

1 AN ACT

2 relating to health benefits offered by certain nonprofit  
3 agricultural organizations.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

5 SECTION 1. Subtitle C, Title 8, Insurance Code, is amended  
6 by adding Chapter 1275 to read as follows:

7 CHAPTER 1275. BALANCE BILLING PROHIBITIONS AND OUT-OF-NETWORK  
8 CLAIM DISPUTE RESOLUTION FOR CERTAIN PLANS

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1275.001. DEFINITIONS. In this chapter:

11 (1) "Enrollee" means an individual enrolled in a  
12 health benefit plan to which this chapter applies.

13 (2) "Usual and customary rate" means the relevant  
14 allowable amount as described by the applicable master benefit plan  
15 document.

16 Sec. 1275.002. APPLICABILITY OF CHAPTER. This chapter  
17 applies to a health benefit plan offered by a nonprofit  
18 agricultural organization under Chapter 1682.

19 Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE.

20 (a) The administrator of a health benefit plan to which this  
21 chapter applies shall provide written notice in accordance with  
22 this section in an explanation of benefits provided to the enrollee  
23 and the physician or health care provider in connection with a  
24 health care or medical service or supply provided by an

1 out-of-network provider. The notice must include:

2 (1) a statement of the billing prohibition under  
3 Section 1275.051, 1275.052, or 1275.053, as applicable;

4 (2) the total amount the physician or provider may  
5 bill the enrollee under the enrollee's health benefit plan and an  
6 itemization of copayments, coinsurance, deductibles, and other  
7 amounts included in that total; and

8 (3) for an explanation of benefits provided to the  
9 physician or provider, information required by commissioner rule  
10 advising the physician or provider of the availability of mediation  
11 or arbitration, as applicable, under Chapter 1467.

12 (b) The administrator shall provide the explanation of  
13 benefits with the notice required by this section to a physician or  
14 health care provider not later than the date the administrator  
15 makes a payment under Section 1275.051, 1275.052, or 1275.053, as  
16 applicable.

17 Sec. 1275.004. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION.  
18 Chapter 1467 applies to a health benefit plan to which this chapter  
19 applies, and the administrator of a health benefit plan to which  
20 this chapter applies is an administrator for purposes of that  
21 chapter.

22 SUBCHAPTER B. PAYMENTS FOR CERTAIN SERVICES; BALANCE BILLING

23 PROHIBITIONS

24 Sec. 1275.051. EMERGENCY CARE PAYMENTS. (a) In this  
25 section, "emergency care" has the meaning assigned by Section  
26 1301.155.

27 (b) The administrator of a health benefit plan to which this

1 chapter applies shall pay for covered emergency care performed by  
2 or a covered supply related to that care provided by an  
3 out-of-network provider at the usual and customary rate or at an  
4 agreed rate. The administrator shall make a payment required by  
5 this subsection directly to the provider not later than, as  
6 applicable:

7 (1) the 30th day after the date the administrator  
8 receives an electronic claim for those services that includes all  
9 information necessary for the administrator to pay the claim; or

10 (2) the 45th day after the date the administrator  
11 receives a nonelectronic claim for those services that includes all  
12 information necessary for the administrator to pay the claim.

13 (c) For emergency care subject to this section or a supply  
14 related to that care, an out-of-network provider or a person  
15 asserting a claim as an agent or assignee of the provider may not  
16 bill an enrollee in, and the enrollee does not have financial  
17 responsibility for, an amount greater than an applicable copayment,  
18 coinsurance, and deductible under the enrollee's health benefit  
19 plan that:

20 (1) is based on:

21 (A) the amount initially determined payable by  
22 the administrator; or

23 (B) if applicable, a modified amount as  
24 determined under the administrator's internal appeal process; and

25 (2) is not based on any additional amount determined  
26 to be owed to the provider under Chapter 1467.

27 Sec. 1275.052. OUT-OF-NETWORK FACILITY-BASED PROVIDER

1 PAYMENTS. (a) In this section, "facility-based provider" means a  
2 physician or health care provider who provides health care or  
3 medical services to patients of a health care facility.

4 (b) Except as provided by Subsection (d), the administrator  
5 of a health benefit plan to which this chapter applies shall pay for  
6 a covered health care or medical service performed for or a covered  
7 supply related to that service provided to an enrollee by an  
8 out-of-network provider who is a facility-based provider at the  
9 usual and customary rate or at an agreed rate if the provider  
10 performed the service at a health care facility that is a  
11 participating provider. The administrator shall make a payment  
12 required by this subsection directly to the provider not later  
13 than, as applicable:

14 (1) the 30th day after the date the administrator  
15 receives an electronic claim for those services that includes all  
16 information necessary for the administrator to pay the claim; or

17 (2) the 45th day after the date the administrator  
18 receives a nonelectronic claim for those services that includes all  
19 information necessary for the administrator to pay the claim.

