BILL ANALYSIS

C.S.S.B. 481
By: Hancock
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which the physician practices. Although interested parties contend that the mediation process created in response to recently enacted legislation is working for consumers when it is available, concerns remain that balance billing continues to be common practice and it has become increasingly difficult for consumers to avoid in emergency care situations. C.S.S.B. 481 seeks to better protect consumers of medical treatment.

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.S.B. 481 amends the Health and Safety Code and Insurance Code to add an assistant surgeon to the definition of "facility-based physician" for purposes of statutory provisions relating to consumer access to health care information, disclosure of provider status, and out-of-network claim dispute resolution.

C.S.S.B. 481 amends the Insurance Code to revise the content of the billing statement that a facility-based physician who bills a patient covered by a preferred provider benefit plan or a health benefit plan under the Texas Employees Group Benefits Act that does not have a contract with the facility-based physician is required to send to the patient to specify that the statement contain a conspicuous, plain-language explanation of the mandatory mediation process available under statutory provisions relating to out-of-network claim dispute resolution under certain conditions, instead of contain information sufficient to notify the patient of such mediation process under certain conditions. The bill revises the monetary condition triggering the requirement that the statement be sent from the amount for which the enrollee is responsible to the physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, being greater than $1,000 to such an amount being greater than $500.

C.S.S.B. 481 lowers from $1,000 to $500 the threshold amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer above which an enrollee is authorized to request mediation of a settlement of an out-of-network health benefit claim.

EFFECTIVE DATE

September 1, 2015.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 481 may differ from the engrossed version in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the engrossed and committee substitute versions of the bill.

ENGROSSED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 324.001(8), Health and Safety Code, is amended.	SECTION 1. Same as engrossed version.
SECTION 2. Section 1456.001(3), Insurance Code, is amended.	SECTION 2. Same as engrossed version.
SECTION 3. Section 1456.004(c), Insurance Code, is amended to read as follows: (c) A facility-based physician who bills a patient covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551 that does not have a contract with the facility-based physician shall send a billing statement to the patient that contains a conspicuous, plain-language explanation [~~with information sufficient to notify the patient~~] of the mandatory mediation process available under Chapter 1467 if [~~the amount for which~~] the enrollee is responsible to the physician, after copayments, deductibles, and coinsurance, for an [~~including the~~] amount unpaid by the administrator or insurer[~~, is greater than $1,000~~].	SECTION 3. Same as engrossed version.
SECTION 4. Section 1467.001(4), Insurance Code, is amended.	SECTION 4. Same as engrossed version.
SECTION 5. Section 1467.051(a), Insurance Code, is amended to read as follows: (a) An enrollee may request mediation of a settlement of an out-of-network health benefit claim if: (1) [~~the amount for which~~] the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, for an [~~including the~~] amount unpaid by the administrator or	SECTION 5. Same as engrossed version.

insurer[~~, is greater than $1,000~~]; and	greater than $500 [~~$1,000~~]; and
(2) the health benefit claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator.	(2) the health benefit claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator.
SECTION 6. Sections 1456.004(c) and 1467.051(a), Insurance Code, as amended by this Act, apply only to charges for a medical service or supply provided on or after the effective date of this Act. Charges for a medical service or supply provided before the effective date of this Act are governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 6. Same as engrossed version.
SECTION 7. This Act takes effect September 1, 2015.	SECTION 7. Same as engrossed version.