overpayment, to reimburse the third-party payor for any payment amount that exceeds the amount owed to the preferred provider for an eligible charge.

(b) Requires a preferred provider that fails to make a reimbursement required by this section to pay, in addition to the reimbursement, a late payment penalty in an amount equal to 10 percent of the amount of the required reimbursement.

Sec. 324.106. COLLECTION OF BILLED CHARGES BY OTHERS. Requires a person collecting a billed charge of a facility subject to this chapter to comply with the requirements of this chapter before submitting a demand for payment. Provides that this section applies without regard to whether the person collecting the billed charge is acting on behalf of the facility or otherwise.

SECTION 5. Makes application of this Act prospective.

SECTION 6. Effective date: September 1, 2009.