20 (c) Except as provided by Subsection (d), an out-of-network  
21 provider who is a facility-based provider or a person asserting a  
22 claim as an agent or assignee of the provider may not bill an  
23 enrollee receiving a health care or medical service or supply  
24 described by Subsection (b) in, and the enrollee does not have  
25 financial responsibility for, an amount greater than an applicable  
26 copayment, coinsurance, and deductible under the enrollee's health  
27 benefit plan that:

1           (1) is based on:

2                   (A) the amount initially determined payable by  
3 the administrator; or

4                   (B) if applicable, a modified amount as  
5 determined under the administrator's internal appeal process; and

6           (2) is not based on any additional amount determined  
7 to be owed to the provider under Chapter 1467.

8           (d) This section does not apply to a nonemergency health  
9 care or medical service:

10                   (1) that an enrollee elects to receive in writing in  
11 advance of the service with respect to each out-of-network provider  
12 providing the service; and

13                   (2) for which an out-of-network provider, before  
14 providing the service, provides a complete written disclosure to  
15 the enrollee that:

16                           (A) explains that the provider does not have a  
17 contract with the enrollee's health benefit plan;

18                           (B) discloses projected amounts for which the  
19 enrollee may be responsible; and

20                           (C) discloses the circumstances under which the  
21 enrollee would be responsible for those amounts.

22           Sec. 1275.053. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER  
23 OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section,  
24 "diagnostic imaging provider" and "laboratory service provider"  
25 have the meanings assigned by Section 1467.001.

26                   (b) Except as provided by Subsection (d), the administrator  
27 of a health benefit plan to which this chapter applies shall pay for

1 a covered health care or medical service performed for or a covered  
2 supply related to that service provided to an enrollee by an  
3 out-of-network provider who is a diagnostic imaging provider or  
4 laboratory service provider at the usual and customary rate or at an  
5 agreed rate if the provider performed the service in connection  
6 with a health care or medical service performed by a participating  
7 provider. The administrator shall make a payment required by this  
8 subsection directly to the provider not later than, as applicable:

9 (1) the 30th day after the date the administrator  
10 receives an electronic claim for those services that includes all  
11 information necessary for the administrator to pay the claim; or

12 (2) the 45th day after the date the administrator  
13 receives a nonelectronic claim for those services that includes all  
14 information necessary for the administrator to pay the claim.

15 (c) Except as provided by Subsection (d), an out-of-network  
16 provider who is a diagnostic imaging provider or laboratory service  
17 provider or a person asserting a claim as an agent or assignee of  
18 the provider may not bill an enrollee receiving a health care or  
19 medical service or supply described by Subsection (b) in, and the  
20 enrollee does not have financial responsibility for, an amount  
21 greater than an applicable copayment, coinsurance, and deductible  
22 under the enrollee's health benefit plan that:

23 (1) is based on:

24 (A) the amount initially determined payable by  
25 the administrator; or

26 (B) if applicable, the modified amount as  
27 determined under the administrator's internal appeal process; and

1           (2) is not based on any additional amount determined  
2 to be owed to the provider under Chapter 1467.

3           (d) This section does not apply to a nonemergency health  
4 care or medical service:

5           (1) that an enrollee elects to receive in writing in  
6 advance of the service with respect to each out-of-network provider  
7 providing the service; and

8           (2) for which an out-of-network provider, before  
9 providing the service, provides a complete written disclosure to  
10 the enrollee that:

11           (A) explains that the provider does not have a  
12 contract with the enrollee's health benefit plan;

13           (B) discloses projected amounts for which the  
14 enrollee may be responsible; and

15           (C) discloses the circumstances under which the  
16 enrollee would be responsible for those amounts.

17           SECTION 2. The heading to Subtitle K, Title 8, Insurance  
18 Code, is amended to read as follows:

19           SUBTITLE K. CERTAIN BENEFITS AND ARRANGEMENTS THAT ARE NOT  
20 INSURANCE [~~HEALTH CARE SHARING MINISTRIES~~]

21           SECTION 3. Subtitle K, Title 8, Insurance Code, is amended  
22 by adding Chapter 1682 to read as follows:

23           CHAPTER 1682. HEALTH BENEFITS PROVIDED BY CERTAIN NONPROFIT  
24 AGRICULTURAL ORGANIZATIONS

25           Sec. 1682.001. DEFINITIONS. In this chapter:

26           (1) "Nonprofit agricultural organization" means an  
27 organization that:

1           (A) is exempt from taxation under Section 501(a),  
2 Internal Revenue Code of 1986, as an organization described by  
3 Section 501(c)(5) of that code;

4           (B) is domiciled in this state;

5           (C) was in existence prior to 1940;

6           (D) is composed of members who are residents of  
7 at least 98 percent of the counties in this state;

8           (E) collects annual dues from its members; and

9           (F) was created to promote and develop the most  
10 profitable and desirable system of agriculture and the most  
11 wholesome and satisfactory conditions of rural life in accordance  
12 with its articles of organization and bylaws.

