BILL ANALYSIS

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S.B. 800
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Currently, most people purchase health insurance through either a health maintenance organization (HMO) or a preferred provider plan (PPP). Under the current system, patients who try to utilize the out-of-network benefits that they pay for under a PPP policy, have no way of knowing what their financial obligations will be any time they seek treatment.

As it stands now, the patient chooses his or her health care provider to perform a treatment procedure. After the treatment is completed, the health care provider submits his or her billed charges to the insurance company. When the insurance company receives the bill from the provider, it is processed and at some point in time the health care provider is sent payment (or sometimes no payment). The patient is then responsible for the remainder of the unpaid bill which is commonly referred to as "balance billing."

The problem in the current situation is that neither the policyholders (patients) nor the health care provider are ever able to avail themselves of what the insurance company is going to reimburse or even what the reimbursement methodology is to make the calculation.

S.B. 800 seeks to create a more transparent environment for patients and physicians alike when trying to navigate through health insurance policies by requiring insurance carriers to tell policyholders what the out-of-network costs would be for a medical procedure, as well as how the insurance carrier arrived at that cost.

As proposed, S.B. 800 amends current law relating to the disclosure of the calculation of out-of-network payments by the issuers of preferred provider benefit plans and by health maintenance organizations.

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 Subchapter F, Chapter 843, Insurance Code, by adding Section 843.212, as follows:

Sec. 843.212. CALCULATION OF NONPARTICIPATING PROVIDER PAYMENTS. (a) Defines, in this section, "usual charge for out-of-network health care services."

(b) Requires a health maintenance organization to disclose to each enrollee and, if applicable, each group contract holder the methodology used by the health maintenance organization to calculate payment under the health plan for health care services provided by a physician or provider that does not participate in the health maintenance organization's delivery network. Requires that the disclosure required by this section express the payment amount in terms of a percentage of the usual charge for out-of-network health care services that will be paid to the physician or provider and include examples of the anticipated out-of-pocket payment responsibility for frequently billed health care services provided by

physicians or providers that do not participate in the health maintenance organization's delivery network.

(c) Requires a health maintenance organization to, at the request of an enrollee, provide the enrollee with information, in writing or through publication on an Internet website, that allows the enrollee to determine the anticipated out-of-pocket payment responsibility for a specific health care service provided by a physician or provider that does not participate in the health maintenance organization's delivery network based on the methodology used by the health maintenance organization to calculate payment under the health plan for health care services provided by physicians and providers that do not participate in the health maintenance organization's delivery network and the usual charge for out-of-network health care services.

SECTION 2. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.010, as follows:

Sec. 1301.010. CALCULATION OF NONPREFERRED PROVIDER PAYMENTS. (a) Defines, in this section, "usual charge for out-of-network health care services."

(b) Requires an insurer offering a preferred provider benefit plan to disclose to each insured and, if applicable, each group policy holder the methodology used by the insurer to calculate payment under the plan for health care services provided by nonpreferred providers. Requires that the disclosure required by this section express the payment amount in terms of a percentage of the usual charge for out-of-network health care services that will be paid to the provider and include examples of the anticipated out-of-pocket payment responsibility for frequently billed health care services provided by nonpreferred providers.

(c) Requires an insurer offering a preferred provider benefit plan to, at the request of an insured, provide the insured with information, in writing or through publication on an Internet website, that allows the insured to determine the anticipated out-of-pocket payment responsibility for a specific health care service provided by a nonpreferred provider based on the methodology used by the insurer to calculate payment under the plan for health care services provided by nonpreferred providers and the usual charge for out-of-network health care services.

SECTION 3. Makes application of this Act prospective to January 1, 2014.

SECTION 4. Effective date: September 1, 2013.