13           (2) "Nonprofit agricultural organization health  
14 benefits" means health benefits:

15           (A) sponsored by a nonprofit agricultural  
16 organization or an affiliate of the organization;

17           (B) offered only to:

18                   (i) members of the nonprofit agricultural  
19 organization; and

20                   (ii) family members of members of the  
21 nonprofit agricultural organization;

22           (C) that are not provided through an insurance  
23 policy or other product the offering or issuance of which is  
24 regulated as the business of insurance in this state; and

25           (D) that are deemed by the nonprofit agricultural  
26 organization to be important in assisting its members to live long  
27 and productive lives.



1           (3) "Preexisting condition" means a condition present  
2 before the effective date of an individual's enrollment in  
3 nonprofit agricultural organization health benefits.

4           Sec. 1682.002. NONPROFIT AGRICULTURAL ORGANIZATION HEALTH  
5 BENEFITS AUTHORIZED. A nonprofit agricultural organization or an  
6 affiliate of the organization may offer in this state nonprofit  
7 agricultural organization health benefits.

8           Sec. 1682.003. WAITING PERIOD FOR PREEXISTING CONDITION.  
9 Notwithstanding any other provision of this chapter, a nonprofit  
10 agricultural organization that offers nonprofit agricultural  
11 organization health benefits may not require a waiting period of  
12 more than six months for treatment of a preexisting condition  
13 otherwise included in nonprofit agricultural organization health  
14 benefits.

15           Sec. 1682.004. REQUIRED DISCLOSURE BY NONPROFIT  
16 AGRICULTURAL ORGANIZATION. (a) A nonprofit agricultural  
17 organization that offers nonprofit agricultural organization  
18 health benefits must provide to an individual applying for  
19 nonprofit agricultural organization health benefits written notice  
20 that the benefits are not provided through an insurance policy or  
21 other product the offering or issuance of which is regulated as the  
22 business of insurance in this state.

23           (b) An individual must sign and return to the nonprofit  
24 agricultural organization the notice described by Subsection (a)  
25 before the individual may enroll in nonprofit agricultural  
26 organization health benefits. The nonprofit agricultural  
27 organization must:

1           (1) maintain a copy of the signed written notice for  
2 the duration of the term during which the nonprofit agricultural  
3 organization health benefits are provided to the individual; and

4           (2) at the request of the individual, provide a copy of  
5 the written notice to the individual.

6           Sec. 1682.005. NONPROFIT AGRICULTURAL ORGANIZATION NOT  
7 ENGAGED IN BUSINESS OF HEALTH INSURANCE. Notwithstanding any other  
8 provision of this code, for the purposes of offering nonprofit  
9 agricultural organization health benefits, a nonprofit  
10 agricultural organization that acts in accordance with this chapter  
11 is not a health insurer and is not engaging in the business of  
12 health insurance in this state.

13           Sec. 1682.006. RISK TRANSFER OR COVERAGE. A nonprofit  
14 agricultural organization that offers nonprofit agricultural  
15 organization health benefits under this chapter may contract with a  
16 company authorized to engage in the business of insurance in this  
17 state that is not under common control with the nonprofit  
18 agricultural organization to:

19           (1) transfer to that company all or a portion of the  
20 organization's risks arising from nonprofit agricultural  
21 organization health benefits offered under this chapter; or

22           (2) obtain insurance coverage from the company  
23 guarantying the nonprofit agricultural organization's obligations  
24 arising from nonprofit agricultural organization health benefits  
25 offered under this chapter.

26           SECTION 4. This Act takes effect September 1, 2021.

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President of the Senate

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Speaker of the House

I certify that H.B. No. 3924 was passed by the House on May 5, 2021, by the following vote: Yeas 106, Nays 39, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 3924 on May 28, 2021, by the following vote: Yeas 104, Nays 42, 2 present, not voting.

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Chief Clerk of the House

I certify that H.B. No. 3924 was passed by the Senate, with amendments, on May 22, 2021, by the following vote: Yeas 18, Nays 11.

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Secretary of the Senate

APPROVED: \_\_\_\_\_

Date

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Governor